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

JUNE 6, 2024
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Clayton Corwin, Chair	Isabel Becerra, Vice Chair
Maura Byron	Supervisor Doug Chaffee
Blair Contratto	Norma García Guillén
Veronica Kelley, DSW, LCSW	José Mayorga, M.D.
Supervisor Vicente Sarmiento	Trieu Tran, M.D.

Supervisor Donald Wagner, Alternate

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

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

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

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

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_SOHez9X7TPqj588XHnz8gQ
and Join the Meeting.
Webinar ID: **824 5757 1652**

Passcode: **031259**-- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
1. Housing and Homelessness Incentive Program Round Three Grantee Check Presentations

MANAGEMENT REPORTS
2. Chief Executive Officer Report

3. Digital Transformation Update

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

CONSENT CALENDAR
4. Minutes
   a. Approve Minutes of the May 2, 2024 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the February 15, 2024 Regular Meeting to the CalOptima Health Board of Directors' Finance and Audit Committee

5. Adopt Resolution No. 24-0606-01 Authorizing and Directing Execution of Contract MS-2425-41 with the California Department of Aging for the Multipurpose Senior Services Program

6. Adopt Resolution No. 24-0606-02 Approving and Adopting Updated CalOptima Health Human Resources Policies

7. Authorize Actions Related to CalOptima Health's Supplemental Retirement Plan

8. Approve Amended Policy for Election of Officers

9. Approve Actions Related to a Contract with Infomedia Group, Inc dba Carenet Healthcare Services

10. Authorize Property Management Contract Amendment Related to the Garden Grove Street Medicine Support Center

11. Approve Contract for Federal Advocacy Services

12. Authorize Actions Related to Utilization Management Clinical Decision Criteria Application

13. Authorize the Chief Executive Officer to Execute an Amendment to the Contract with Kennaday Leavitt PC

14. Authorize a New Delegation Agreement for Claims Payment and Processing, Credentialing, and Utilization Management Delegated Responsibilities

15. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023

16. Approve Actions Related to the Workforce Development Initiative: Training and Development Innovation Fund

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

REPORTS/DISCUSSION ITEMS

18. Approve the CalOptima Health Fiscal Year 2024-25 Operating Budget

19. Approve the CalOptima Health Fiscal Year 2024-25 Routine Capital and Digital Transformation Year Three Capital Budgets

20. Authorize Amendments to the CalOptima Health Medi-Cal Shared-Risk Group, Physician-Hospital Consortia, and Health Maintenance Organization Health Network Contracts

21. Authorize Amendments to the CalOptima Health Medi-Cal Fee-for-Service Hospital Services Contracts

22. Authorize Amendments to the CalOptima Health Medi-Cal Fee-for-Service Professional Services, Community Clinics, and Federally Qualified Health Centers Contracts

23. Authorize Amendments to the CalOptima Health Medi-Cal Fee-for-Service Ancillary Services Contracts

24. Approve Actions Related to AltaMed Health Services Medi-Cal Contract

25. Approve the CalOptima Health Comprehensive Community Cancer Screening and Support Grantees

26. Adopt the Proposed CalOptima Health Board of Directors Meeting Schedule for Fiscal Year 2024-25

27. Election of Officers of the Board of Directors for terms beginning July 1, 2024

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on June 6, 2024 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_SOHez9X7TPqj588XHnz8gQ

To **Join** from a PC, Mac, iPad, iPhone or Android device:
https://us06web.zoom.us/s/82457571652?pwd=Jfte15hhj7g2lTRbs43gTUsq7NrHiM.1

Or One tap mobile:
+16694449171,,82457571652#,,,,*031259# US
+17193594580,,82457571652#,,,,*031259# US

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

Webinar ID: 824 5757 1652
Passcode: 031259

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

PRESENTATIONS/INTRODUCTIONS

1. Housing and Homelessness Incentive Program Round Three Check Presentations – Verbal Update

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CalOptima Health

MEMORANDUM

DATE:	May 31, 2024
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — June 6, 2024, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. Governor Announces May Revision to FY 2024–25 Proposed State Budget

On Friday, May 10, Gov. Gavin Newsom released the May Revision to the Fiscal Year (FY) 2024–25 Proposed State Budget, which includes total spending of $288.1 billion ($201 billion General Fund). The May Revision estimates the budget deficit has grown to $44.9 billion, up $7 billion from the January projection of $37.9 billion. Although the governor and Legislature passed "early action" budget measures in April to reduce the original shortfall by approximately $17.3 billion, this leaves a remaining deficit of $27.6 billion. The May Revision seeks to address this balance with additional spending cuts, including in health care programs. Reductions that may impact CalOptima Health include the following:

- Diverts Managed Care Organization (MCO) tax revenues to the General Fund to support existing core services, resulting in the following changes to previously proposed MCO tax allocations:
  - Eliminates targeted rate increases (TRIs) for Medi-Cal providers that were scheduled to be effective on January 1, 2025. TRIs previously implemented on January 1, 2024, will be maintained.
  - Eliminates annual funding for Graduate Medical Education and the Medi-Cal Workforce Pool.
- Due to triggers included in the 2022 Budget Act, these previously passed initiatives will not be funded or implemented at this time:
  - Continuous Medi-Cal coverage for children ages 0–4
  - Medi-Cal share of cost reform
- Reduces funding for Equity and Practice Transformation payments to Medi-Cal providers for quality, health equity and primary care infrastructure
- Reduces funding for several behavioral health initiatives, including the Children & Youth Behavioral Health Initiative, Behavioral Health Continuum Infrastructure Program and Behavioral Health Bridge Housing Program
- Reduces funding for certain substance use disorder initiatives, including the Naloxone Distribution Project and Medication Assisted Treatment Expansion Project
- Reduces funding for multiple housing and homelessness initiatives, including the Multifamily Housing Program and the Homeless Housing, Assistance and Prevention Grant Program
- Eliminates funding for various health care workforce initiatives related to community health workers, nursing, social work, residencies and more

- Eliminates In-Home Supportive Services coverage for undocumented individuals of all ages
- Eliminates remaining funding for health enrollment navigators
- Eliminates Medi-Cal's adult acupuncture benefit
- Eliminates augmented funding for free clinics
- Eliminates ongoing funding to state and local public health

Despite these reductions, the May Revision preserves funding for CARE Court and the recent expansion of Medi-Cal coverage to undocumented adults. In addition, new funding is proposed for directed payments to children's hospitals to support access to critical services. Budget negotiations continue regarding funding for the health care worker minimum wage increases that are set to take effect this summer, pursuant to Senate Bill 525. In its initial assessment of the May Revision, the Legislative Analyst's Office concluded that the governor's proposals are largely prudent solutions to address the growing deficit but also provided additional suggestions for legislators to consider. On May 29, legislative leaders released a budget counterproposal to the May Revision, which would, of note, instead delay the future MCO TRIs from January 1, 2025 to January 1, 2026, rather than eliminate those TRIs altogether. Next, the governor and legislators will continue to negotiate a final budget, which is required to pass both houses of the State Legislature by June 15.

B. CalOptima Health Submits One-Year Update on State Audit

On May 2, 2024, CalOptima Health submitted to the California State Auditor (CSA) a one-year status update on the implementation of CSA's audit recommendations. This is the final of three updates due 60 days, six months and one year after the release of the audit report on May 2, 2023. The enclosed CSA status tracker includes our latest actions in response to the four outstanding recommendations that CSA had not yet deemed fully implemented. That document is also posted publicly on the CalOptima Health website. Specifically, on April 4, 2024, the Board approved modifications to the Non-Retaliation for Reporting Violations policy to add contractors as participants in CalOptima Health's annual, anonymous employee survey. On May 2, 2024, to address the balance of unallocated resources, the Board increased the Board-Designated Reserve Fund levels from 1.4–2.0 months to 2.5–3.0 months of consolidated capitation revenues and committed approximately $526 million over 30 months to provider rate increases (subject to formal appropriation as part of the Fiscal Year 2024–25 Operating Budget). Also on May 2, 2024, the Board approved amending the CalOptima Health Bylaws to prohibit all Board members from being employed by CalOptima Health for a period of one year after their Board terms end. With these latest actions, CalOptima Health has deemed all seven recommendations as fully implemented. While no additional updates are required at this time, CSA indicates that it will contact CalOptima Health in the fall of each year to discuss any outstanding recommendations that CSA has not yet deemed fully implemented.

C. Governor Newsom Holds Proposition 1 Press Conference

On May 14, Gov. Gavin Newsom held a press conference to provide an update on the implementation of Proposition 1, which was narrowly approved by voters during the March 5, 2024, primary election. Emphasizing that "decisions will be made in months, not years," the governor shared that state agencies will open applications for the first round of behavioral health treatment facility bonds this July, followed by applications for supportive housing bonds in late 2024. As part of the accountability measures required in Proposition 1, the governor's office has created a new website (mentalhealth.ca.gov), which will eventually include a comparative map of counties' progress on Proposition 1 requirements and related behavioral health and housing initiatives. Of note, the state is also closely monitoring counties' implementation of CARE Court.

D. CalOptima Health Is a Certified Great Place to Work

Following an employee survey in April, CalOptima Health is proud to now be a Certified Great Place to Work! Great Place to Work Certification is a highly coveted achievement that requires consistent and intentional dedication to the overall employee experience. This year, 80% of employees said it's a great place to work — 23 percentage points higher than the average U.S. company. Great Place to Work Certification is the only recognition based entirely on what employees report about their workplace experience — specifically, how consistently they experience a high-trust workplace. Great Place to Work Certification is recognized worldwide by employees and employers alike and is the global benchmark for identifying and recognizing outstanding employee experience. Every year, more than 10,000 companies across 60 countries apply for certification as a Great Place to Work. We owe our continued success to our team of dedicated employees at CalOptima Health. We celebrate and thank them for all they do to earn this incredible recognition. Please view our certified company profile here: CalOptima Health: Great Place to Work.

E. Provider Workforce Development Initiative Grants Celebrated by Recipients

During the past month, three institutions that were awarded first-round funding for the Provider Workforce Development Initiative announced their grants during special presentations:

- On April 29, Chief Executive Officer Michael Hunn presented a ceremonial check for $1.2 million to Rancho Santiago Community College District's Board of Trustees. Santiago Canyon College will use the funding for expanded programs for behavior technicians and medical assistants, and a new tuition-free program for Licensed Vocational Nurses.
- On May 3, CalOptima Health Chief Operating Officer Yunkyung Kim visited Concordia University to present a $5 million check to the Board of Trustees. The funding will be used for Concordia University's Nursing Pipeline Program to increase and diversify enrollment in Concordia's Accelerated Bachelor of Science in Nursing and ultimately boost the number of nurses joining the workforce in Orange County.
- On May 15, CalOptima Health co-hosted a press conference at Cal State Fullerton with Vice Chairman of the Board of Supervisors and CalOptima Health Board Member Doug Chaffee in the nursing school's training simulation center. The press conference announced and celebrated CalOptima Health's $5 million Provider Workforce Development Initiative grant. The funding will allow Cal State Fullerton to increase the number of Associate Degree in Nursing (ADN) to Bachelor of Science in Nursing (BSN) students in the Jump Start, Concurrent Enrollment and regular BSN programs.

Upcoming Press Conference:

- On June 5, leaders from UC Irvine, CalOptima Health and the Orange County Board of Supervisors are hosting a press conference to announce CalOptima Health's $5 million grant to UCI to help launch the NURSE-OC program to expand the nursing workforce and boost access to quality care for Medi-Cal members. This program will offer externships to 60 prelicensure nursing students and residencies to six graduate students pursuing Family Nurse Practitioner and Psychiatric Mental Health Nurse Practitioner licensure. The five-year program will aim to recruit more than 50% of participants from underrepresented groups or low-income backgrounds to promote a workforce that represents CalOptima Health's members.

F. Garden Grove Sees Reduction in Homelessness; Program Honored With Award

Every two years, the County of Orange, in compliance with HUD guidelines, conducts a Point in Time count (PIT) to establish a baseline for understanding the scope of homelessness in our county. The results of the most recent PIT have been released, demonstrating a collective 28% increase in homelessness across the county from 2022 to 2024. While there are several variables that impact this

reality, we do know that increasing service provision and permanent affordable and supportive housing are proven strategies to address and ultimately reduce homelessness. The City of Garden Grove has shown us that this strategy works! By embracing a collaborative approach by inviting vital services into their community, including CalOptima Health's Street Medicine Program, the recent PIT count showed a 39% reduction in Garden Grove's population of people experiencing homelessness compared with the prior count in 2022. We are honored to be a part of the solution to ending homelessness in Garden Grove. As further recognition, on May 8, the Association of California Cities–Orange County honored the program with its Golden Hub of Innovation Award in the category of Collaborative Community Development & Innovation, recognizing the successful partnership of the City of Garden Grove, CalOptima Health and Healthcare in Action.

G. New Senior Housing Funded in Part by CalOptima Health

On May 20, I spoke at the grand opening of Santa Angelina, a senior housing development in Placentia built by National CORE, with an investment of $1.3 million from CalOptima Health. In the past few years, we have become a major player in affordable housing and permanent supportive housing for Orange County. In fact, our funding in 2023 alone has contributed toward 1,175 units. The 65 units at Santa Angelina's are among the newest to open to address housing for our vulnerable senior population.

H. CalOptima Health Gains Media Coverage

Reflecting the media's recognition of our ongoing innovation and program development, CalOptima Health recently received the following coverage:

- California Healthline published an article on Tuesday, May 14, about CalAIM featuring a quote from an interview with Kelly Bruno-Nelson, DSW, Executive Director of Medi-Cal/CalAIM. The article also appeared on NPR.
- As a result of CalOptima Health's press conference at Cal State Fullerton to announce the $5 million Provider Workforce Development Initiative grant to the nursing program, the following media covered the news:
  - **Daily Pilot/LA Times OC** published an article online and in the Sunday, May 19, print edition on Page A4.
  - Orange County Register mentioned the grant in a piece about the nursing school.
  - Univision ran a lengthy piece about the grant and nursing student experience.
  - KNX Radio aired an interview that ran multiple times.
  - KFI Radio also aired an interview that ran multiple times.
  - CSUF Newswire posted an article announcing the news.

CalOptima Health

Fast Facts
June 2024

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

Membership Data* (as of April 30, 2024)

Total CalOptima Health Membership

928,430

Program	Members
Medi-Cal	910,806
OneCare (HMO D-SNP)	17,138
Program of All-Inclusive Care for the Elderly (PACE)	486

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for 10 months ended April 30, 2024)

	YTD Actual	YTD Budget	Difference
Revenues	$4,048,391,120	$3,394,943,442	$653,447,678
Medical Expenses	$3,699,385,794	$3,187,898,080	($511,487,714)
Administrative Expenses	$185,721,701	$213,035,296	$27,313,595
Operating Margin	$163,283,626	($5,989,934)	$169,273,560
Medical Loss Ratio (MLR)	91.4%	93.9 %	(2.5%)
Administrative Loss Ratio (ALR)	4.6%	6.3%	1.7%

Note: Totals may not add due to rounding

Reserve Summary (as of April 30, 2024)

	Amount (in millions)
Board Designated Reserves	$629.8*
Capital Assets (Net of depreciation)	$96.1
Resources Committed by the Board	$535.6
Resources Unallocated/Unassigned	$682.3*
Total Net Assets	$1,943.8

Total of Board-designated reserves and unallocated resources can support approximately 112 days of CalOptima Health's current operations.

Note: On May 2, 2024, the Board approved a commitment of $526.2 million from undesignated reserves to support Medi-Cal provider rate increases for a 30-month period. The unallocated resources balance will be reduced by this amount in the May 2024 month-end closing.

Total Annual Budgeted Revenue **$4 Billion**

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

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CalOptima Health Fast Facts

June 2024

Personnel Summary (as of May 18, 2024, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,308.9	85.85	45.45%	54.55%	6.16%
Supervisor	79	5	60%	40%	5.95%
Manager	114	6	50%	50%	5%
Director	64.75	2	100%	---%	3%
Executive	19	3	---%	100%	13.64%
Total FTE Count	1,585.6	101.9	47.89%	52.11%	6.04%

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

Provider Network Data (as of April 30, 2024)

	Number of Providers
Primary Care Providers	1,231
Specialists	9,712
Pharmacies	528
Acute and Rehab Hospitals	39
Community Health Centers	52
Long-Term Care Facilities	104

Treatment Authorizations (as of March 31, 2024)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	34.18 hours
Prior Authorization – Urgent	72 hours	19.78 hours
Prior Authorization – Routine	5 days	2.37 days

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

Member Demographics (as of April 30, 2024)

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

Language Preference	
English	55%
Spanish	30%
Vietnamese	9%
Other	2%
Korean	2%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	39%
Expansion	38%
Optional Targeted Low-Income Children	7%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Digital Transformation Update

Board of Directors Meeting
June 6, 2024

Yunkyung Kim
Chief Operating Officer

Our Mission

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

Our Vision

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

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Digital Transformation Strategy

Achieve CalOptima Health's mission and strategic vision through digital transformation

Member Experience	Seamless access to care, personalized support and communication to ensure members both are, and feel, cared for
Provider Experience	Streamlined processes to enhance the delivery of quality care, enabling same day treatment authorizations and real time claims payments
Employee Experience	Employees are equipped with the tools to succeed in delivering on the commitment to improved member and provider experience
Infrastructure & Governance	Secure, resilient and flexible infrastructure to support transformation, and alignment between the business, technology, and finance for ongoing transformation

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CalOptima Health

Digital Transformation Strategy

DELIVERABLES

	YEAR 1 DELIVERED	YEAR 2 DELIVERED
Member Experience	✓ Implemented call center call-back system ✓ Enhanced member portal	✓ Implemented texting platform ✓ Launched predictive analytics for member outreach ✓ Implemented social determinants data collection
Provider Experience	✓ Enhanced CalAIM referral system ✓ Enhanced provider portal	✓ Replaced care management system ✓ Launched robotics for claims automation
Employee Experience	✓ Increased network and device mobility ✓ Implemented encounter processing system	✓ Replaced IT/facilities service management system ✓ Implemented fraud/waste/abuse detection system ✓ Upgraded phone system ✓ Replaced recruitment and onboarding system ✓ Expanded remote access
Infrastructure & Governance	✓ Enhanced ITS staffing ✓ Implemented cybersecurity program ✓ Application clean-up and access ✓ Launched cloud migration	✓ Full system architecture ✓ Data protection/recovery system ✓ Governance model and playbook ✓ Zero Trust Network Architecture ✓ 24/7 security monitoring

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CalOptima Health

Digital Transformation Strategy

DELIVERABLES

	YEAR 3 IN FLIGHT / PLANNED
Member Experience	○ New contact center ○ Implement Customer Relations Management system ○ Website redesign ○ Unified member engagement platform
Provider Experience	○ Implement provider management system ○ Enable provider self-service for treatment authorizations ○ Implement quality reporting system ○ Unified provider engagement platform
Employee Experience	○ Replace HR systems ○ Replace finance system
Infrastructure & Governance	○ Create single source of truth for data ○ Develop data governance and access strategy ○ Eliminate VPN risk ○ Implement centralized network monitoring system (NOC) ○ Implement governance, regulatory and compliance system ○ Implement business continuity system

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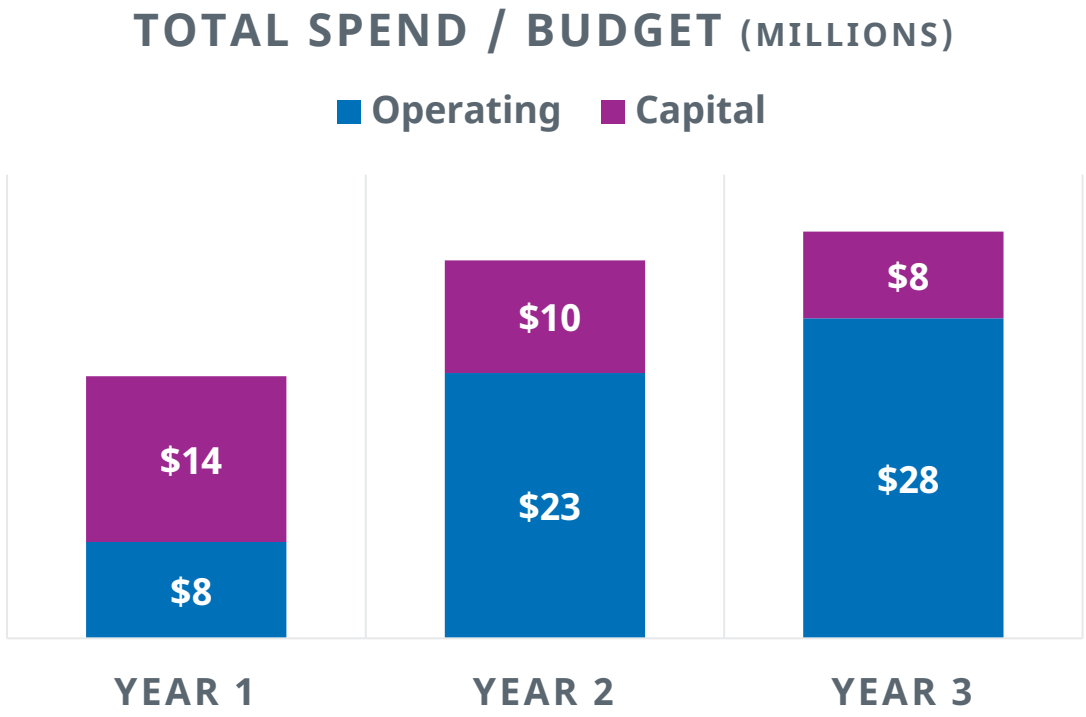
CalOptima Health

Digital Transformation Strategy

BUDGET



BUDGET AREA	ALLOCATION (MILLIONS)	% OF TOTAL
Salaries	$18	20%
Applications	$27	30%
Infrastructure	$20	22%
Data / Architecture	$9	10%
Cybersecurity	$2	2%

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MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS
May 2, 2024

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on May 2, 2024, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials. Chair Corwin called the meeting to order at 2:01 p.m., and Vice Chair Isabel Becerra led the Pledge of Allegiance.

ROLL CALL

Members Present: Clayton Corwin, Chair; Isabel Becerra, Vice Chair; Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén (left meeting at 6:00 p.m.); Veronica Kelley (non-voting); Jose Mayorga, M.D.; Supervisor Vicente Sarmiento; Trieu Tran, M.D.

(All Board members in attendance participated in person)

Members Absent: None.

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

The Clerk noted that staff would like to move Agenda Item 22, Advisory Committee Updates, up on the agenda to be heard immediately after Management Reports.

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

Michael Hunn, CEO, started his report with an opening statement that he hopes everyone is doing well and taking care of their health. Mr. Hunn added that CalOptima Health continues to be out in the community and attending various events and he has added the following to his talking points: "How are you? Are you taking care of yourself? Have you completed your annual physical? Do you have a primary care doctor? Have you had your annual checkups? Have you been screened for breast cancer? Are you taking care of your mental health and wellbeing?" Mr. Hunn asked those same questions for all who are attending in person and listening in to the CalOptima Health Board meeting today.

Mr. Hunn reviewed the Fast Facts data and reported that CalOptima Health currently serves about 932,000 individuals. CalOptima Health spends 93% of every dollar on medical care, and 4.6% is the overhead cost to administer the program.

CalOptima Health's Board-designated reserves are $632.5 million; its capital assets are $95.8 million; its

resources committed by the Board are $545.4 million; and its unallocated and unassigned resources are $588.3 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $1.8 billion.

Mr. Hunn also reviewed the CalOptima Health personnel data and noted that there are about 1,600 employees with a vacancy/turnover rate of about 6.18% as of the April 20, 2024, pay period. CalOptima Health's vacancy/turnover target is to be at less than 12.5% to 15% at any given time.

Mr. Hunn reviewed the provider data, noting that CalOptima Health has about 10,806 providers, 1,229 primary care providers, and 9,577 specialists; 538 pharmacies; 39 acute and rehab hospitals; 52 community health centers; and 104 long term care facilities.

Mr. Hunn reviewed CalOptima Health's treatment authorizations, noting that the data is as of February 29, 2024. For urgent inpatient treatment authorizations, the average approval is within 45.25 hours; the state-mandated response is 72 hours. For urgent prior authorizations, the average approval is within 24.74 hours; the state-mandated response is 72 hours. And for routine prior authorizations, the average approval is 2.2 days; the state-mandated response is 5 days.

Mr. Hunn also highlighted a few items from his CEO Report, which included leadership passing out giant checks for the workforce development initiatives at various events in the community, including an event held at Santiago Canyon College at which a total of about $1.2 million dollars in grants were distributed to grantees. He added that next week CalOptima Health will be at Cal State Fullerton to do a presentation and hand out giant checks for about $5 million dollars in grants. Mr. Hunn thanked the Board for its support and wanted the public to know that these grants are really going to be meaningful and help create the workforce of the future that will be there to take care of CalOptima Health's members. These community education investment dollars will not only touch the lives of the students and individuals that will be beneficiaries of the grant dollars but ultimately touch CalOptima Health's members for decades to come.

Mr. Hunn reported the CalOptima Health's Street Medicine Program continues to get quite a bit of media coverage. It was picked up by the CBS networks and has been streamed out over three other large metropolitan feeds across the United States. CalOptima Health's Street Medicine Program recently held a launch meeting in Costa Mesa, which was very well attended with representatives from the city of Costa Mesa, other government officials, and representatives from the fire and police departments. Mr. Hunn added that Supervisor Foley was also in attendance. He commented that it was nice to talk to everyone and share some of the success stories from the street medicine program in Garden Grove. Next step will be a kickoff meeting with the City of Anaheim. Mr. Hunn also added that pending Board approval, CalOptima Health is hoping to expand the Street Medicine Program next year into the city of Santa Ana, which has the largest number of CalOptima Health members.

Mr. Hunn provided an update on the Change Healthcare cyberattack, noting that CalOptima Health is still feeling the effects of the cyberattack. This cyberattack has been well documented in the news, and Mr. Hunn thanked Nancy Huang, Chief Financial Officer, and the finance team for their work to ensure providers are getting paid by issuing checks the old-fashioned way, manually printing the checks and mailing them out to providers. Mr. Hunn reported that Change Healthcare is slowly getting its systems back, but this ordeal has been tremendously disruptive to provider offices, hospitals, and pharmacies.

2. Fiscal Year 2024-25 Budget and Reserve Planning

Nancy Huang, Chief Financial Officer, presented a high-level budget and reserve overview for Fiscal

Year (FY) 2024-25.

Part One. Ms. Huang started by providing details on the California State (State) budget, noting that there is an estimated deficit of between $38 billion to $73 billion. On April 4, 2024, State legislative leaders and the Governor agreed to $17 billion in early budget actions to reduce the budget deficit, which did not include cuts to key health and human services programs. Ms. Huang added that CalOptima Health will know more once the Governor's May Revise is released and noted that the legislative deadline to pass the State budget is June 15, 2024. Ms. Huang reviewed CalOptima Health's January budget assumptions, which included a decrease in Medi-Cal enrollment. For FY 2024-25 there are planned Medi-Cal provider rate changes, which will increase rates for fee-for-service providers and provider capitation for professional and for hospital services. Ms. Huang also reviewed the general and administrative base costs, for which staff anticipates higher costs. She provided additional details for all the budget categories.

Part Two. Ms. Huang reviewed CalOptima Health's net asset analysis as of March 31, 2024, and noted that Board Designed Reserves were $632.5 million; Capital Assets were $95.8 million; Resources Committed by the Board were $545.4 million; and Unallocated Resources were $588.3 million. Ms. Huang noted that as of March 31, 2024, CalOptima Health's total net assets were $1.86 billion. She also reviewed the Tangible Net Equity (TNE), which as defined by the Department of Managed Health Care (DMHC) is the greater of $1 million or a percentage of premium revenues or a percentage of healthcare expenses. Ms. Huang reviewed in detail the resources committed by the Board as of March 31, 2024.

Part Three. Ms. Huang reviewed CalOptima Health's reserve planning recommendations. She reviewed a comparison of board reserve policies at other public plans, noting that CalOptima Health's Board reserve policy is 1.4 to 2.0 months of revenue. Ms. Huang reviewed recommendation one, which is to modify Policy GA.3001: Statutory and Board-Designated Reserve Funds, effective June 1, 2024. In the current policy the TNE requirement is included in the Board-designated reserve calculation. In the proposed policy, the recommendation is to create a separate reserve fund for the TNE requirement. Also, in the current policy the Board-designated reserves are at 1.4-to-2.0 months of capitation. In the proposed policy, the recommendation is that Board-designated reserves be increased to 2.0 to 3.0 months of capitation. Ms. Huang reviewed recommendation two, which is to commit CalOptima Health's reserves to support provider rate increases to improve member access to high quality care by strengthening the healthcare delivery system. The recommendation is to commit reserves to fund 2.5 years of support for Medi-Cal provider and health network rates increases. For FY 2024-25 the reserve commitment would be $210.5 million, and the total reserve commitment for 2.5 years would be $526.2 million.

Ms. Huang and Mr. Hunn responded to Board comments and questions and noted that later on the agenda the Board would vote on recommendations reviewed in the management report.

PUBLIC COMMENTS

1. Jim Peterson, Orange County Medical Association: Oral report regarding reallocation of CalOptima Health's reserves.
2. Victor Madero and Dr. Shah, Optum: Oral report in support of reallocation of CalOptima Health's reserves.
3. Peter Baronoff, KPC Hospitals Orange County: Oral report regarding Agenda Item 13, Approve Actions Related to Medi-Cal Provider Rate Increases for Fee for Service Hospitals Effective July 1, 2024.
4. Sara May, Hospital Association of Southern California: Oral report regarding Agenda Item 13,

Approve Actions Related to Medi-Cal Provider Rate Increases for Fee for Service Hospitals Effective July 1, 2024.

ADVISORY COMMITTEE UPDATES

22. Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee Update

Jena Jensen, Chair of the Provider Advisory Committee presented an update on the recent activities at the Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee held on April 11, 2024.

CONSENT CALENDAR

3. Minutes

a. Approve Minutes of the April 4, 2024 Regular Meeting of the CalOptima Health Board of Directors

4. Authorize and Direct Execution of Amendment 10 to Agreement 16-93274 (Care Coordination Agreement) with the California Department of Health Care Services in Order to Continue Operation of the Dual Eligible Special Needs Plan OneCare Program

5. Approve New CalOptima Health Policy EE.1144: Memorandum of Understanding Requirements for CalOptima Health and Third-Party Entities

6. Receive and File:

a. March 2024 Financial Summary
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Health Community Outreach and Program Summary

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 3 through 6, as presented. (Motion carried; 9-0-0)***

REPORTS/DISCUSSION ITEMS

7. Adopt Resolution No. 24-0502-01 Approving and Adopting Updated CalOptima Health Human Resources Policies

Mr. Hunn provided introductory comments noting that CalOptima Health had engaged independent compensation consultant AJ Gallagher in 2023 to perform a comprehensive market study of CalOptima Health's compensation practices. Mr. Hunn added that the last time a similar study was conducted was in 2018. Mr. Hunn then introduced Sal DiFonzo, Managing Director at AJ Gallagher. Mr. DiFonzo noted that he and Martina Young, Principal Consultant, conducted a benchmarking and analysis of CalOptima Health's compensation guidelines and salary ranges and presented an overview of the processes used and the results. Mr. DiFonzo added that AJ Gallagher's market study and analysis did not include chief and executive director positions.

After considerable discussion, the Board took the following action.

Supervisor Sarmiento noted for the record that he would be abstaining on this item.

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Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Received presentation from independent consultant AJ Gallagher on employee compensation benchmarking and analysis; and 2.) Adopted Resolution No. 24-0502-01 Approving Updated CalOptima Health Policies: a.) GA.8058: Salary Schedule and Attachment A – CalOptima Health Annual Base Salary Schedule implemented on May 5, 2024; and b.) GA.8012: Conflict of Interest and Attachments A – C. (Motion carried; 8-0-1; Supervisor Sarmiento abstained)***

8. Approve Amending the CalOptima Health Bylaws

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Approved amending the CalOptima Health Bylaws, effective May 2, 2024. (Motion carried; 9-0-0)***

9. Approve Modifications to CalOptima Health Statutory and Board-Designated Reserve Funds Policy

Ms. Huang briefly introduced this item as some discussion regarding the current and proposed reserve levels was held during the earlier Fiscal Year 2024-25 Budget and Reserve Planning Management Report. Ms. Huang reminded the Board of the current reserve levels and staff's recommendations to increase the reserve levels from the current 1.4 to 2.0 months of reserves to 2.0 to 3.0 months of reserves. After much discussion, Supervisor Chaffee amended the motion to increase the reserves to 2.5 to 3.0 months of reserves instead of the staff recommendation of 2.0 to 3.0 months of reserves.

Supervisor Sarmiento added that he will agree to the increased reserve policy if the Board reviews the reserve levels at least on an annual basis and that the Board could adjust the reserve levels if needed.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved modifications to CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds, effective June 1, 2024, which included the amended reserve level of 2.5 to 3.0 months of reserves. (Motion carried; 9-0-0)***

10. Approve Contract for Real Estate Advisory and Brokerage Services

Chair Corwin passed the gavel to Vice Chair Becerra and did not participate in this item due his role as CEO at the Stonecreek Company, which is a real estate investment, developer, and management company and has had business relationships with several of the request for proposals (RFP) respondents for real estate advisory and brokerage services, including the proposed awardee.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors authorized the Chief Executive Officer to execute an agreement with CBRE, Inc. for real estate advisory and brokerage services for a three-year term with two one-year extension options, each exercisable at CalOptima Health's sole discretion. (Motion carried; 8-0-0; Chair Corwin recused)***

11. Approve Actions Related to CalOptima Health Policy GA.5002: Purchasing

Supervisor Sarmiento made a motion to approve CalOptima Health Policy GA.5002: Purchasing, with a

recommendation to strike the word "dependent" under section II. POLICIES, A. Ethics, 4. Vendor Relations, d. Personal Conflict of Interest, section ii. "CalOptima Health's employee's, officer's, Board member's, or agent's spouse or ~~dependent~~ children;" from the approved policy.

The Board approved the new policy as amended with the word "dependent" stricken from section II(A)(4)(d)(ii) as noted above.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors retired the current version of CalOptima Health Policy GA.5002: Purchasing and approved a new CalOptima Health Policy GA.5002, effective May 2, 2024, with the word "dependent" stricken from the policy as noted above. (Motion carried; 9-0-0)***

12. Approve Actions Related to Medi-Cal Provider Rate Increases for Health Networks Effective July 1, 2024

The Clerk read into the record the entire recommended action for Agenda Item 12, noting that Agenda Items 13 through 16 have the same recommended actions and as such, would read only the changes in provider type for Agenda Items 13 through 16.

After considerable discussion regarding the provider rate increases, the Board approved Agenda Item 12 as written with the caveat that staff bring back amendments that include quality metrics in the provider contracts.

Vice Chair Becerra did not participate in this item due to her role as CEO of the Coalition of Orange County Community Health Centers and Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Healthcare.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Directed the Chief Executive Officer, or designees, to make a commitment of up to $526 million from undesignated reserves to support provider rates to ensure longer-term provider network stability, network adequacy, and access to care for CalOptima Health members throughout Orange County; and 2.) As part of this initiative, authorize the Chief Executive Officer, or designees, to develop and implement rate increases to health networks to be implemented July 1, 2024, through December 31, 2026; and 3.) Sunset the temporary, short-term supplemental Medi-Cal payment increases of up to 7.5% for health networks to support expenses for services provided to members during the transition out of the Public Health Emergency, effective for dates of service on and after July 1, 2024. (Motion carried; 7-0-0; Vice Chair Becerra and Director Mayorga recused)***

13. Approve Actions Related to Medi-Cal Provider Rate Increases for Fee for Service Hospitals Effective July 1, 2024

Chair Corwin passed the gavel to Vice Chair Becerra and did not participate in this item due to his affiliation with Pomona Valley Hospital, and Director Mayorga did not participate in this item due to his role as Executive Director of UC Irvine Healthcare.

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After considerable discussion regarding the provider rate increases, the Board approved Agenda Item 13 as written with the caveat that staff bring back amendments that include quality metrics in the provider contracts.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Directed the Chief Executive Officer, or designees, to make a commitment of up to $526 million from undesignated reserves to support provider rates to ensure longer-term provider network stability, network adequacy, and access to care for CalOptima Health members throughout Orange County; and 2.) As part of this initiative, authorized the Chief Executive Officer, or designees, to develop and implement rate increases to contracted fee for service hospitals to be implemented July 1, 2024, through December 31, 2026; and 3.) Sunset the temporary, short-term supplemental Medi-Cal payment increases of up to 7.5% for contracted fee for service hospitals to support expenses for services provided to members during the transition out of the Public Health Emergency, effective for dates of service on and after July 1, 2024. (Motion carried; 6-1-0; Supervisor Chaffee voting no; Chair Corwin and Director Mayorga recused)***

14. Approve Actions Related to Medi-Cal Provider Rate Increases for Fee for Service Clinics Effective July 1, 2024

Vice Chair Becerra did not participate in this item due to her role as CEO of the Coalition of Orange County Community Health Centers. Director Mayorga did not participate in this item due to his role as Executive Director of UC Irvine Healthcare. Supervisor Sarmiento did not participate in this item due to campaign contributions under the Levine Act.

After considerable discussion regarding the provider rate increases, the Board approved Agenda Item 14 as written with the caveat that staff bring back amendments that include quality metrics in the provider contracts.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Directed the Chief Executive Officer, or designees, to make a commitment of up to $526 million from undesignated reserves to support provider rates to ensure longer-term provider network stability, network adequacy, and access to care for CalOptima Health members throughout Orange County; and 2.) As part of this initiative, authorized the Chief Executive Officer, or designees, to develop and implement rate increases to contracted fee for service community clinics to be implemented July 1, 2024, through December 31, 2026; and 3.) Sunset the temporary, short-term supplemental Medi-Cal payment increases of up to 7.5% for contracted fee for service community clinics to support expenses for services provided to members during the transition out of the Public Health Emergency, effective for dates of service on and after July 1, 2024. (Motion carried; 6-0-0; Vice Chair Becerra, Director Mayorga, and Supervisor Sarmiento recused)***

15. Approve Actions Related to Medi-Cal Provider Rate Increases for Fee for Service Behavioral

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Health, Applied Behavior Analysis and Ancillary and Other Providers, Effective July 1, 2024
Vice Chair Becerra did not participate in this item due to her role as CEO of the Coalition of Orange County Community Health Centers. Director García Guillén did not participate in this item due to conflicts of interest. Supervisor Sarmiento did not participate in this item due to campaign contributions under the Levine Act.

After considerable discussion regarding the provider rate increases, the Board approved Agenda Item 15 as written with the caveat that staff bring back amendments that include quality metrics in the provider contracts.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Directed the Chief Executive Officer, or designees, to make a commitment of up to $526 million from undesignated reserves to support provider rates to ensure longer-term provider network stability, network adequacy, and access to care for CalOptima Health members throughout Orange County; and 2.) As part of this initiative, authorized the Chief Executive Officer, or designees, to develop and implement rate increases to contracted fee for service behavioral health, applied behavior analysis, ancillary and other providers, to be implemented July 1, 2024, through December 31, 2026; and 3.) Sunset the temporary, short-term supplemental Medi-Cal payment increases of up to 7.5% for contracted fee for service behavioral health, applied behavior analysis, ancillary and other providers to support expenses for services provided to members during the transition out of the Public Health Emergency, effective for dates of service on and after July 1, 2024. (Motion carried; 6-0-0; Vice Chair Becerra, Director García Guillén, and Supervisor Sarmiento recused)***

16. Approve Actions Related to Medi-Cal Provider Rate Increases for Fee for Service Physicians Effective July 1, 2024
Director Mayorga did not participate in this item due to his role as Executive Director of UC Irvine Healthcare. Supervisor Sarmiento did not participate in this item due to campaign contributions under the Levine Act. Director Tran did not participate in this item due to his role as a physician specialist serving CalOptima Health members.

After considerable discussion regarding the provider rate increases, the Board approved Agenda Item 16 as written with the caveat that staff bring back amendments that include quality metrics in the provider contracts.

Action: ***On motion of Chair Corwin, seconded and carried, the Board of Directors: 1.) Directed the Chief Executive Officer, or designees, to make a commitment of up to $526 million from undesignated reserves to support provider rates to ensure longer-term provider network stability, network adequacy, and access to care for CalOptima Health members throughout Orange County; and 2.) As part of this initiative, authorized the Chief Executive Officer, or designees, to develop and implement rate increases to contracted fee for service physicians to be implemented July 1, 2024, through December 31, 2026; and 3.) Sunset the temporary,***

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short-term supplemental Medi-Cal payment increases of up to 7.5% for contracted fee for service physicians to support expenses for services provided to members during the transition out of the Public Health Emergency, effective for dates of service on and after July 1, 2024. (Motion carried; 6-0-0; Director Mayorga, Supervisor Sarmiento and Director Tran recused)

17. Approve the CalOptima Health Applied Behavior Analysis Pay-for-Value Program

Action: ***On motion of Director Mayorga, seconded and carried, the Board of Directors approved the CalOptima Health Applied Behavior Analysis Pay-for-Value Program effective July 1, 2024, through June 30, 2027. (Motion carried; 9-0-0)***

18. Approve CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program

Vice Chair Becerra did not participate in this item due to her role as CEO of the Coalition of Orange County Community Health Centers.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors approved the CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program with measurement periods starting January 1, 2025, through December 31, 2026. (Motion carried; 8-0-0; Vice Chair Becerra recused)***

19. Approve Actions Related to the Housing and Homelessness Incentive Program for the Nonprofit Healthcare Academy

Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, introduced this item.

The Board recommended that staff look at increasing funding to $10,000 per grantee going forward.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Approved allocation of up to $350,000 in Housing and Homelessness Incentive Program funding from the California Department of Health Care Services to the HHIP Priority 4, Innovation and Implementation of Strategic Interventions; 2.) Authorized the Chief Executive Officer to exercise a one-year contract extension option under the same terms and conditions with Consilience Group, LLC, effective September 1, 2024, to provide Nonprofit Healthcare Academy technical services; and 3.) Authorized CalOptima Health staff to conduct a notice of funding opportunity process related to the Nonprofit Healthcare Academy, administer grant agreements, and release award payments to up to 20 selected community-based organizations in an amount up to $5,000 per grantee. (Motion carried; 9-0-0)***

20. Approve Housing and Homelessness Incentive Program's Notice of Funding Opportunity Round Three

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Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Approved CalOptima Health staff recommendations to administer grant agreements and total award payments up to $25 million for transitional housing projects (Attachment 2); and 2.) Authorized the Chief Executive Officer to execute grant agreements with organizations selected for the transitional housing projects. (Motion carried; 9-0-0)***

CLOSED SESSION

The Board adjourned to Closed Session at 4:42 p.m. Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: OneCare; Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: PACE; CONFERENCE WITH LEGAL COUNSEL – PUBLIC EMPLOYMENT PURSUANT TO GOVERNMENT CODE SECTION 54957(b); and CONFERENCE WITH LABOR NEGOTIATORS PURSUANT TO GOVERNMENT CODE SECTION 54957.6 Unrepresented Employee: General Counsel, CalOptima's Designated Negotiator: Michael Hunn, Chief Executive Officer. CalOptima's Special Legal Counsel: J. Scott Tiedemann, Liebert Cassidy Whitmore, Title: General Counsel.

The Board returned to Open Session at 6:02 p.m. and the Clerk re-established a quorum.

ROLL CALL

Members Present: Clayton Corwin, Chair; Isabel Becerra, Vice Chair; Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Veronica Kelley (non-voting); Jose Mayorga, M.D.; Trieu Tran, M.D.

(All Board members in attendance participated in person)

Members Absent: Norma García Guillén (left meeting at 6:00 p.m.); Supervisor Vicente Sarmiento

For Closed Session items CS-1 and CS-2, the Board met in Closed Session and the Clerk read Agenda Item 21, which covers both of those items.

21. Authorize Actions Related to CalOptima Health's Programs for Older Adults including OneCare and the Program of All-Inclusive Care for the Elderly (PACE) (to Follow in Closed Session).

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO) to: 1.) Submit OneCare Bid for Calendar Year 2025 and execute contracts with the Centers for Medicare & Medicaid Services and the California Department of Health Care Services; Authorized the CEO to amend/execute OneCare Health Network contracts and ancillary provider contracts and take other actions as necessary to implement; and 2.) Amend existing PACE Alternative Care Setting (ACS) provider contracts and enter into new contracts with additional ACS sites based on CalOptima Health's established criteria and strategic needs. (Motion carried; 7-0-0; Director García Guillén and Supervisor Sarmiento absent)***

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CS-3. CONFERENCE WITH LEGAL COUNSEL – PUBLIC EMPLOYMENT PURSUANT TO GOVERNMENT CODE SECTIONS 54957(b)
J. Scott Tiedemann, General Counsel, Liebert Cassidy Whitmore, reported that the Board did not meet regarding this item and there is no reportable action.

CS-4. CONFERENCE WITH LABOR NEGOTIATORS PURSUANT TO GOVERNMENT CODE SECTION 54957.6, Unrepresented Employee: General Counsel, CalOptima's Designated Negotiator: Michael Hunn, Chief Executive Officer, CalOptima's Special Legal Counsel: J. Scott Tiedemann, Liebert Cassidy Whitmore, Title: General Counsel
J. Scott Tiedemann, General Counsel, Liebert Cassidy Whitmore, reported that the Board did meet regarding this item and there were no reportable actions taken.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS
Mr. Hunn noted for the record that it was the CEO's decision to exclude the chief and executive director positions from the increases in the revised salary schedule.

ADJOURNMENT
Hearing no further business, Chair Corwin adjourned the meeting at 6:05 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: June 6, 2024

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 15, 2024

A Regular Meeting of the CalOptima Health Board of Directors' (Board) Finance and Audit Committee (FAC) was held on February 15, 2024, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Chair Isabel Becerra called the meeting to order at 3:04 p.m., and Director Clayton Corwin led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Blair Contratto; Clayton Corwin (All members participated in person)

Members Absent: None

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

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, provided several updates regarding the new 2024 Department of Health Care Services (DHCS) contract that may impact CalOptima Health's financial performance during the remainder of this fiscal year. The first update was on the targeted rate increases (TRI), which were briefly discussed at the last FAC meeting held on November 16, 2023. Ms. Huang reported that based on staff's preliminary analysis, 70% to 80% of TRI funding will be a shift from existing Proposition 56 program physician services with the remaining 20% to 30% being new funding. She noted that the DHCS draft timeline for managed care plans to implement the TRI adjustments are July 31, 2024 (to pay fee-for-service providers the correct TRI rates on a go forward basis) and December 31, 2024 (to pay capitated providers adjusted payment levels on a go forward basis). Ms. Huang added that CalOptima Health intends to implement the TRI adjustments ahead of the DHCS timeline, tentatively July 1, 2024, for go forward payments and August 31, 2024, for retroactive adjustments. This will help ensure timely cash flow for CalOptima Health's health network partners and to allow sufficient time to plan and implement these changes.

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Ms. Huang also provided an update on another 2024 DHCS contract requirement, which is the quality withhold. DHCS began applying a 0.5% quality withhold of capitation payments from CalOptima Health. The withhold percentage may increase in future contracts, and, depending on CalOptima Health's performance on the DHCS quality measures, it may earn back some or all of the withheld amounts.

For the last update related to the 2024 DHCS contract, Ms. Huang noted that CalOptima Health is required to reinvest a portion of its net income into local communities through community reinvestment activities. She added that at the October 5, 2023, Board meeting, the Board made an initial commitment of up to $38 million in undesignated reserves to fund such activities in Calendar Year 2024 and authorized subsequent funding allocations of up to 20% of its annual Medi-Cal net operating income for future years.

Michael Hunn, Chief Executive Officer, and Ms. Huang responded to committee members' questions regarding the TRI, community reinvestment, and quality withholds.

2. Fiscal Year 2023-24 Mid-Year Budget Update

Ms. Huang presented the 2023-24 mid-year budget update. She noted that CalOptima Health's fiscal year begins on July 1 and ends June 30 of the following year. Ms. Huang reported that she will provide an overview of the first six months of the current fiscal year, which is July 1, 2023, through December 31, 2023. She reviewed the mid-year budget highlights for July through December 2023, which included year-to-date (YTD) Actual, YTD Budget, and YTD Variance for the following categories: for Average Enrollment - YTD variance of 21,264; for Revenue - YTD variance of $280 million; for Medical Costs - YTD variance of negative $229 million; for Medical Loss Ratio – YTD variance of negative 1.4%; for Administrative Expenses – YTD variance of $15 million; for Administrative Loss Ratio (ALR) – YTD variance of 1.3%; for Operating Income/Margin – YTD variance of $66 million; and Net Non-Operating Income (Loss) – YTD variance of $77 million. Ms. Huang also reviewed the notable drivers of the Operating budget variances, which for Revenue included membership, directed payments, and DHCS incentive payments. For Medical Costs, the drivers of the variances included membership, directed payments, incentive program payments, such as Housing and Homelessness Incentive Program, Student Behavioral Health Incentive Program, and hospital quality incentives. For Administrative Expenses, the drivers for variances included salaries, wages and employee benefits, and non-salary operating expenses. For the Non-Operating budget variances, the notable driver of the variances included investment income and grants payments. Ms. Huang reviewed the dollars associated with these variances as well as a detailed look of the dollars associated with the notable drivers for each of the above categories.

Ms. Huang also reviewed the enrollment analysis of actual versus budget based on member eligible months, from July 2019 through January 1, 2024, noting differences between the forecasted enrollment and actual enrollment. She also reviewed the budget outlook for the second half of FY 2023-24 (January through June 2024). Ms. Huang noted that there are several items that may impact CalOptima Health's financial performance, including funding levels from DHCS, full scope Medi-Cal adult expansion (ages 26-49) regardless of immigration status, TRI for certain providers, and network risk arrangement changes, which includes the Kaiser transition and Optum consolidation for Monarch, Talbert and Arta. She added that community reinvestment as required by DHCS may also impact CalOptima Health's financial performance.

Ms. Huang and Mr. Hunn responded to committee members' questions and comments.

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3. Cybersecurity Update

James Steele, Senior Director, Information Security, presented an update on CalOptima Health's cybersecurity. He noted that CalOptima Health has experienced zero major cybersecurity incidents in the past three months. Mr. Steele reported that CalOptima Health has not received any new notifications of cybersecurity incidents in the past three months from its third-party vendors.

Mr. Steele also reviewed four recent cybersecurity news articles. Three of the articles were from the HIPAA Journal, which included *HIPAA Updates and Changes in 2023-2024*; *At Least 141 Were Hospitals Directly Affected by Ransomware Attacks in 2023*; and *Lincare Holdings Proposes $7.25 Million Settlement to Resolve Data Breach Lawsuit*, and one from Becker's Health IT, *Children's hospital of Chicago takes IT systems offline after 'cybersecurity matter'*. Mr. Steele also updated the committee on security projects, which included privilege account management, zero trust network architecture, asset management, penetration test and risk assessment, security information and event monitoring upgrade hardware and license, and managed security service provider 24/7 monitoring, alerting and response. He also reviewed the status of CalOptima Health's various security measures, including which projects are complete and which projects are in progress, as well as the on-going projects. Mr. Steele also reported that CalOptima Health has selected the NIST cybersecurity framework. NIST is the National Institute of Standards and Technology, and it is a government organization that is one of the top providers of controls for cybersecurity and measurements. There is no cost to CalOptima Health for using the NIST framework, and many other organizations align their cybersecurity framework using NIST.

Mr. Hunn also added that he is grateful to the Board for its various approvals of these security measures because cyber thieves are always adapting and looking for new ways to exploit and find vulnerabilities.

Mr. Steele and Mr. Hunn responded to committee members' questions and comments.

INVESTMENT ADVISORY COMMITTEE UPDATE

4. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period of October 1, 2023, through December 31, 2023. The portfolio totaled approximately $3 billion as of December 31, 2023. Of this amount, $2.4 billion was in CalOptima Health's operating account, and $629 million was included in CalOptima Health's Board-designated reserves. Meketa Investment Group Inc. (Meketa), CalOptima Health's investment advisor, completed an independent review of the monthly investment reports. Meketa reported that all investments were compliant with Government Code section 53600 *et seq*. and with CalOptima Health's Board-approved Annual Investment Policy during that period.

Ms. Huang responded to committee members' questions.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

5. Approve the Minutes of the November 16, 2023 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee and Receive and File Minutes of the October 23, 2023 Regular Meeting of the CalOptima Health Board of Directors' Investment Advisory Committee

Back to Agenda

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

The following items were accepted as presented.

6. December 2023 Financial Summary

7. Quarterly Operating and Capital Budget Update

8. CalAIM Program Summary

9. Quarterly Reports to the Finance and Audit Committee
   a. Net Asset Analysis
   b. Enrollment Trend Report
   c. Shared Risk Pool Performance Report
   d. Health Network Financial Report

COMMITTEE MEMBER COMMENTS
Committee members thanked staff for the detail provided in the meeting materials and presentations.

ADJOURNMENT
Hearing no further business, Chair Becerra adjourned the meeting at 4:50 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: May 23, 2024

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Adopt Resolution No. 24-0606-01 Authorizing and Directing Execution of Contract MS-2425-41 with the California Department of Aging for the Multipurpose Senior Services Program

Contacts

Richard Pitts, Chief Medical Officer, (714) 246-8491
Kelly Giardina, Executive Director, Medical Management, (657) 900-1013

Recommended Actions

Adopt Board Resolution No. 24-0606-01, authorizing and directing the Chairman of the Board of Directors to execute Contract MS-2425-41 with the California Department of Aging for the Multipurpose Senior Services Program for Fiscal Year 2024-25.

Background

The Multipurpose Senior Services Program (MSSP) is a home and community-based services program, operated pursuant to a waiver in the state's Medi-Cal program. MSSP provides case management of social and health care as a cost-effective alternative to institutionalization of frail, elderly adults.

The California Department of Health Care Services (DHCS), through an Interagency Agreement, delegates the administration of the MSSP to the California Department of Aging (CDA). The CDA contracts with local government entities and private non-profit organizations for local administration of the MSSP in various areas of the state.

As the operator of the MSSP site for Orange County, CalOptima Health improves the quality of care for the aging population by linking frail, elderly members to home and community-based services as an alternative to institutionalization and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima Health has successfully implemented the MSSP program over the past 23 years for up to 568 members at any given point in time.

Discussion

CalOptima Health has received CDA Contract MS-2425-41 for execution by the Chairman of the CalOptima Health Board of Directors (Board), which, upon the adoption of a Board resolution and execution of the contract, will extend the MSSP through June 30, 2025, with a contract maximum of $3,042,208.

The scope of work and other obligations are consistent with existing MSSP contract obligations. The contract reflects an updated waiver number from CA.0141.R06.00 to CA.0141.R07.00, which applies to this contract cycle as the new waiver number for the waiver renewal is effective July 1, 2024.

Back to Agenda

Fiscal Impact
Staff has incorporated projected revenue and expense related to the MSSP in the CalOptima Health Fiscal Year 2024-25 Operating Budget, pending Board approval.

Rationale for Recommendation
Adoption of Board Resolution No. 24-0606-01, authorizing and directing the Chairman of the Board to execute the Fiscal Year 2024–25 contract with the CDA for the MSSP, will allow CalOptima Health to continue to address the long-term community care needs of some of the frailest older adult CalOptima Health members by helping them to remain in their homes.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Board Resolution No. 24-0606-01, Execute Contract No. MS-2425-41 with the State of California Department of Aging for the Multipurpose Senior Services Program.
2. Contract No. MS-2425-41 with the California Department of Aging for the Multipurpose Senior Services Program

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

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RESOLUTION NO. 24-0606-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima Health

EXECUTE CONTRACT MS-2425-41
WITH THE STATE OF CALIFORNIA
DEPARTMENT OF AGING FOR THE
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

WHEREAS, The Orange County Health Authority, d.b.a. CalOptima Health ("CalOptima Health") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging;

WHEREAS, the California Department of Aging notified CalOptima Health of its intent to contract for the assignment of 568 MSSP participant slots to CalOptima Health;

WHEREAS, the California Department of Aging has requested the execution of Contract MS-2425-41 ("Contract"); and

WHEREAS, the Board of Directors has determined that it is in the best interest of the ongoing development of CalOptima Health home and community-based services to the Medi-Cal beneficiaries residing in Orange County to approve CalOptima Health executing the Contract.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima Health is hereby authorized to enter into contract MS-2425-41 with the California Department of Aging on the terms and conditions set forth in the form provided to the Board of Directors; and,

II. That the Chair of the Board of Directors is hereby authorized and directed to execute and deliver the Contract by and on behalf of CalOptima Health on the terms and conditions set forth in the form provided to the Board of Directors.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 6th day of June 2024.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Clayton M. Corwin, Chair, Board of Directors

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

All documents listed are required to execute your contract unless otherwise noted.

- All documents must identify the Contractor's legal name exactly as shown on the standard agreement or amendment (STD. 213 or 213A).
- Contract packages must be complete and able to stand alone. For example, if you have more than one contract with the California Department of Aging (CDA),you may have one Insurance Certificate to cover all contracts but must include a copy of the Certificate in each contract package returned to CDA.
- This checklist does not need to be submitted as part of the contract package.
- **Return final contract packages to:**
  California Department of Aging
  Attn: Contract Analyst
  2880 Gateway Oaks Drive, Suite 200
  Sacramento, CA 95833

  Or by email at BMBSubvention@aging.ca.gov

☒ **Two (2) Standard Agreements or Amendments (STD. 213 or 213A)** – Print, sign and submit four copies of the Std. 213 or 213A (signature page) with ***original signatures*** (Blue ink is preferable). Signature stamps or copies of any type will not be accepted. CDA can provide documents for signature via DocuSign. This option must be requested via email at BMBSubvention@aging.ca.gov

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☒ **Agreement Authorization Document** – Submit a signed Board Resolution, Order, or Meeting Minutes that demonstrates the Organization's approval of each contract. The contract number(s) must be referenced in the document. If the document does not demonstrate authorization to sign amendments, another authorization document will be needed to amend the contract. If Board Meeting Minutes are used, they must be signed off as approved or the following Board Meeting Minutes must be submitted showing the previous Board Meeting Minutes were approved. For local governments and public entities, authorization is required from the Board of Supervisors or equivalent governing body. For Nonprofits, authorization is required from the Board of Directors. [See MSSP Contract, Exhibit D, Article II, Section K.]

☒ **Information Integrity and Security Statement (CDA 1024)** – Print, sign and submit one copy of the CDA 1024 for each contract. The contract number must be referenced on the document. Resubmission of this document is not required for amendments. [See MSSP Contract, Exhibit D, Article XVII, Section F.]

☒ **Contractor Certification Clauses (CCC 4/2017)** – Print, sign, and submit a signed copy of the CCC 4/2017 certification, certifying your organization's compliance. Resubmission of this document is not required for amendments. [See MSSP Contract Exhibit D, Article II, Section C.3]

☒ **California Civil Rights Laws Certification (CDA 9026)** – Print, sign and submit a signed copy of the CDA 9026 certification, certifying your organization's compliance. Resubmission of this document is not required for amendments. [See MSSP Contract Exhibit D, Article II, Section C.3]

☒ **Insurance Requirements** – Submit a Certificate of Insurance or Letter of Self-Insurance for each contract. Insurance document(s) are required and must meet the General, Automobile and Professional liability coverages and conditions in the contract. The Certificate or Letter of Self Insurance must reference the contract number(s) and demonstrate coverage for the entire term of the Contract. General and Automobile Liability coverage requires an additional insured statement naming the State of California as an additional insured entity. Resubmission of this document is not required for amendments. [See MSSP contract Exhibit D, Article XI.]

STATE OF CALIFORNIA – DEPARTMENT OF GENERAL SERVICES

STANDARD AGREEMENT
STD 213 (Rev. 04/2020)

SCO ID: 4260-MS242541

AGREEMENT NUMBER	PURCHASING AUTHORITY NUMBER (If Applicable)
MS-2425-41	

1. This Agreement is entered into between the Contracting Agency and the Contractor named below:

CONTRACTING AGENCY NAME
California Department of Aging

CONTRACTOR NAME
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA

2. The term of this Agreement is:

START DATE
07/01/2024

THROUGH END DATE
06/30/2025

3. The maximum amount of this Agreement is:
$ 3,042,208 Three million, forty two thousand, two hundred eight and 00/100 dollars

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of the Agreement.

	Exhibits	Title	Pages
	Exhibit A	Scope of Work	19 pages
	Exhibit A, Attachment 1	General Information	1 page
	Exhibit B	Budget Detail and Payment Provisions	7 pages
	Exhibit B, Attachment 1	Budget Display	1 page
	Exhibit C	General Terms and Conditions – GTC-4/2017*	0 pages
	Exhibit D	Special Terms and Conditions	34 pages
	Exhibit E	Additional Provisions Specific to this MSSP Agreement	7 pages
	Exhibit F	HIPPA Business Associates Addendum	10 pages
	Exhibit G	Catchment Area Zip Codes	1 page

Items shown with an asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto.
These documents can be viewed at https://www.dgs.ca.gov/OLS/Resources

IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES HERETO.

CONTRACTOR

CONTRACTOR NAME (if other than an individual, state whether a corporation, partnership, etc.)
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA

CONTRACTOR BUSINESS ADDRESS	CITY	STATE	ZIP
505 City Parkway West	Orange	CA	92868

PRINTED NAME OF PERSON SIGNING	TITLE
Clayton M. Corwin	Chair, CalOptima Health Board of Directors

CONTRACTOR AUTHORIZED SIGNATURE	DATE SIGNED

STATE OF CALIFORNIA

CONTRACTING AGENCY NAME
California Department of Aging

CONTRACTING AGENCY ADDRESS	CITY	STATE	ZIP
2880 Gateway Oaks Drive, Suite 200	Sacramento	CA	95833

PRINTED NAME OF PERSON SIGNING	TITLE
Nate Gillen	Chief, Business Management Bureau

CONTRACTING AGENCY AUTHORIZED SIGNATURE	DATE SIGNED

CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL	EXEMPTION (If Applicable)
	AG OP 80-111

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STATE OF CALIFORNIA – DEPARTMENT OF GENERAL SERVICES

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Adopt Resolution No. 24-0606-01 Authorizing and Directing Execution of Contract MS-2425-41 with the California Department of Aging for the Multipurpose Senior Services Program

Contacts

Richard Pitts, Chief Medical Officer, (714) 246-8491
Kelly Giardina, Executive Director, Medical Management, (657) 900-1013

Recommended Actions

Adopt Board Resolution No. 24-0606-01, authorizing and directing the Chairman of the Board of Directors to execute Contract MS-2425-41 with the California Department of Aging for the Multipurpose Senior Services Program for Fiscal Year 2024-25.

Background

The Multipurpose Senior Services Program (MSSP) is a home and community-based services program, operated pursuant to a waiver in the state's Medi-Cal program. MSSP provides case management of social and health care as a cost-effective alternative to institutionalization of frail, elderly adults.

The California Department of Health Care Services (DHCS), through an Interagency Agreement, delegates the administration of the MSSP to the California Department of Aging (CDA). The CDA contracts with local government entities and private non-profit organizations for local administration of the MSSP in various areas of the state.

As the operator of the MSSP site for Orange County, CalOptima Health improves the quality of care for the aging population by linking frail, elderly members to home and community-based services as an alternative to institutionalization and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima Health has successfully implemented the MSSP program over the past 23 years for up to 568 members at any given point in time.

Discussion

CalOptima Health has received CDA Contract MS-2425-41 for execution by the Chairman of the CalOptima Health Board of Directors (Board), which, upon the adoption of a Board resolution and execution of the contract, will extend the MSSP through June 30, 2025, with a contract maximum of $3,042,208.

The scope of work and other obligations are consistent with existing MSSP contract obligations. The contract reflects an updated waiver number from CA.0141.R06.00 to CA.0141.R07.00, which applies to this contract cycle as the new waiver number for the waiver renewal is effective July 1, 2024.

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Fiscal Impact
Staff has incorporated projected revenue and expense related to the MSSP in the CalOptima Health Fiscal Year 2024-25 Operating Budget, pending Board approval.

Rationale for Recommendation
Adoption of Board Resolution No. 24-0606-01, authorizing and directing the Chairman of the Board to execute the Fiscal Year 2024–25 contract with the CDA for the MSSP, will allow CalOptima Health to continue to address the long-term community care needs of some of the frailest older adult CalOptima Health members by helping them to remain in their homes.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Board Resolution No. 24-0606-01, Execute Contract No. MS-2425-41 with the State of California Department of Aging for the Multipurpose Senior Services Program.
2. Contract No. MS-2425-41 with the California Department of Aging for the Multipurpose Senior Services Program

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

RESOLUTION NO. 24-0606-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima Health

EXECUTE CONTRACT MS-2425-41
WITH THE STATE OF CALIFORNIA
DEPARTMENT OF AGING FOR THE
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

WHEREAS, The Orange County Health Authority, d.b.a. CalOptima Health ("CalOptima Health") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging;

WHEREAS, the California Department of Aging notified CalOptima Health of its intent to contract for the assignment of 568 MSSP participant slots to CalOptima Health;

WHEREAS, the California Department of Aging has requested the execution of Contract MS-2425-41 ("Contract"); and

WHEREAS, the Board of Directors has determined that it is in the best interest of the ongoing development of CalOptima Health home and community-based services to the Medi-Cal beneficiaries residing in Orange County to approve CalOptima Health executing the Contract.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima Health is hereby authorized to enter into contract MS-2425-41 with the California Department of Aging on the terms and conditions set forth in the form provided to the Board of Directors; and,

II. That the Chair of the Board of Directors is hereby authorized and directed to execute and deliver the Contract by and on behalf of CalOptima Health on the terms and conditions set forth in the form provided to the Board of Directors.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 6th day of June 2024.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Clayton M. Corwin, Chair, Board of Directors

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

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
INFORMATION INTEGRITY AND SECURITY STATEMENT
CDA 1024 (REV 03/2020)

In compliance with California Government Code Section 11019.9, California Civil Code Section 1798 et seq., Department of General Services Management Memo 06-12, and Statewide Information Management Manual (SIMM) 5300 the California Department of Aging (CDA) hereby requires the Contractor/Vendor to:

ACKNOWLEDGE:

- Any wrongful access, inspection, use, or disclosure of Personal, Confidential or Sensitive Information (PSCI) is a crime and is prohibited under state and federal laws, including but not limited to California Penal Code Section 502, California Government Code Section 15619, California Civil Code Section 1798.53 and 1798.55, and the Health Insurance Portability and Accountability Act. Acknowledge.
- Any wrongful access, inspection, use, disclosure, or modification of PSCI information may result in termination of this Contract/Agreement.

MEET THE FOLLOWING REQUIREMENTS:

- PSCI information shall be protected from disclosure in accordance with all applicable laws, regulations, and policies.
- PSCI data be protected by authorized access using the principles of least privilege.
- Any occurrence that actually or potentially jeopardizes the confidentiality, integrity, or availability of an information system or the information the system processes, stores, or transmits or that constitutes a violation or imminent threat of violation of security policies, security procedures or acceptable use policies will immediately be reported to CDA by completing a Security Incident Report CDA (1025A and 1025B).
- All access codes which allow access to confidential information will be properly safeguarded.
- Obligations to protect PSCI information obtained under this Contract/Agreement will continue after termination of the Contract/Agreement with CDA.
- All employees/subcontractors of the Contractor/Vendor will complete the required Security Awareness Training module located at https://aging.ca.gov/Information_security/ within 30 days of the start date of the Contract/Agreement or within 30 days of the start date of any new employee or subcontractor. This training must be completed annually.
- All employees/subcontractors of the Contractor/Vendor must comply with CDA's confidentiality and data security requirements as outlined in the Contract/Agreement.
- All employees/subcontractors of the Contract/Vendor must comply with the Appendix D, section XVIII encryption and self-certification requirements as outlined in the contract.

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
INFORMATION INTEGRITY AND SECURITY STATEMENT
CDA 1024 (REV 03/2020)

CERTIFY:

To protect PSCI information by:

- Accessing, inspecting, using, disclosing or modifying PSCI information only for the purpose of performing official duties.
- Never accessing, inspecting, using, disclosing, or modifying PSCI information for curiosity, personal gain, or any non-business-related reason.
- Securing PSCI information in approved locations.
- Never removing PSCI information from the work site without authorization.

Meets the encryption requirements in Exhibit D Article 18:

☑ Is in full compliance with the 128 Encryption requirements.

☐ Is not in compliance with the 128 Encryption requirements and will achieve compliance by _____.

I hereby certify that I have reviewed this Confidentiality Statement and will comply with the above statements.

OC Health Authority, DBA CalOptima / Clayton M. Corwin, Chair, Board of Directors
Contractor/Vendor Printed Name and Title

Contractor/Vendor Signature

Date

CDA Program/Project

MS-2025-41
Contract Number

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Contractor Certification Clauses

CCC 04/2017

CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

Contractor/Bidder Firm Name (Printed)	Federal ID Number
Orange County Health Agency, DBA CalOptima	33059989 1

By (Authorized Signature)

Printed Name and Title of Person Signing

Clayton M. Corwin

Date Executed	Executed in the County of
	Orange

CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 11102) (Not applicable to public entities.)

2. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

1) the dangers of drug abuse in the workplace;

2) the person's or organization's policy of maintaining a drug-free workplace;

3) any available counseling, rehabilitation and employee assistance programs; and,

4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

1) receive a copy of the company's drug-free workplace policy statement; and,

2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (Gov. Code §8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (Pub. Contract Code §10296) (Not applicable to public entities.)

4. CONTRACTS FOR LEGAL SERVICES $50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that Contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lessor of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

5. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

6. SWEATFREE CODE OF CONDUCT:

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably

required by authorized officials of the contracting agency, the Department of Industrial Relations, or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

7. DOMESTIC PARTNERS: For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.3.

8. GENDER IDENTITY: For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.35.

DOING BUSINESS WITH THE STATE OF CALIFORNIA

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

Current State Employees (Pub. Contract Code §10410):

1). No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

2). No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

Former State Employees (Pub. Contract Code §10411):

1). For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2). For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (Pub. Contract Code §10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (Pub. Contract Code §10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and

Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be*:* (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.

STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
CALIFORNIA CIVIL RIGHTS LAWS CERTIFICATION
CDA 9026 (NEW 04/2018)

Pursuant to Public Contract Code section 2010, a person that submits a bid or proposal to, or otherwise proposes to enter into or renew a contract with, a state agency with respect to any contract in the amount of $100,000 or above shall certify, under penalty of perjury, at the time the bid or proposal is submitted or the contract is renewed, all of the following:

1. CALIFORNIA CIVIL RIGHTS LAWS: For contracts executed or renewed after January 1, 2017, the contractor certifies compliance with the Unruh Civil Rights Act (Section 51 of the Civil Code) and the Fair Employment and Housing Act (Section 12960 of the Government Code); and

2. EMPLOYER DISCRIMINATORY POLICIES: For contracts executed or renewed after January 1, 2017, if a Contractor has an internal policy against a sovereign nation or peoples recognized by the United States government, the Contractor certifies that such policies are not used in violation of the Unruh Civil Rights Act (Section 51 of the Civil Code) or the Fair Employment and Housing Act (Section 12960 of the Government Code).

CERTIFICATION

I, the official named below, certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Contractor Name (Printed): OC Health Authority, DBA CalOptima	Federal ID Number: 33059989 1
By (Authorized Signature):	
Printed Name and Title of Person Signing: Clayton M. Corwin	
Date Executed:	Executed in the County and State of: Orange, CA

Indicate all California Department of Aging contracts your organization participates in:

- ☐ Area Plan (AP)
- ☐ Financial Alignment (FA)
- ☐ HICAP (HI)
- ☐ MIPPA (MI)
- ☑ MSSP (MS)
- ☐ SNAP-Ed (SP)
- ☐ Title V (TV)

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/12/2024

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Alliant Insurance Services, Inc.
560 Mission St 6th Fl
San Francisco CA 94105
License#: 0C36861

CONTACT NAME: Elizabeth Scarborough
PHONE (A/C, No, Ext): 415-855-8590 **FAX (A/C, No):**
E-MAIL ADDRESS: elizabeth.scarborough@alliant.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : National Fire Insurance Compan	20478
INSURER B : Continental Insurance Company	35289
INSURER C : American Casualty Company of R	20427
INSURER D : Syndicate 2623/623 at Lloyd's	
INSURER E : TDC National Assurance Company	41050
INSURER F : Allied World Surplus Lines Ins	24319

INSURED
Orange County Health Authority dba CalOptima
505 City Parkway West
Orange CA 92868
CALOHEA-01

COVERAGES **CERTIFICATE NUMBER:** 1359937067 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
B	X **COMMERCIAL GENERAL LIABILITY** CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:	Y		7063951685	4/7/2024	4/7/2025	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG 	$ 1,000,000 $ 100,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000 $
B	**AUTOMOBILE LIABILITY** X ANY AUTO OWNED AUTOS ONLY SCHEDULED AUTOS HIRED AUTOS ONLY X NON-OWNED AUTOS ONLY	Y		7063950620	4/7/2024	4/7/2025	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) 	$ 1,000,000 $ $ $ $
B	X **UMBRELLA LIAB** X OCCUR **EXCESS LIAB** CLAIMS-MADE DED RETENTION $			7063953632	4/7/2024	4/7/2025	EACH OCCURRENCE AGGREGATE 	$ 25,000,000 $ 25,000,000 $
A C	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N: N **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		7063950326 7063950648	4/7/2024 4/7/2024	4/7/2025 4/7/2025	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000
D E F	Cyber Liability E&O Med Care MedMal Liability			FN2417834 MCP-00174-24-05 0311-7585	4/7/2024 4/7/2024 4/7/2024	4/7/2025 4/7/2025 4/7/2025	Per Claim/Aggregate Limit Per Claim/Aggregate	$5,000,000 $10,000,000 $1M/$3M

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Coverage: 1st excess Cyber Liability, Policy #652088245, Term: 04/07/2024 to 04/07/2025, Carrier: Columbia Casualty Company, Limit: $5M xs $5M.

RE: MS-2425-41.

CA Department of Aging and MSSP are included as Additional Insured with respect to the General Liability and Auto Liability to the extent provided in the selected pages of the attached forms.

CERTIFICATE HOLDER

CA Department of Aging
1300 National Drive, Suite 200
Sacramento CA 95834

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

1. ADDITIONAL INSUREDS

a. **WHO IS AN INSURED** is amended to include as an **Insured** any person or organization described in paragraphs **A.** through **K.** below whom a **Named Insured** is required to add as an additional insured on this **Coverage Part** under a written contract or written agreement, provided such contract or agreement:

(1) is currently in effect or becomes effective during the term of this **Coverage Part**; and

(2) was executed prior to:

(a) the **bodily injury** or **property damage**; or

(b) the offense that caused the **personal and advertising injury**,

for which such additional insured seeks coverage.

b. However, subject always to the terms and conditions of this policy, including the limits of insurance, the Insurer will not provide such additional insured with:

(1) a higher limit of insurance than required by such contract or agreement; or

(2) coverage broader than required by such contract or agreement, and in no event broader than that described by the applicable paragraph **A.** through **K.** below.

Any coverage granted by this endorsement shall apply only to the extent permissible by law.

A. Controlling Interest

Any person or organization with a controlling interest in a **Named Insured**, but only with respect to such person or organization's liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of:

1. such person or organization's financial control of a **Named Insured**; or

2. premises such person or organization owns, maintains or controls while a **Named Insured** leases or occupies such premises;

provided that the coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

B. Co-owner of Insured Premises

A co-owner of a premises co-owned by a **Named Insured** and covered under this insurance but only with respect to such co-owner's liability for **bodily injury**, **property damage** or **personal and advertising injury** as co-owner of such premises.

C. Grantor of Franchise

Any person or organization that has granted a franchise to a **Named Insured**, but only with respect to such person or organization's liability for **bodily injury**, **property damage** or **personal and advertising injury** as grantor of a franchise to the **Named Insured**.

D. Lessor of Equipment

Any person or organization from whom a **Named Insured** leases equipment, but only with respect to liability for **bodily injury**, **property damage** or **personal and advertising injury** caused, in whole or in part, by the **Named Insured's** maintenance, operation or use of such equipment, provided that the **occurrence** giving rise to such **bodily injury**, **property damage** or the offense giving rise to such **personal and advertising injury** takes place prior to the termination of such lease.

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E. Lessor of Land

Any person or organization from whom a **Named Insured** leases land but only with respect to liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of the ownership, maintenance or use of such land, provided that the **occurrence** giving rise to such **bodily injury**, **property damage** or the offense giving rise to such **personal and advertising injury** takes place prior to the termination of such lease. The coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

F. Lessor of Premises

An owner or lessor of premises leased to the **Named Insured**, or such owner or lessor's real estate manager, but only with respect to liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of the ownership, maintenance or use of such part of the premises leased to the **Named Insured**, and provided that the **occurrence** giving rise to such **bodily injury** or **property damage**, or the offense giving rise to such **personal and advertising injury**, takes place prior to the termination of such lease. The coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

G. Mortgagee, Assignee or Receiver

A mortgagee, assignee or receiver of premises but only with respect to such mortgagee, assignee or receiver's liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of the **Named Insured's** ownership, maintenance, or use of a premises by a **Named Insured**.

The coverage granted by this paragraph does not apply to structural alterations, new construction or demolition operations performed by, on behalf of, or for such additional insured.

H. State or Governmental Agency or Subdivision or Political Subdivisions – Permits

A state or governmental agency or subdivision or political subdivision that has issued a permit or authorization but only with respect to such state or governmental agency or subdivision or political subdivision's liability for **bodily injury**, **property damage** or **personal and advertising injury** arising out of:

1. the following hazards in connection with premises a **Named Insured** owns, rents, or controls and to which this insurance applies:

a. the existence, maintenance, repair, construction, erection, or removal of advertising signs, awnings, canopies, cellar entrances, coal holes, driveways, manholes, marquees, hoistaway openings, sidewalk vaults, street banners, or decorations and similar exposures; or

b. the construction, erection, or removal of elevators; or

c. the ownership, maintenance or use of any elevators covered by this insurance; or

2. the permitted or authorized operations performed by a **Named Insured** or on a **Named Insured's** behalf.

The coverage granted by this paragraph does not apply to:

a. **Bodily injury**, **property damage** or **personal and advertising injury** arising out of operations performed for the state or governmental agency or subdivision or political subdivision; or

b. **Bodily injury** or **property damage** included within the **products-completed operations hazard**.

With respect to this provision's requirement that additional insured status must be requested under a written contract or agreement, the Insurer will treat as a written contract any governmental permit that requires the **Named Insured** to add the governmental entity as an additional insured.

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I. Trade Show Event Lessor

1. With respect to a **Named Insured's** participation in a trade show event as an exhibitor, presenter or displayer, any person or organization whom the **Named Insured** is required to include as an additional insured, but only with respect to such person or organization's liability for **bodily injury**, **property damage** or **personal and advertising injury** caused by:

a. the **Named Insured's** acts or omissions; or

b. the acts or omissions of those acting on the **Named Insured's** behalf,

in the performance of the **Named Insured's** ongoing operations at the trade show event premises during the trade show event.

2. The coverage granted by this paragraph does not apply to **bodily injury** or **property damage** included within the **products-completed operations hazard**.

J. Vendor

Any person or organization but only with respect to such person or organization's liability for **bodily injury** or **property damage** arising out of **your products** which are distributed or sold in the regular course of such person or organization's business, provided that:

1. The coverage granted by this paragraph does not apply to:

a. **bodily injury** or **property damage** for which such person or organization is obligated to pay **damages** by reason of the assumption of liability in a contract or agreement unless such liability exists in the absence of the contract or agreement;

b. any express warranty unauthorized by the **Named Insured**;

c. any physical or chemical change in any product made intentionally by such person or organization;

d. repackaging, except when unpacked solely for the purpose of inspection, demonstration, testing, or the substitution of parts under instructions from the manufacturer, and then repackaged in the original container;

e. any failure to make any inspections, adjustments, tests or servicing that such person or organization has agreed to make or normally undertakes to make in the usual course of business, in connection with the distribution or sale of the products;

f. demonstration, installation, servicing or repair operations, except such operations performed at such person or organization's premises in connection with the sale of a product;

g. products which, after distribution or sale by the **Named Insured**, have been labeled or relabeled or used as a container, part or ingredient of any other thing or substance by or for such person or organization; or

h. **bodily injury** or **property damage** arising out of the sole negligence of such person or organization for its own acts or omissions or those of its employees or anyone else acting on its behalf. However, this exclusion does not apply to:

(1) the exceptions contained in Subparagraphs **d.** or **f.** above; or

(2) such inspections, adjustments, tests or servicing as such person or organization has agreed with the **Named Insured** to make or normally undertakes to make in the usual course of business, in connection with the distribution or sale of the products.

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2. This Paragraph **J.** does not apply to any insured person or organization, from whom the **Named Insured** has acquired such products, nor to any ingredient, part or container, entering into, accompanying or containing such products.

3. This Paragraph **J.** also does not apply:

a. to any vendor specifically scheduled as an additional insured by endorsement to this **Coverage Part**;

b. to any of **your products** for which coverage is excluded by endorsement to this **Coverage Part**; nor

c. if **bodily injury** or **property damage** included within the **products-completed operations hazard** is excluded by endorsement to this **Coverage Part**.

K. Other Person Or Organization

Any person or organization who is not an additional insured under Paragraphs **A.** through **J.** above. Such additional insured is an **Insured** solely for **bodily injury**, **property damage** or **personal and advertising injury** for which such additional insured is liable because of the **Named Insured's** acts or omissions.

The coverage granted by this paragraph does not apply to any person or organization:

1. for **bodily injury**, **property damage**, or **personal and advertising injury** arising out of the rendering or failure to render any professional service;

2. for **bodily injury** or **property damage** included within the **products-completed operations hazard**; nor

3. who is specifically scheduled as an additional insured on another endorsement to this **Coverage Part**.

2. ADDITIONAL INSURED - PRIMARY AND NON-CONTRIBUTORY TO ADDITIONAL INSURED'S INSURANCE

A. The **Other Insurance** Condition in the **COMMERCIAL GENERAL LIABILITY CONDITIONS** Section is amended to add the following paragraph:

If the **Named Insured** has agreed in writing in a contract or agreement that this insurance is primary and non-contributory relative to an additional insured's own insurance, then this insurance is primary, and the Insurer will not seek contribution from that other insurance. For the purpose of this Provision **2.**, the additional insured's own insurance means insurance on which the additional insured is a named insured.

B. With respect to persons or organizations that qualify as additional insureds pursuant to paragraph **1.K.** of this endorsement, the following sentence is added to the paragraph above:

Otherwise, and notwithstanding anything to the contrary elsewhere in this Condition, the insurance provided to such person or organization is excess of any other insurance available to such person or organization.

3. BODILY INJURY – EXPANDED DEFINITION

Under **DEFINITIONS**, the definition of **bodily injury** is deleted and replaced by the following:

Bodily injury means physical injury, sickness or disease sustained by a person, including death, humiliation, shock, mental anguish or mental injury sustained by that person at any time which results as a consequence of the physical injury, sickness or disease.

4. BROAD KNOWLEDGE OF OCCURRENCE/ NOTICE OF OCCURRENCE

Under **CONDITIONS**, the condition entitled **Duties in The Event of Occurrence, Offense, Claim or Suit** is amended to add the following provisions:

A. BROAD KNOWLEDGE OF OCCURRENCE

The **Named Insured** must give the Insurer or the Insurer's authorized representative notice of an **occurrence**, offense or **claim** only when the **occurrence**, offense or **claim** is known to a natural person **Named Insured**, to a

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partner, executive officer, manager or member of a **Named Insured**, or to an **employee** designated by any of the above to give such notice.

B. NOTICE OF OCCURRENCE

The **Named Insured's** rights under this **Coverage Part** will not be prejudiced if the **Named Insured** fails to give the Insurer notice of an **occurrence**, offense or **claim** and that failure is solely due to the **Named Insured's** reasonable belief that the **bodily injury** or **property damage** is not covered under this **Coverage Part**. However, the **Named Insured** shall give written notice of such **occurrence**, offense or **claim** to the Insurer as soon as the **Named Insured** is aware that this insurance may apply to such **occurrence**, offense or **claim**.

5. BROAD NAMED INSURED

WHO IS AN INSURED is amended to delete its Paragraph **3.** in its entirety and replace it with the following:

3. Pursuant to the limitations described in Paragraph **4.** below, any organization in which the **First Named Insured** has management control directly or indirectly:

a. on the effective date of this **Coverage Part**; or

b. by reason of a **Named Insured** creating or acquiring the organization during the **policy period**,

qualifies as a **Named Insured**, provided that there is no other similar liability insurance, whether primary, contributory, excess, contingent or otherwise, which provides coverage to such organization, or which would have provided coverage but for the exhaustion of its limit, and without regard to whether its coverage is broader or narrower than that provided by this insurance.

But this **BROAD NAMED INSURED** provision does not apply to any organization for which coverage is excluded by another endorsement attached to this **Coverage Part**.

For the purpose of this provision, and of this endorsement's **JOINT VENTURES / PARTNERSHIP / LIMITED LIABILITY COMPANIES** provision, management control means owning interests representing more than 50% of the voting, appointment or designation power for the selection of a majority of: the Board of Directors of a corporation; the management committee members of a joint venture; the management board of a limited liability company; the general partners of a limited partnership; or the partnership managers of a general partnership.

4. With respect to organizations which qualify as **Named Insureds** by virtue of Paragraph **3.** above, this insurance does not apply to:

a. **bodily injury** or **property damage** that first occurred prior to the date of management control, or that first occurs after management control ceases; nor

b. **personal or advertising injury** caused by an offense that first occurred prior to the date of management control or that first occurs after management control ceases.

5. The insurance provided by this **Coverage Part** applies to **Named Insureds** when trading under their own names or under such other trading names or doing-business-as names (dba) as any **Named Insured** should choose to employ.

6. ESTATES, LEGAL REPRESENTATIVES, AND SPOUSES

The estates, heirs, legal representatives and **spouses** of any natural person **Insured** shall also be insured under this policy; provided, however, coverage is afforded to such estates, heirs, legal representatives, and **spouses** only for **claims** arising solely out of their capacity or status as such and, in the case of a **spouse**, where such **claim** seeks **damages** from marital community property, jointly held property or property transferred from such natural person **Insured** to such **spouse**. No coverage is provided for any act, error or omission of an estate, heir, legal representative, or **spouse** outside the scope of such person's capacity or status as such, provided however that the **spouse** of a natural person **Named Insured** and the **spouses** of members or partners of joint venture or partnership

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING

CONTRACT SUMMARY OF CHANGES

CDA 9008 (NEW 6/16)

Program: CDA-MSSP

Contract Number: MS2425

Contract Term: Fiscal Year July 2024- June 2025

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
EXAMPLE: Exhibit A, Article II.A.4.	**EXAMPLE:** n/a	**EXAMPLE:** c) Include staff timesheets that detail how much time is spent on each activity.	**EXAMPLE:** New regulatory language added by the CA Dept. of Oversight	**EXAMPLE:** Sam Smith
Exhibit A, Article II.	CA.0141.R06.00	CA.0141.R07.00	Waiver Renewal effective 7/1/24- so the new number would be applicable to this contract cycle.	MSSP Policy
Exhibit A, Article II.	Individuals eligible for MSSP must be age sixty-five (65) or older; meet the eligibility criteria as a Medi-Cal recipient with an eligible Medi-Cal Aid Code for MSSP as described in the MSSP Medi-Cal Aid Codes, Article IV of this Exhibit; and be certifiable for placement in a nursing facility	Individuals eligible for MSSP must be age sixty-five (65) or older; meet the eligibility criteria as a Medi-Cal recipient with an eligible Medi-Cal Aid Code; and be certifiable for placement in a nursing facility	Full scope aid codes will be incorporated into the DHCS system, rather than manually cross checked against this list.	MSSP Policy
Exhibit A, Article IV.	MEDI-CAL AID DEFINITION & CODES	Section deleted entirely	Similar to language above, this is no longer applicable upon wavier renewal approval.	MSSP Policy
Exhibit A, Article V, #2	**Minor Home Repairs and Maintenance** (2.2): Minor Home Repairs do not involve structural changes or repairs to a dwelling.	**Minor Home Repairs and Maintenance** (2.2): Minor Home Repairs do not involve structural changes or major repairs to a dwelling.	Added "major" for clarity	MSSP Policy
Exhibit A, Article V, #2	**Community Transition Services-** (2.4-2.5:	**Community Transition Services-** (2.4):	No longer applies, as these codes have been combined.	MSSP Policy

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
CONTRACT SUMMARY OF CHANGES
CDA 9008 (NEW 6/16)

Program: CDA-MSSP
Contract Number: MS2425
Contract Term: Fiscal Year July 2024- June 2025

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
Exhibit A, Article V, #10,a)	**Care Management**: Assists waiver participants in gaining access to needed Waiver and other State Plan services, as well as needed medical, social, and other services, regardless of the funding source. Care managers are responsible for ongoing monitoring of the provision of services included in the waiver participant's plan of care. Additionally, care managers initiate and oversee the process of assessment and reassessment of waiver participant level of care and the monthly review of plans of care.	**Care Management**: Assists waiver participants in gaining access to needed Waiver and other State Plan services, as well as needed medical, social, and other services, regardless of the funding source. Care managers are responsible for ongoing monitoring of the provision of services included in the waiver participant's plan of care.	Removing for clarity and ultimately will be transitioning this duty to state staff	MSSP Policy
Exhibit B, Article I, #6	Repayment of any remaining advances funds not collected through the process described in subsection 6 above, will be recovered through the Audit process.	Repayment of any remaining advance funds not collected through the process described in subsection 6 above, will be recovered through the Audit process.	Changing Advance to Advances for clarity	MSSP Team
Exhibit B, Article X, a)	California Department of Aging Attention: Audits Branch 2880 Gateway Oaks Drive, Suite 200 Sacramento, California 95833	California Department of Aging Attention: Audits and Risk Management Branch 2880 Gateway Oaks Drive, Suite 200 Sacramento, California 95833	Adding "and Risk Management" to the name of the audits branch for clarity	MSSP Policy
Exhibit B, Article XI, G.	The Contractor shall require its subcontractors under this Agreement, other than units of local government which are similarly self-insured, to maintain adequate insurance coverage for general liability, Worker's Compensation liabilities, and if	The Contractor shall require its subcontractors under this Agreement, other than units of local government which are similarly self-insured, to maintain insurance appropriate to the work to be performed, in alignment with industry standards and the	Removal of the word adequate to describe insurance policies. Replaced with more specific language about appropriate work performed to industry standards	MSSP Policy and CDA Legal upon prompting from DHCS legal

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
CONTRACT SUMMARY OF CHANGES
CDA 9008 (NEW 6/16)

Program: CDA-MSSP
Contract Number: MS2425
Contract Term: Fiscal Year July 2024- June 2025

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
	appropriate, auto liability including non-owned auto and professional liability further, the Contractor shall require all of its subcontractors to hold the Contractor harmless.	requirements set forth in the California Civil Code, California Public Contracting Code, and the relevant sections of the California Insurance Code. This insurance shall be for general liability, Worker's Compensation liabilities, and if appropriate, auto liability including non-owned auto and professional liability, and/or any other form of insurance as may be proper in the industry in which the Contractor is performing under this Agreement. Further, the Contractor shall require all of its subcontractors to hold the Contractor harmless.		
Exhibit E, Article VI, A.	Contractor, and its Subcontractors/Vendors, agrees that any security incidents or breaches of unsecured PHI or PI will be immediately reported to DHCS in the manner described in Exhibit F.	Contractor, and its Subcontractors/Vendors, agrees that any security incidents or breaches of unsecured PHI or PI will be immediately reported to CDA as described in CDA's Security Incident Reporting Procedures and to DHCS in the manner described in Exhibit F.	Updating to reflect current processes for Security Incident reporting	MSSP Team
Exhibit D, Article XII, A	The parties agree that for the terminated portion of the Agreement, the remainder of the Agreement shall be deemed to remain in effect and is not void.	The parties agree that, with the exception of the terminated portion of the Agreement, the remainder of the Agreement shall be deemed to remain in effect and is not void.	Added language for clarity	CDA Legal

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING

CONTRACT SUMMARY OF CHANGES

CDA 9008 (NEW 6/16)

Program: CDA-MSSP

Contract Number: MS2425

Contract Term: Fiscal Year July 2024- June 2025

Section	Current Language in Existing Contract	New/Amended Language in New Contract	Reason for Change	Editor's Name
Exhibit D, Article XII, A	In case of threat of life, health, or safety of the public, termination of the Agreement shall be effective immediately.	In case of threat of life, health, or safety of the public, termination of the Agreement shall be effective immediately.	Moved language from 1 to 12 in the order of reason for termination for cause.	CDA Legal

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CALIFORNIA DEPARTMENT OF AGING
Multipurpose Senior Services Program
2880 Gateway Oaks Drive, Suite 200
Sacramento, CA 95833
www.aging.ca.gov
TEL 916-419-7500
FAX 916-928-2267
TTY1-800-735-2929

March 4, 2024

Ms. Evelyn Rounds, Site Director
Multipurpose Senior Services Program -41
505 City Parkway West
Orange, California 92868

Dear Ms. Rounds,

The California Department of Aging, Multipurpose Senior Services Program (MSSP) Bureau has completed a review of your MSSP site budget for Fiscal Year (FY) 2024-2025. As a result of our review, the Department approves the projected expenditure of MSSP funds by budget category.

Enclosed is a copy of the signed and approved budget for your records. The original will be kept on file at the Department. If you have any questions, please contact your assigned program analyst.

Sincerely,

Kimberly Bymers, Operations Manager
Multipurpose Senior Services Program Bureau
California Department of Aging

Enclosure

cc: Jeff Mercer, Program Analyst
Multipurpose Senior Services Program
California Department of Aging

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Site Name	41 - Orange County Health Authority (dba CalOptima)	Funded Slots	568	Date Submitted to CDA-MSSP	4-Mar-24

Fiscal Year 2024-25

A. Care Management

Line #	Position Title	Last Name	Base Salary	Salary Adjustment	FTE	Adjusted Salary
1	Nurse Care Manager	Baylis	$127,094	3.000%	1.000	$130,907
2	Nurse Care Manager	Dang	$126,485	3.000%	1.000	$130,280
3	Nurse Care Manager	Holton	$127,094	3.000%	1.000	$130,907
4	Nurse Care Manager	Nguyen K.	$108,665	3.000%	1.000	$111,925
5	Nurse Care Manager	Nguyen V.	$127,094	3.000%	1.000	$130,907
6	Nurse Care Manager	St. Lawrence	$127,094	3.000%	1.000	$130,907
7	Nurse Care Manager	TBH	$102,047	0.000%	1.000	$102,047
8	Social Work Care Manager	Anderson	$95,152	3.000%	1.000	$98,007
9	Social Work Care Manager	Benedik	$86,241	3.000%	1.000	$88,828
10	Social Work Care Manager	Gil	$81,871	3.000%	1.000	$84,327
11	Social Work Care Manager	Nguyen S.	$94,549	3.000%	1.000	$97,385
12	Social Work Care Manager	Pratt	$106,106	3.000%	1.000	$109,289
13	Social Work Care Manager	TBH	$85,553	0.000%	1.000	$85,553
14	Social Work Care Manager	TBH	$85,553	0.000%	1.000	$85,553
15	Social Work Care Manager	TBH	$85,553	0.000%	1.000	$85,553
16			$0	0.000%	0.000	$0
17			$0	0.000%	0.000	$0
18			$0	0.000%	0.000	$0
19			$0	0.000%	0.000	$0
20			$0	0.000%	0.000	$0
21			$0	0.000%	0.000	$0
22			$0	0.000%	0.000	$0
23			$0	0.000%	0.000	$0
24			$0	0.000%	0.000	$0
25			$0	0.000%	0.000	$0
26					Subtotal Care Management Salaries	$1,602,373
27	Total Care Management (CM) FTE	15.00			Care Management Benefits	$20,030
28	Ratio	37.9				
29	**Total Care Management**			% Budget	53%	$1,622,403

B. Care Management Support/Administration

Salaries

Line #	Position Title	Last Name	Base Salary	Salary Adjustment	FTE	Adjusted Salary
30	Accounting Specialist	Vu	$87,029	3.000%	0.500	$44,820
31	Accounting Specialist	Cuevas Rios	$78,208	3.000%	0.250	$20,139
32	Site Director	Rounds	$170,846	3.000%	1.000	$175,972
33	Care Manager Aide	Castaneda	$61,798	3.000%	1.000	$63,652
34	Care Manager Aide	Diaz De Leon	$61,041	3.000%	1.000	$62,872
35	Care Manager Aide	Pham	$52,891	3.000%	1.000	$54,478
36	Care Manager Aide	Olivia Hernandez	$60,757	3.000%	1.000	$62,580
37	Supervising Care Manager	Dinh	$104,963	3.000%	1.000	$108,112
38	Supervising Care Manager	Rivera	$121,347	3.000%	1.000	$124,988
39	Supervising Care Manager	Young	$119,977	3.000%	1.000	$123,576
40			$0	0.000%	0.000	$0
41			$0	0.000%	0.000	$0
42			$0	0.000%	0.000	$0
43			$0	0.000%	0.000	$0
44			$0	0.000%	0.000	$0
45			$0	0.000%	0.000	$0
46			$0	0.000%	0.000	$0
47			$0	0.000%	0.000	$0
48					Subtotal CMS/Administration Salaries	$841,187
49					CMS/Administration Benefits	$10,515
50	Total CMS/Administration FTE	8.75				
51					Total CMS/Administration Salaries	$851,702

Operating Costs

52	Consultation, Professional Services					$69,000
53	Facility, Rent & Operations					$0
54	Equipment Cost equal to or greater than $5,000 per Unit (Any Computing Equipment regardless of Cost)					$0
55	Equipment, Maintenance & Rental Costs; Supplies					$0
56	Travel (In & Out of State)					$12,000
57	Training without Associated Travel Costs					$500
58	Subscriptions, Membership Dues					$6,000
59	Insurance					$0
60	Communications, Postage, Internet					$17,000
61						$0
62						$0
63	Indirect Costs (Indirect Costs/Base) - 15% maximum				3%	$68,116
64	Base = Salaries & Benefits			$2,474,105		
65						$0
66						$0
67					Total CMS/Administration Operating Costs	$172,616
68	**Total CMS/Admin**			% Budget	34%	$1,024,318

C. Waived Services

69	**Total Waived Services**			% Budget	13%	$395,487

D. Total Budget Amounts

70	**Fiscal Year Total Allocation**					$3,042,208

By completing Part I, I understand that this is an electronic signature and by checking the box I certify that all the provided information is believed to be accurate, reliable and complete to the best of my knowledge and ability to confirm it.

Full Name	Title	Date	Check box to indicate agreement with information provided in report.
Evelyn Rounds	Site Director	3/7/24	☑

For CDA Use Only.

Approved by:

Poonam Deo — Analyst Signature

3/4/2024 — Date

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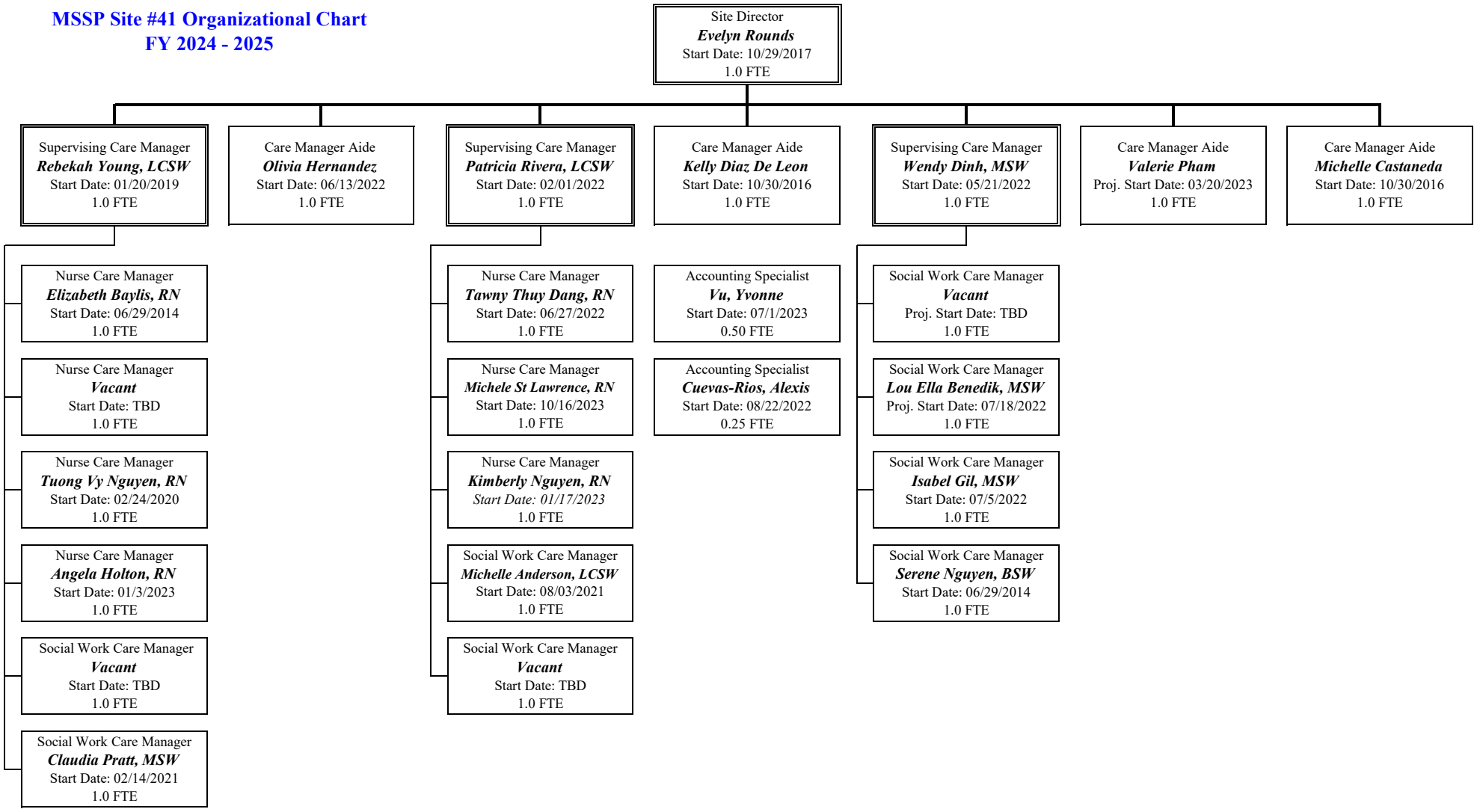
MSSP Site #41 Organizational Chart
FY 2024 - 2025



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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
MSSP AGENCY CONTRACTS REPRESENTATIVE (ACR)
CDA 9028 (NEW 03/2020)

MSSP Site Number(s): 41	Submission Date:

CONTRACTOR INFORMATION:	*** Change Requires STD 204**
*Legal Name: Orange County Health Authority	
*DBA Name: CalOptima Health	
*Business Address: 505 City Parkway West	City, State, Zip: Orange, CA 92868
*Mailing Address: Same as above	City, State, Zip:
General Email: erounds@caloptima.org	Website: caloptima.org
Public Line: (714) 246-8400	Fax:

ACR CONTACT INFORMATION:		
First Name: Evelyn	Last Name: Rounds	Title: Site Director
Email: erounds@caloptima.org	Business: (714) 246-8773	Fax:
Role: MSSP Agency Contract Representative		

PROJECT REPRESENTATIVE CONTACT INFORMATION:		
First Name: Scott	Last Name: Robinson	Title: Director, LTSS
Email: scott.robinson@caloptima.org	Business: (657) 900-1457	Fax:
Role: ☐ MSSP Site Director ☐ Program Director		

Authorized Signature: Evelyn Rounds, LCSW Print Name: Evelyn Rounds

Title: Site Director Phone: (714) 246-8773 Date: 04/17/24

Once completed, email this form to CDA Business Services: CDABusinessServices@aging.ca.gov.

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
MSSP AGENCY CONTRACTS REPRESENTATIVE (ACR)
CDA 9028 (NEW 03/2020)

Background and Instructions

What we are requesting from you and why?

The California Department of Aging (CDA) is requesting that you fill in the Authorized Contract Representative (ACR) Form to update CDA's MSSP contract contact database. The information collected is placed in your MSSP Site contract with CDA.

Who is the ACR and what do they do?

The ACR is the person designated by the MSSP site to handle all questions regarding the documents needed to execute a MSSP contract. The ACR will be the person CDA contacts first to handle any documents required to complete final execution of your MSSP Contract.

The ACR may be anyone ranging from a site Director to site support staff. The ACR is not required to be the person who signs (Director, Board Member) the contract. This allows the Contractor the flexibility to designate a separate staff member to bring together required contract documents, gather required signatures and mail final documents to CDA.

Who is the Project Representative and what do they do?

The Project Representative is the person designated by the MSSP site to handle all questions regarding the MSSP contracted services. The Project Representative manages the contract at service level and works with CDA MSSP staff regarding performance of the contracted services, etc. Other names for a Project Representative may be Contract/Program Administrator/Manager.

The Project Manager is typically a Site Director or Upper level Manager directly supervising services or sub-contracts.

How often is this form completed?

This form is completed on a yearly basis or as needed. CDA will send out ACR form requests once per year or upon a change request by a MSSP site.

May I designate a separate ACR for my AAA and MSSP contracts?

Yes, if your organization participates in both AAA programs and the MSSP Program, you will designate an ACR as follows:

- For AAA Programs use CDA 045 process outlined in your AAA contracts (Exhibit D, Article XVII, Section B)
- For MSSP use CDA 9028 MSSP process outlined in your MSSP contract (Exhibit D, Article XVII, Section B)

Additional Questions?

Additional questions are encouraged! If you have any additional questions, please feel free to contact me at CDABusinessService@aging.ca.gov, by replying to my original e-mail request, or by phone at (916) 419-7157.

EXHIBIT A, Attachment 1
General Information

1. The Contractor agrees to provide to the California Department of Aging (CDA) the services described herein Agreement number MS-2425-41.

2. The number of client slots per month shall be 568.

3. The services shall be performed in the catchment area zip codes listed in Exhibit G.

4. The services shall be provided as needed.

5. The project representatives during the term of this agreement will be:

State Agency: California Department of Aging	Contractor: ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
Name: MSSP Operations Manager	Name: Evelyn Rounds
Section/Unit: MSSP	Section/Unit: Multipurpose Senior Services Program
Address: 2880 Gateway Oaks Dr., Ste 200 Sacramento, CA 95834	Address: 505 City Parkway West Orange, CA 92868
Phone: (916) 419-7561	Phone: (714) 246-8773
Email: MSSPservice@aging.ca.gov	Email: erounds@caloptima.org

Direct all contract document inquiries to:

State Agency: California Department of Aging	Contractor: ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
Section/Unit: Subvention and Local Assistance Contracts Section	Section/Unit: Multipurpose Senior Services Program
Attention: Amanda Towers, Manager	Attention: Evelyn Rounds, Site Director
Address: 2880 Gateway Oaks Dr., Ste 200 Sacramento, CA 95834	Address: 505 City Parkway West Orange, CA 92868
Phone: (916) 931-1805	Phone: (714) 246-8773
Email: BMBSubvention@aging.ca.gov	Email: erounds@caloptima.org

The parties may change their representatives upon providing ten days written notice to the other party. Said changes do not require an amendment to this agreement.

ARTICLE II. MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP) OVERVIEW

The Multipurpose Senior Services Program (MSSP) is a Medi-Cal Home and Community Based Services (HCBS) Waiver, Control Number CA.0141.R07.00 authorized pursuant to Section 1915(c) of Title XIX of the Social Security Act (HCBS Waiver). The primary objectives of the MSSP are to:

1. Avoid the premature placement of frail older persons in nursing facilities

2. Foster independent living in their communities

Pursuant to an Interagency Agreement between Department of Health Care Services (DHCS) and California Department of Aging (CDA), CDA contracts with local government entities and private nonprofit organizations for local administration of the MSSP throughout the State. The Contractor is responsible for arranging for and monitoring community services to the MSSP waiver participant population in the catchment area identified in Exhibit G of this Agreement. Individuals eligible for MSSP must be age sixty-five (65) or older; meet the eligibility criteria as a Medi-Cal recipient with an eligible Medi-Cal Aid Code I; and be certifiable for placement in a nursing facility; live within a site's catchment area; be served within the program's cost limitations; and be deemed appropriate for care management services.

The Contractor uses a care management team to assess eligibility and need and provide for delivery of services. The Contractor is reimbursed for expenditures through a claims process operated by the State's Medi-Cal Fiscal Intermediary (see definition in Article VI of this Exhibit).

ARTICLE III. MSSP PROGRAM OPERATIONS

The Contractor shall be responsible for all care management obligations including processing waiver participant applications, determining eligibility, conducting assessments, developing care plans, case recording and documentation, and providing follow-up. The Contractor shall directly provide or arrange for the continuous availability and accessibility of all services identified in each waiver participant's care plan. The Contractor shall also ensure that the administrative integrity of the MSSP is maintained at all times. In order to maintain adequate administrative control, the Contractor shall incorporate the following components into the scope of operations:

A. Care Management Team

1. The Contractor shall maintain and have on file a written description and an organizational chart that outlines the structure of authority, responsibility, and accountability within the MSSP and the MSSP parent organization. The Contractor shall provide to its assigned CDA analyst a copy of the organization chart within thirty (30) days of the execution of this Agreement.

2. The Contractor shall employ a care management team, which consists of a social worker and a registered nurse, that meet the qualifications set forth in

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

the Waiver. The care management team shall determine waiver participant eligibility based on the criteria specified in the MSSP Site Manual, herein incorporated by reference. This team shall work with the waiver participant throughout the care management process (e.g., assessment, care plan development, service coordination, and service delivery).

3. The care management team shall: 1) provide information, education, counseling, and advocacy to the waiver participant and family, and 2) identify resources to help assure the timely, effective, and efficient mobilization and allocation of all services, regardless of the source, to meet the waiver participant's care plan goals.

4. The Contractor shall annually self-certify that staff meet the requirements as outlined in the MSSP Site Manual as well as participate in required trainings.

B. Care Plan

1. The Contractor's Care Management Team shall perform the MSSP waiver participant's assessments and work with the MSSP waiver participant, family, managed care plans, and others to develop a care plan covering the full range of required psychosocial and health services. The Care Management Team shall continue to work with the MSSP waiver participant to assure that the waiver participant is receiving and benefiting from the services and to determine if modification of the care plan is required.

2. Such MSSP subcontracts shall specify terms and conditions and payment amount and shall assure that subcontractors shall not seek additional or outstanding unpaid amounts from the MSSP participant.

C. Purchased Waiver Services

"Purchased Waiver Services" means goods and services approved for purchase under Title XIX of the Social Security Act, 1915(c) Home and Community Based Waiver authority. The list of MSSP Purchased Waiver Services is included in Article VI. The Contractor may purchase MSSP Purchased Waiver Services when necessary to support the well-being of a MSSP waiver participant.

1. Prior to purchasing services, the Contractor shall verify, and document its efforts, that alternative resources are not available (e.g., family, friends and/or other community resources)

2. The Contractor may either enter into contracts with subcontractors to provide Purchased Waiver Services or directly purchase items through the use of a purchase order.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

3. The Contractor shall maintain written, signed and dated subcontracts for the following array of Purchased Waiver Services as defined in MSSP Site Manual at all times during the terms of this Agreement:

   a) Adult Day Care (ADC)
   b) Minor Home Repair/Maintenance Services
   c) Supplemental Homemaker, Personal Care and Protective Supervision Services
   d) Consultative Clinical Services
   e) Respite Care
   f) Transportation
   g) Meal Services
   h) Counseling and Therapeutic Services
   i) Communication Services

4. The Contractor shall assure that its subcontractors have the license(s), credentials, qualifications or experience to provide services to the MSSP Participant.

5. The Contractor shall be responsible for coordinating and tracking MSSP Purchased Waiver Services for a MSSP waiver participant.

6. The Contractor shall operate a Multipurpose Senior Services Program at a location and in a manner approved by the State, ensuring that waiver participant inquiries and requests for service(s) receive prompt response.

D. Case Files

The Contractor shall maintain an up-to-date, centralized, and secured case file record for each waiver participant, consisting, at a minimum, of the following documents prescribed by CDA:

1. Application for the MSSP

2. MSSP Authorization for Use and Disclosure of Protected Health Information

3. Participant Enrollment/Termination Information

4. Level of Care Certification “Level of Care” (LOC) means a clinical certification by the Contractor that a MSSP Applicant or MSSP waiver participant meets the requirement(s) for a nursing facility placement.

5. MSSP Initial Health Assessment, MSSP Initial Psychosocial Assessment, and MSSP Reassessments

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

6. Care Plan and Service Planning and Utilization Summary (SPUS)

7. Waiver Participant monthly progress notes and other waiver participant-related information (e.g., correspondence, medical/psychological/social records, service delivery verification)

8. Denial or discontinuance letters (Notice of Action)

9. Termination documents

10. Fair Hearing documentation

E. Management Information Systems (MIS)

The Contractor shall maintain and operate an MIS at its site. The Contractor shall:

1. Maintain office space with proper security and climate control for on-site computer hardware, e.g., terminals, processors, modems, and printers.

2. Provide adequate staff for timely, accurate, and complete MIS data input, including but not limited to:

   a. Waiver participant name, MSSP waiver participant number, Medi-Cal aid code, county code, Medicare and Social Security numbers, birth date, level of care, emergency contact information, physician information, and demographic information

   b. Tracking of Waiver Services and costs

   c. Enrollment and termination dates

   d. Provider Index Report

3. Accommodate State-required changes in MIS procedures which may be necessary from time to time.

4. Generate reports as required by the State.

5. Submit to CDA by the 5th working day of the month (unless otherwise specified by CDA), the active waiver participant count for the preceding month. The active waiver participant count consists of the number of waiver participants actively enrolled in MSSP on the last (business) day of the reporting month. This does not include waiver participant cases closed (or terminated) during the reporting month.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

6. Submit to CDA, by the 5th working day of the month (unless otherwise specified by CDA), the Wait List of participants as of the last day of the previous month. "Wait List" means a list of potential MSSP participants, established, and maintained by the Contractor, when the Contractor has reached its capacity. To ensure compliance with MSSP Waiver requirements and Centers for Medicare and Medicaid Services (CMS) direction, MSSP sites must develop and implement a wait list policy and procedure. The policy and procedure must include provisions for: prescreening individuals to determine eligibility; managing applicants' placement on and removal from the wait list; periodically reviewing the eligibility and identified needs of applicants on the wait list; and assigning priority for enrollment based on identified needs and level of risk. The Contractor determines the priority of enrollment into the MSSP in accordance with CDA and CMS requirements.

7. Verify all service data within ninety (90) calendar days of the date of service. The Contractor shall submit this data to CDA by the 5th calendar day of the following month, ninety-five (95) days from the end of the month of services.

8. Submit claims to the State's Medi-Cal Fiscal Intermediary (FI), per instructions stated in the Medi-Cal Provider Manual.

F. Enrollment Levels

The Contractor shall maintain a caseload of no less than 95 percent and no more than 105 percent of the specified number of participant slots for the term of contract (12 months). This is a performance requirement to ensure compliance with the terms and conditions of this Agreement and Waiver requirements. If the Contractor's active participant count falls below ninety-five percent (95%) of the number of budgeted participant slots for more than three (3) consecutive months, the Contractor shall be required to submit an enrollment plan for review, approval, and monitoring by CDA.

"Participant slot" means a position, whether vacant or filled, which is funded according to a Contractor's site budget and allocated for a participant during a given month.

G. Emergency Preparedness

1. The Contractor shall prepare and implement an emergency preparedness plan that ensures the provision of services to meet the emergency needs of waiver participants they are charged to serve during medical or natural disasters: a pandemic, earthquake, fire, flood, or public emergencies, such as riot, energy shortage, hazardous material spill, etc. This plan shall conform to any statewide requirements issued by any applicable State or local authority.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

2. The Contractor shall adopt policies and procedures that address emergency situations and ensure that there are safeguards in place to protect and support waiver participants in the event of natural disasters or other public emergencies.

3. The Contractor shall ensure that emergency preparedness policies and procedures are clearly communicated to site staff and subcontractors in order to provide care under emergency conditions and to provide for back-up in the event that usual care is unavailable.

4. The Contractor shall develop an emergency preparedness training plan to be provided to all staff at least annually and as needed when new staff are hired. The training shall consist of:

   a. Familiarity with telephone numbers of fire, police, and ambulance services for the geographic area served by the provider

   b. Techniques to obtain vital information from older individuals who require emergency assistance

   c. Written emergency procedures for all staff that have contact with older individuals

5. The Contractor shall develop a method for documenting the emergency preparedness training provided for all staff.

6. The Contractor shall develop a program for testing its emergency preparedness plan at least annually.

H. Other Provisions

1. The Contractor is relieved of all obligations to arrange for and provide services to a waiver participant under this Agreement after the waiver participant has been terminated from the MSSP and has exhausted their appeal rights.

2. The Contractor shall provide a notice of termination to a waiver participant prior to terminating the Participant from the MSSP and shall reference the MSSP Site Manual to determine how many days' notice are required based on the type of termination code that is used.

3. The Contractor shall administer a subcontractor appeal and adjudication process. The subcontractor appeal and adjudication process must be included in all subcontracts. This process shall assure fair consideration and disposition of subcontractor claims against the Contractor. Final authority to decide claims shall be vested with the Contractor. The subcontractor has no right of appeal to CDA.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

4. The Contractor shall serve participants in the Catchment Area as defined in Exhibit G of this Agreement.

5. The Contractor shall abide by the MSSP Site Manual, training manuals, and other guidance issued by the CDA MSSP Bureau. The Contractor shall comply with any and all changes to State and federal law. The Contractor shall include this requirement in each of its subcontracts.

6. The Contractor shall make staff available to CDA for training and meetings which CDA may find necessary from time to time.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER

Services Provided Under the Waiver – Contractors must have the ability to provide the following services to MSSP waiver participants:

Definitions of each of the services approved by the Centers for Medicare and Medicaid Services of the Department of Health and Human Services under the existing 1915(c) Home and Community-Based Services Waiver are as follows. The numbers in parentheses are program code designations for the particular service.

1. **Adult Day Care** (1.1): Will be provided to MSSP waiver participants who are identified in their plan of care as benefiting from being in a social setting with less intense supervision and fewer professional services than offered in an adult day health support center. Adult Day Care services will be provided when the waiver participant's plan of care indicates that the service is necessary to reach a therapeutic goal. Adult day care centers are community-based programs that provide nonmedical care to persons eighteen (18) years of age or older in need of personal care services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis. The Department of Social Services (DSS) licenses these centers as community care facilities.

   Adult Day Care centers are subject to Federal Home and Community-Based Settings (HCBS) requirements, meaning they must:
   - Support access to the greater community;
   - Be selected by the Participant from among setting options;
   - Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
   - Optimize autonomy and independence in making life choices;
   - Facilitate choice regarding services and who provides them; and
   - Be physically accessible.

   Vendor contracts with Adult Day Care centers must contain language that addresses Home and Community-Based Settings requirements as specified in 42 CFR 441.301(c)(4).

2. **Minor Home Repairs and Maintenance** (2.2): Minor Home Repairs do not involve structural changes or major repairs to a dwelling. Maintenance is defined as those services necessary for accessibility (e.g., ramps, grab bars, handrails, items above what is covered by the State Plan, and installation), safety (e.g., electrical wiring, smoke alarms), or security (e.g., locks). Eligible waiver participants are those whose health and/or safety or independence are jeopardized because of deficiencies in their place of residence. This service is limited to waiver participants who are owners/occupiers of their own home, or those in rental housing where the owner refuses to make needed repairs or otherwise alter the residence to adapt to special waiver participant needs. Written permission from the landlord (including provision for removal of modifications, if necessary) is required before undertaking repairs or

maintenance on leased premises. All services shall be provided in accordance with applicable State or local building codes.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

3. **Non-medical Home Equipment** (2.3): Includes equipment and supplies which address a waiver participant's functional limitation and/or condition, are necessary to assure the waiver participant's health, safety, and independence, and are not otherwise provided through this Waiver or through the State Plan.

   Allowable items:
   Small appliances; large appliances; furniture; home safety devices; clothing-related items; paperwork-related items; organizing items; household items (items that are not specifically designed for home safety, but are necessary to maintain independence and safety in the home); kitchenware; bedding/bath items; exercise equipment; social support/therapeutic activity supplies; personal care items (items related to personal care and the prevention of skin breakdown); health-related supplies (items that have a health component, but are not covered by the State Plan); and incontinence supplies (gloves, wipes, washcloths and creams).

   Experimental or prohibited treatments are excluded as well as those items and services solely for entertainment or recreation. The costs associated with delivery and repairs of the items allowable under this service are also included.

4. **Community Transition Services-** (2.4): These services allow for non-recurring moving and/or set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community. Eligible waiver participants are those who reside in a facility/institution or care provider-owned residence and are transitioning from a facility/institution to their own home or apartment in the community where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the waiver participant's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving services, which may include materials and necessary labor; (f) activities to assess need, arrange for and procure need resources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

5. **Assistive Technology** (2.6): Assistive technology means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a waiver participant in the selection, acquisition, or use of an assistive technology device. Assistive Technology includes: (A) the evaluation of the assistive technology needs of a waiver participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the waiver participant; (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; applying, maintaining, repairing, or replacing assistive technology devices; (C) services consisting of selecting, designing, fitting, customizing, adapting; (D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the care plan. The costs associated with delivery and repairs of the items allowable under this service are also included.

   Examples include, but are not limited to, a transfer pole, grabber/reacher, dressing aid or sock aid, etc.

6. **Supplemental Homemaker Services** (3.1): are for purposes of household support and applies to the performance of household tasks rather than to the care of the waiver participant. Homemaker activities are limited to: household cleaning, laundry (including the services of a commercial laundry or dry cleaner), shopping, food preparation, and household maintenance. waiver participant instruction in performing household tasks and meal preparation may also be provided.

   The care manager completes a health and psychosocial assessment which assess all waiver participant needs including the need for homemaker services and personal care. The assessments also consider IHSS services in place and whether the waiver participant's needs are being met.

   Supplemental Homemaker Services under the MSSP Waiver are limited to additional services not otherwise covered under the State Plan or under IHSS, but consistent with the Waiver objectives of avoiding institutionalization.

   Services purchased using 3.1 can supplement but not supplant IHSS.

7. **Supplemental Personal Care** (3.2): This service provides assistance to maintain bodily hygiene, personal safety, and activities of daily living (ADL). These tasks are limited to nonmedical personal services: feeding, bathing, oral hygiene, grooming, dressing, care of and assistance with prosthetic devices, rubbing skin to promote circulation, turning in bed and other types of

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

repositioning, assisting the individual with walking, and moving the individual from place to place (e.g., transferring). waiver participant instruction in self-care may also be provided; may also include assistance with preparation of meals but does not include the cost of the meals themselves.

Supplemental Personal Care under the MSSP Waiver is limited to additional services not otherwise covered under the State Plan or under IHSS, but consistent with the Waiver objectives of avoiding institutionalization. Services are provided when personal care services furnished under the approved State Plan limits are exhausted. The scope and nature of these services do not differ from personal care services furnished under the State Plan. The provider qualifications specified in the State Plan apply.

Services purchased using 3.2 can supplement but not supplant IHSS.

Personal care service providers may be paid while the waiver participant is institutionalized. This payment is made to retain the services of the care provider and is limited to seven (7) calendar days per institutionalization.

8. **Counseling & Therapeutic Services- Therapeutic Services** (3.3): This service addresses unmet needs of waiver participants when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria: The waiver participant assessment identifies need for this support and the care plan reflects the required service(s). MSSP waiver participants are extremely frail and, on occasion, in need of services that cannot be provided under that cannot be provided under Medi-Cal. This MSSP service supplements but does not supplant benefits provided by the State Plan. Therapeutic Services includes the following: foot care, massage therapy, and swim therapy.

9. **Supplemental Protective Supervision** (3.7): Ensures provision of supervision in the absence of the usual care provider to persons residing in their own homes, who are very frail or otherwise may suffer a medical emergency. Such supervision serves to prevent immediate placement in an acute care hospital, skilled nursing facility, or other 24-hour care facility. Such supervision does not require medical skills and can be performed by an individual trained to summon aid in the event of an emergency. This service may also provide a visit to the waiver participant's home to assess a medical situation during an emergency (e.g., natural disaster). Waiver Service funds may not be used to purchase this service until existing county Title XX Social Services and Title XIX Medi-Cal resources have been fully utilized and an unmet need remains.

Waiver Participants that receive Supplemental Protective Supervision may also receive a room monitor under Communication: Device (9.2); however, are not allowed to also receive Emergency Response System (ERS) services.

Services purchased using 3.7 can supplement but not supplant IHSS.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

10. **Care Management**: Assists waiver participants in gaining access to needed Waiver and other State Plan services, as well as needed medical, social, and other services, regardless of the funding source. Care managers are responsible for ongoing monitoring of the provision of services included in the waiver participant's plan of care. waiver participant

    a) **Care Management** (50): The MSSP care management system vests responsibility for assessing, care planning, authorizing, locating, coordinating, and monitoring a package of long-term care services for community-based waiver participants with a local MSSP site contractor and specifically with the site care management team. The care management teams at each of the local sites are trained professionals working under the job titles of Nurse Care Manager and Social Work Care Manager; these professionals may be assisted by Care Manager Aides. The teams are responsible for Care Management services including the assessment, care plan development, service authorization/delivery, monitoring, and follow-up components of the program. Case records must document all waiver participant contact activity each month.

    b) **Deinstitutional Care Management (DCM)** (4.6): This service is used ONLY with individuals who are institutionalized. It allows care management and Waiver Services to begin up to one hundred eighty (180) days prior to an individual's discharge from an institution. It may be used in two situations, as follows:

    - Where MSSP has gone into a facility (nursing facility or acute hospital) to begin working with a resident to facilitate their discharge into the community
    - Where an established MSSP waiver participant is institutionalized and MSSP services are necessary for the person to be discharged back into the community

    In either situation, all services (monthly Administration and Care Management, plus any purchased services) provided during this period are combined into one unit of DCM and billed upon discharge. For those individuals who do not successfully transition to the Waiver, all services provided are combined into one unit of DCM and billed at the end of the month in which the decision is made to cease MSSP activity. For those individuals who do not successfully transition to the Waiver, billing is disallowed, as Federal Financial Participation (FFP) cannot be claimed for DCM services where the participant does not transition into the Waiver. No care management services available under the State Plan will be duplicated under the MSSP Waiver.

11. **Consultative Clinical Services** (4.3): This service addresses the unmet needs of waiver participants when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria:

    - The waiver participant assessment identifies need for this support and the care plan reflects the required service(s).

    - MSSP utilizes all of the services available under the State Plan prior to purchasing these services as Waiver Services. MSSP's waiver participants are extremely frail and, on occasion, in need of services that cannot be provided under Medi-Cal. This service is especially critical for persons recently discharged from acute hospitals or who are otherwise recovering at home from an acute illness or injury. This MSSP service supplements, but does not supplant, benefits provided by the State Plan.

    In addition to the provision of care, waiver participants and their families/caregivers are trained in techniques which will enable them (or their caregivers) to carry out their own care whenever possible.

    Allowable services are:
    • Social services consultation
    • Legal and paralegal professionals' consultation
    • Dietitian/Nutrition consultation
    • Pharmacy consultation
    • Vital sign monitoring

12. **Respite** (5.1, 5.2): The State Plan does not provide for respite care. "Respite care services shall be subject to EVV requirements required by Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b)." By definition, the purpose of respite care is to relieve the waiver participant's informal caregiver and thereby prevent breakdown in the informal support system. Respite service will include the supervision and care of a waiver participant, while the family or other individuals who normally provide primary care take short-term relief or respite which allows them to continue as caregivers. Respite may also be needed in order to cover emergencies and extended absences of the caregiver. As dictated by the waiver participant's circumstances, services will be provided In-Home (5.1) or Out-of-Home (5.2) through appropriate available resources such as board and care facilities, skilled nursing facilities, etc. Federal Financial Participation will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. Individuals providing services in the waiver participant's residence shall be trained and experienced in homemaker services, personal care, or home health services, depending on the requirements in the waiver participant's plan of care.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

13. **Transportation** (6.3 and 6.4): These services provide access to the community (e.g., non-emergency medical transportation to health and social service providers) and special events for waiver participants who do not have means for transportation or whose mobility is limited, or who have functional disabilities requiring specialized vehicles and/or escort. These services are in contrast to the transportation service authorized by the State Plan which is limited to medical services, or waiver participants who have documentation from their physician that they are medically unable to use public or ordinary transportation. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

Transportation services are usually provided under public paratransit or public social service programs (e.g., Title III of the Older Americans Act) and shall be obtained through these sources without the use of MSSP resources, except in situations where such services are unavailable or inadequate. Service providers may be paratransit subsystems or public mass transit; specialized transport for the older adults and adults with disabilities; private taxicabs where no form of public mass transit or paratransit is available or accessible; or private taxicabs when they are subsidized by public programs or local government to service frail older adults and handicapped (e.g., in California, some counties provide reduced fare vouchers for trips made via private taxicabs for frail older adults and handicapped).

Escort services will be provided when necessary to assure the safe transport of the waiver participant. Escort services may be authorized for those waiver participants who cannot manage to travel alone and require assistance beyond what is normally offered by the transportation provider. This service will be provided by trained paraprofessionals or professionals, depending on the waiver participant's condition and care plan requirements.

14. **Nutritional Services** (7.1, 7.2, and 7.3): These services may be provided daily but are not to constitute a full nutritional regimen (three (3) meals a day).

a) **Congregate Meals** (7.1): Meals served in congregate meal settings for waiver participants who are able to leave their homes or require the social stimulation of a group environment in order to maintain a balanced diet. Congregate meals can be a preventive measure for the frail older person who has few (if any) informal supports, as well as a rehabilitative activity for people who have been physically ill or have suffered emotional stress due to losses associated with aging. This service should be available to MSSP waiver participants through Title III of the Older Americans Act. MSSP funds shall only be used to supplement congregate meals when funding is unavailable or inadequate through Title III or other public or private sources.

Congregate Meal Sites are subject to Federal Home and Community-Based Settings (HCBS) requirements, meaning they must:

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

- Support access to the greater community;
- Be selected by the participant from among setting options;
- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize autonomy and independence in making life choices;
- Facilitate choice regarding services and who provides them; and
- Be physically accessible.

Vendor contracts with Congregate Meal Sites must contain language that addresses Home and Community-Based Settings requirements as specified in 42 CFR 441.301(c)(4).

b) **Home Delivered Meals** (7.2): Meals for waiver participants who are homebound, unable to prepare their own meals and have no caregiver at home to prepare meals for them. As with Congregate Meals, the primary provider of this service is Title III of the Older Americans Act. MSSP funds shall only be used to supplement home-delivered meals when they are unavailable or inadequate through Title III or other public or private sources.

c) Oral Nutritional Supplements (7.3): If oral nutritional supplements (ONS) are to be purchased using Waiver Service funds, the following actions must occur and be documented in the Participant record:

- The Nurse Care Manager (NCM) must assess the waiver participant's nutritional needs and determine that an ONS is advisable.
- The use of home-prepared drinks/supplements (instant breakfast, pureed food) has been explored and found not to meet the Participant's needs.
- All other options for payment of an ONS have been exhausted (Waiver Participant, family, etc.).

If all three criteria have been satisfied, an ONS may be purchased initially for a period of three (3) months. If an ONS needs to be continued beyond the three-month timeframe, a physician order must be obtained. Upon annual reassessment, if all criteria, including a new nutritional screen, are satisfied and the previous physician order has expired, another three months may be purchased. The physician's order must be renewed on an annual basis.

15. **Counseling & Therapeutic Services** (8.3, 8.4, and 8.5): These services include protection for waiver participants who are isolated and homebound due to health conditions; who suffer from depression and other psychological problems; individuals who have been harmed or threatened with harm (physical or mental) by other persons or by their own actions; or those whose cognitive functioning is impaired to the extent they require assistance and support in

making and carrying out decisions regarding personal finances.

a. **Social Support** (8.3): Includes periodic telephone contact, visiting, or other social and reassurance services to verify that the individual is not in medical, psychological, or social crisis, or to offset isolation. Such services shall be provided based on need, as designated in the waiver participant's plan of care. The MSSP has found that isolation and lack of social interaction can seriously impact some waiver participants' capacity to remain independent. Lack of motivation or incentive or the lack of any meaningful relationships can contribute to diminishing functional capacity and premature institutionalization.

   These services are often provided by volunteers or through Title III of the Older Americans Act; however, these services may not be available in a particular community and do, infrequently, require purchase. The Waiver will be used to purchase friendly visiting only if the service is unavailable in the community or is inadequate as provided under other public or private programs.

b. **Therapeutic Counseling** (8.4): Includes individual or group counseling to assist with social, psychological, or medical problems which have been identified in the assessment process and included in the waiver participant's care plan. The MSSP has found that therapeutic counseling is essential for preventing some waiver participants from being placed in a nursing facility. This service may be utilized in situations where waiver participants or their caretakers may face crises, severe anxiety, emotional exhaustion, personal loss/grief, confusion, and related problems. Counseling by licensed or certified counselors in conjunction with other services (e.g., respite, IHSS, meals) may reverse some states of confusion and greatly enhance the ability of a family to care for the waiver participant in the community or allow the waiver participant to cope with increasing impairment or loss.

c. **Money Management** (8.5): This service assists the waiver participant with activities related to managing money and the effective handling of personal finances. Services may be either periodic or as full-time substitute payee. Services may be provided by organizations or individuals specializing in financial management or performing substitute payee functions.

16. **Communication (9.1 and 9.2)**: waiver participants who receive these services are those with special communication problems such as vision, hearing, or speech impairments and persons with physical impairments likely to result in a medical emergency. Services shall be provided by organizations such as: speech and hearing clinics; organizations serving blind individuals; hospitals; senior citizens centers; and providers specializing in communications equipment for disabled or at-risk persons. Services shall be available on a routine or emergency basis as designated in the waiver participant's plan of care.

ARTICLE V. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

a. **Translation** (9.1): The provision of translation and interpretive services for purposes of instruction, linkage with social or medical services, and conduct of business is essential to maintaining independence and carrying out the ADL and Instrumental Activities of Daily Living (IADL) functions.

For non-English speaking waiver participants, this service is the link to the entire in-home and community-based service delivery system. MSSP resources shall be used to support this service only where family and community resources are unable to meet the need, and as described in the care plan.

b. **Device** (9.2): The rental/purchase of 24-hour emergency assistive services, or installation of a telephone to assist in communication (excluding monthly telephone charges) for waiver participants who are at risk of institutionalization due to physical conditions likely to result in a medical emergency. Purchase of Emergency Response Systems (ERS) is limited to those waiver participants who live alone, or who are alone for significant parts of the day and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The following are allowable:

(i) 24-hour answering/paging
(ii) Medic-alert type bracelets/pendants
(iii) Intercoms
(iv) Emergency Response System
(v) Room/two-way monitors
(vi) Light fixture adaptations (blinking lights, etc.)
(vii) Telephone adaptive devices not available from the telephone company

This service is limited to additional services and items not otherwise covered under the State Plan but are consistent with Waiver objectives of avoiding institutionalization. Telephone installation or reactivation of service will only be authorized to enable the use of telephone-based electronic response systems where the waiver participant has no telephone, or for the isolated waiver participant who has no telephone and who resides where the telephone is the only means of communicating health needs. This service will only be authorized when the waiver participant has a medical/health condition that makes him/her vulnerable to medical emergency.

Waiver Participants that receive Supplemental Protective Supervision may also receive a room monitor under Communication: Device; however, are not allowed to also receive ERS services. These types of devices are intended to assist in keeping at-risk waiver participants safe in the home and are not intended to replace an in-person support staff.

ARTICLE VI. ELECTRONIC VISIT VERIFICATION (EVV)

1. Electronic Visit Verification (EVV) is a telephone and computer-based solution validating that in-home service visits occur. EVV solutions shall verify the: a) type of service performed; b) individual receiving the service; c) date of the service; d) location of service delivery; e) individual providing the services; and f) time the service begins and ends.

2. Pursuant to Subsection (l) of Section 1903 of the Social Security Act (SSA) (42 U.S.C. 1396b), Contractor shall implement DHCS-approved EVV solutions for Medicaid-funded personal care services and home health care services. Contractor and subcontractors shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 to prevent use or disclosure of the information as provided for by this Agreement.

ARTICLE I. INVOICING AND PAYMENT

A. To receive payment under the fee-for-service (FFS) payment model, the Contractor shall prepare and submit electronic claims through the State's Fiscal Intermediary (FI) as set forth in the Medi-Cal Provider Manual.

B. Payments shall be made in accordance with the following provisions:

1. The Contractor shall submit claims to Medi-Cal FI, based upon the month of service and only for actual expenses. On each claim, the Contractor shall show the amount billed for each service code.

2. Failure to provide data and reports specified by this Agreement will result in the delay of payment of invoices.

C. Payment will be made in accordance with, and within the time specified in, California Government Code, Chapter 4.5, commencing with Section 927.

D. Reimbursement for Performance

The Contractor shall be entitled to monthly payment for actual services delivered to the Contractor's monthly active participants. This amount may vary from month to month but total annual payments to the Contractor shall not exceed the amount of the Contractor's total participant slot budget for the year.

E. Rate Adjustment

Any rate adjustments must be submitted to CDA for approval. The rate change request should be submitted to MSSPService@aging.ca.gov and include the following information in their rate change request:

- Billing Code
- Effective Date
- Current Rate
- Requested Rate

F. Advance Payments

1. CDA may authorize an advance payment during the term of the Agreement pursuant to the Welfare and Institutions Code Section 9566 for Contractors providing services under the FFS payment model. Upon approval of this Agreement, the Contractor may request an advance not to exceed twenty-five percent (25%) of the total contract amount.

2. A request for an advance payment shall be on the Contractor's letterhead and include both an original signature of authorized designee and the Agreement number. Requests for advances will not be accepted after the first day of that fiscal year unless otherwise authorized by CDA.

3. Any funds advanced under this Agreement, plus interest earned on same, shall be deducted from amounts due the Contractor. If, after settlement of the Contractor's final claim, the California Department of Health Care Services (DHCS) or CDA determines an amount is owed DHCS or CDA hereunder, DHCS or CDA shall notify the Contractor and the Contractor shall refund the requested amount within ten (10) working days of the date of the State's request.

4. The Contractor may at any time repay all or any part of the funds advanced hereunder. Whenever either party gives prior written notice of termination of this Agreement, the Contractor shall repay to DHCS, within ten (10) working days of such notice, the unliquidated balance of the advance payment.

5. Repayment of advances will be recovered from claims submitted to the State's FI after January 1st of each fiscal year and be collected at fifty percent (50%) of each claim submitted until the amount advanced is repaid. The Contractor may at any time be required to repay to DHCS all or any part of the advance.

6. Repayment of any remaining advance funds not collected through the process described in subsection 6 above, will be recovered through the Audit process.

ARTICLE II. FUNDS

A. Expenditure of Funds

1. The Contractor shall expend all funds received hereunder in accordance with this Agreement.

2. Any reimbursement for authorized travel and per diem shall be at rates not to exceed those amounts paid by the State in accordance with the California Department of Human Resources' (CalHR) rules and regulations.

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ARTICLE II. FUNDS (Continued)

In State:

- Mileage/Per Diem (meals and incidentals)/Lodging

Out of State:

- Travel and Relocation Policy-Human Resource Manual

This is not to be construed as limiting the Contractor from paying any differences in costs, from funds other than those provided by CDA, between the CalHR rates and any rates the Contractor is obligated to pay under other contractual agreements. No travel outside the State of California shall be reimbursed unless prior written authorization is obtained from the State. [2 CCR 599.615 et seq.]

The Contractor agrees to include these requirements in all contracts it enters into with subcontractors/vendors to provide services pursuant to this Agreement.

3. DHCS and CDA reserve the right to refuse payment to the Contractor or later disallow costs for any expenditure as determined by DHCS or CDA to be out of compliance with this Agreement; unrelated or inappropriate to contract activities; when adequate supporting documentation is not presented; or where prior approval was required but was either not requested or granted.

4. The Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Contract, shall be paid by the Contractor to DHCS to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Contract.

5. CDA may require prior approval and may control the location, cost, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar workshop or conference conducted by the Contractor in relation to the program funded through this Contract. CDA may also maintain control over any reimbursable publicity, or education materials to be made available for distribution. The Contractor is required to acknowledge the support of CDA in writing, whenever publicizing the work under this Agreement in any media.

ARTICLE II. FUNDS (Continued)

6. Any overpayment of funds must be deposited into an interest-bearing account.

B. The Contractor shall maintain accounting records for funds received under the terms and conditions of this Agreement. These records shall be separate from those for any other funds administered by the Contractor and shall be maintained in accordance with Generally Accepted Accounting Principles and Procedures and Office of Management and Budget's– Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. [2 CFR Part 200]

C. Upon termination, cancellation, or expiration of this Agreement or dissolution of the entity, the Contractor, upon written demand, shall immediately return to DHCS any funds provided under this Agreement, which are not payable for goods or services delivered prior to the termination, cancellation, or expiration of this Agreement or the dissolution of the entity.

D. Interest Earned

1. Interest earned on federal advance payments deposited in interest-bearing accounts must be remitted annually to the Department of Health and Human Services, Payment Management System, Rockville, MD 20852. Interest amounts up to $500 per year may be retained by the non-Federal entity for administrative expense. [2 CFR § 200.305(b)(9)]

2. The Contractor must maintain advance payments of Federal awards in interest-bearing accounts, unless the following apply.

   a. The Contractor receives less than $120,000 in Federal awards per year.

   b. The best reasonably available interest-bearing account would not be expected to earn interest in excess of $500 per year on federal cash balances.

   c. The depository would require an average or minimum balance so high that it would not be feasible within the expected federal and non-federal cash resources.

   d. A foreign government or banking system prohibits or precludes interest bearing accounts.

ARTICLE III. BUDGET AND BUDGET REVISION

Payment for performance by the Contractor under this contract may be dependent upon the availability of future appropriations by the Legislature or Congress for the purposes of this contract. No legal liability on the part of the State for any payment may arise under this contract until funds are made available and until the Contractor has received notice of funding availability, which will be confirmed in writing.

A. Funding Reduction in Subsequent Fiscal Years

1. If funding for any State fiscal year is reduced or eliminated by the Legislature, Congress, or Executive Branch of State Government for the purposes of this program, the State shall have the option to either:

   a. Terminate the Contract pursuant to Exhibit D, Article XII
   b. Offer a contract amendment to the Contractor to reflect the reduced funding for this contract

2. In the event that the State elects to offer an amendment, it shall be mutually understood by both parties that the State reserves the right to determine which contracts, if any, under this program shall be reduced and that some contracts may be reduced by a greater amount than others. The State shall determine, at its sole discretion, the amount that any or all of the contracts shall be reduced for the fiscal year.

B. The Contractor shall be reimbursed for Waivers Services expenses only as itemized in the most recent approved or revised Budget. Care Management and Care Management Support categories shall be reimbursed up to the combined budget amount of both categories.

C. Category amounts stipulated in the Budget, a part of Exhibit B, are the maximum amounts that may be reimbursed by DHCS under this Agreement or the actual category expenditures whichever is less. The Care Management and Care Management Support categories will be treated as a combined total budget for determining maximum allowable reimbursement amount.

D. The budget shall include the following line items:

1. Personnel Costs - monthly, weekly, or hourly rates, as appropriate and personnel classifications together with the percentage of time to be charged to this Agreement.

2. Fringe Benefits.

ARTICLE III. BUDGET AND BUDGET REVISION (CONTINUED)

3. Consultation, Professional Services-Contractual Costs, subcontract, and consultant cost detail.

4. Facility, Rent & Operations – specify square footage and rate.

5. Equipment Cost equal to or greater than $5,000 per Unit (Any Computing Equipment regardless of Cost) - detailed descriptions and unit costs needs to be identified on the Equipment tab in the Budget Template.

6. Travel (Include: In State and Out of State) – mileage reimbursement rate, lodging, per diem and other costs.

7. Equipment, Maintenance & Rental Costs; Supplies.

8. Indirect Costs shall not exceed fifteen percent (15%) of direct salaries plus benefits.

9. Other Costs - a detailed list of other operating expenses.

E. The Contractor shall obtain prior written approval from CDA to transfer funds between the Care Management and Care Management Support categories if the transfer amount is equal to or greater than five (5) percent of either category of the approved budget. This request shall be submitted on a Revised Budget Form. The Contractor must provide justification and supporting documentation for the requested revision.

F. Budgeting processes and conditions will be subject to instructions that will be issued to the Contractor under separate cover.

G. Equipment/Property with per unit cost of $5,000 or more, all computing devices regardless of cost (including but not limited to, workstations, servers, laptops, personal digital assistants, notebook computers, tablets, smartphones, and cellphones), and all portable electronic storage media regardless of cost (including but not limited to, thumb/flash drives and portable hard drives) requires justification and approval from CDA and must be included in its approved MSSP budget.

ARTICLE IV. DEFAULT PROVISIONS

The State, without limiting any rights which it may otherwise have, may, at its discretion and upon written notice to the Contractor, withhold further payments under this Agreement, and/or demand immediate repayment of the unliquidated balance of any advance payment hereunder, upon occurrence of any one of the following events:

A. Termination or suspension of this Agreement

B. A finding by the State that the Contractor:

1. Has failed to observe any of the covenants, conditions, or warrants of these provisions, or has failed to comply with any material provisions of this Agreement; or

2. Has failed to make progress, or is in such unsatisfactory financial condition, as to endanger performance of this Agreement; or

3. Has allocated inventory to this Agreement substantially exceeding reasonable requirements; or

4. Is delinquent in payment of taxes or of the cost of performance of this Agreement in the ordinary course of business

C. Appointment of a trustee, receiver, or liquidator for all or a substantial part of the Contractor's property, or institution of bankruptcy, reorganization, or arrangement of liquidation proceedings by or against the Contractor.

D. Service of any writ of attachment, levy, or execution, or commencement of garnishment proceeding or

E. The commission of an act of bankruptcy.

ARTICLE I. DEFINITIONS AND RESOLUTIONS OF LANGUAGE CONFLICTS

A. General Definitions

1. “Agreement” or “Contract” means the Standard Agreement (Std. 213), Exhibits A, B, C, D, E, F and G, an approved Budget as identified in Exhibit B, and if applicable, a Work Plan or Budget Summary, which are hereby incorporated by reference, amendments, and any other documents incorporated by reference; unless otherwise provided for in this Article.

2. "Contractor" means the governmental or nonprofit entity contracted with CDA to provide MSSP Waiver Services to eligible Medi-Cal beneficiaries on behalf of DHCS pursuant to an Interagency Agreement between DHCS and CDA.

3. “CCR” means California Code of Regulations.

4. “CFR” means Code of Federal Regulations.

5. “DUNS” means the nine-digit, Data Universal Numbering System number established and assigned by Dun and Bradstreet, Inc., to uniquely identify business entities.

6. “Cal. Gov. Code” means California Government Code.

7. “OMB” means the federal Office of Management and Budget.

8. “Cal. Pub. Con. Code” means the California Public Contract Code.

9. “Cal. Civ. Code” means California Civil Code

10. “Reimbursable item” also means “allowable cost” and “compensable item.”

11. “State” and “Department” mean the State of California and the California Department of Aging (CDA) interchangeably.

12. “Subcontractor” means the legal entity that receives funds from the Contractor to provide waiver services identified in this Agreement.

13. “Subcontract” means any form of legal agreement between the Contractor and the Subcontractor, including an agreement that the Contractor considers a contract, including vendor type Agreements for providing goods or services under this Agreement.

14. “Vendor” means an entity selling goods or services to the Contractor or Subcontractor during the Contractor or Subcontractor’s performance of the Agreement.

ARTICLE I. DEFINITIONS AND RESOLUTIONS OF LANGUAGE CONFLICTS (Continued)

15. "Waiver participant" means any individual who has met MSSP eligibility requirements and been enrolled in the MSSP program.

16. "USC" means United States Code.

17. "OAA" means Older Americans Act.

18. "Allocation" means the process of assigning a cost, or a group of costs, to one or more cost objective(s), in reasonable proportion to the benefit provided or other equitable relationship. The process may entail assigning a cost(s) directly to a final cost objective or through one or more intermediate cost objectives. (2 CFR 200.1)

19. "Disallowed costs" means those charges determined to be unallowable, in accordance with the applicable Federal statutes, regulations, or the terms and conditions of the Federal award. (2 CFR 200.1)

20. "Questioned Costs" means a cost that is questioned by the auditor because of an audit finding which resulted from a violation or possible violation of a statute, regulation, or the terms and conditions of a Federal award, including for funds used to match Federal funds; where the costs, at the time of the audit, are not supported by adequate documentation; or where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances. (2 CFR 200.84).

21. "Recoverable cost" means the questioned cost identified from an audit. (2 CFR 200.1)

22. "DHCS" means the Department of Health Care Services.

23. "HHS" means United States Department of Health and Human Services.

B. Resolution of Language Conflicts

Should the terms and conditions of this Agreement be found to conflict with one another, the following order of authority shall control:

1. Statutory law, subject to the doctrine of preemption, including, but not limited to: Section 1915(c) of Title XIX of the Social Security Act, 42 USC 1396n, Welfare and Institutions Code Sections 9560 to 9568, other Federal and California state codes and regulations governing the MSSP, and/or other applicable Federal and California state statutes and their implementing regulations.

ARTICLE I. DEFINITIONS AND RESOLUTIONS OF LANGUAGE CONFLICTS (Continued)

2. Standard Agreement (Std. 213), all Exhibits and any amendments thereto.

3. Any other documents incorporated herein by reference including, as applicable, the MSSP Site Manual found at https://www.aging.ca.gov/Programs Providers/MSSP/.

4. Program memos and other guidance issued by CDA.

ARTICLE II. ASSURANCES

A. Law, Policy and Procedure, Licenses, and Certificates

The Contractor agrees to administer this Agreement and require any subcontractors to administer their subcontracts in accordance with this Agreement, and with all applicable local, State, and federal laws and regulations including, but not limited to, discrimination, wages and hours of employment, occupational safety, and to fire, safety, health, and sanitation regulations, directives, guidelines, and/or manuals related to this Agreement and resolve all issues using good administrative practices and sound judgment. The Contractor and its subcontractors shall keep in effect all licenses, permits, notices, and certificates that are required by law.

B. Subcontracts

The Contractor shall require language in all subcontracts to require all subcontractors to comply with all applicable State and federal laws.

C. Nondiscrimination

The Contractor shall comply with all federal statutes relating to nondiscrimination. These include those statutes and laws contained in the Contractor Certification Clauses (CCC 307), which is hereby incorporated by reference. In addition, the Contractor shall comply with the following:

1. Equal Access to Federally Funded Benefits, Programs and Activities

The Contractor shall ensure compliance with Title VI of the Civil Rights Act of 1964 [42 USC 2000d; 45 CFR 80], which prohibits recipients of federal financial assistance from discriminating against persons based on race, color, religion, or national origin.

ARTICLE II. ASSURANCES (Continued)

2. Equal Access to State-Funded Benefits, Programs and Activities

The Contractor shall, unless exempted, ensure compliance with the requirements of Cal. Gov. Code § 11135 et seq., and 2 CCR § 11140 et seq., which prohibit recipients of state financial assistance from discriminating against persons based on race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability. [22 CCR § 98323]

3. California Civil Rights Laws

The Contractor shall, ensure compliance with the requirements of California Public Contract Code § 2010 by submitting a completed California Civil Rights Laws Certification, prior to execution of this Agreement.

The California Civil Rights Laws Certification ensures Contractor compliance with the Unruh Civil Rights Act (Cal. Civ. Code § 51) and the Fair Employment and Housing Act (Cal. Gov. Code § 12960) and ensures that Contractor internal policies are not used in violation of California Civil Rights Laws.

4. The Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. [42 USC 12101 et seq.]

5. The Contractor agrees to include these requirements in all contracts it enters into with subcontractors to provide services pursuant to this Agreement.

D. Standards of Work

The Contractor agrees that the performance of work and services pursuant to the requirements of this Agreement shall conform to accepted professional standards.

E. Conflict of Interest

1. The Contractor shall prevent employees, consultants, or members of governing bodies from using their positions for purposes including, but not limited to, the selection of subcontractors, that are, or give the appearance of being, motivated by a desire for private gain for themselves or others,

ARTICLE II. ASSURANCES (Continued)

such as family, business, or other ties. In the event that the State determines that a conflict of interest exists, any increase in costs associated with the conflict of interest may be disallowed by the State and such conflict may constitute grounds for termination of the Agreement.

2. This provision shall not be construed to prohibit employment of persons with whom the Contractor's officers, agents, or employees have family, business, or other ties, so long as the employment of such persons does not result in a conflict of interest (real or apparent) or increased costs over those associated with the employment of any other equally qualified applicant, and such persons have successfully competed for employment with the other applicants on a merit basis.

F. Covenant Against Contingent Fees

1. The Contractor warrants that no person or selling agency has been employed or retained to solicit this Agreement. There has been no agreement to make commission payments in order to obtain this Agreement.

2. For breach or violation of this warranty, CDA shall have the right to terminate this Agreement without liability or at its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingency fee.

G. Payroll Taxes and Deductions

The Contractor shall promptly forward payroll taxes, insurances, and contributions, including State Disability Insurance, Unemployment Insurance, Old Age Survivors Disability Insurance, and federal and State income taxes withheld, to designated governmental agencies as required by law.

H. Facility Construction or Repair

1. When applicable for purposes of construction or repair of facilities, the Contractor shall comply with the provisions contained in the following and shall include such provisions in any applicable agreements with subcontractors:

ARTICLE II. ASSURANCES (Continued)

a. Copeland "Anti-Kickback" Act. [18 USC 874, 40 USC 3145] [29 CFR 3]

b. Davis-Bacon Act. [40 USC 3141 et seq.] [29 CFR 5]

c. Contract Work Hours and Safety Standards Act. [40 USC 3701 et seq.] [29 CFR 5, 6, 7, 8]

d. Executive Order 11246 of September 14, 1965, entitled "Equal Employment Opportunity" as amended by Executive Order 11375 of October 13, 1967, as supplemented in Department of Labor Regulations. [41 CFR 60]

2. Payments are not permitted for construction, renovation, alteration, improvement, or repair of privately-owned property which would enhance the owner's value of such property except where permitted by law and by CDA.

3. When funding is provided for construction and non-construction activities, the Contractor must obtain prior written approval from CDA before making any fund or budget transfers between construction and non-construction.

I. Contracts in Excess of $100,000

If all funding provided herein exceeds $100,000, the Contractor shall comply with all applicable orders or requirements issued under the following laws:

1. Clean Air Act, as amended. [42 USC 7401]

2. Federal Water Pollution Control Act, as amended. [33 USC 1251 et seq.]

3. Environmental Protection Agency Regulations. [40 CFR 29] [Executive Order 11738]

4. State Contract Act [Cal. Pub. Con. Code §10295 et seq.]

5. Unruh Civil Rights Act [Cal. Pub. Con. Code § 2010]

J. Debarment, Suspension, and Other Responsibility Matters

1. The Contractor certifies to the best of its knowledge and belief, that it and its subcontractors:

ARTICLE II. ASSURANCES (Continued)

a. Are not presently debarred, suspended, proposed for disbarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency.

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

c. Are not presently indicted for, or otherwise criminally or civilly charged by a governmental entity (federal, State, or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification.

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

2. The Contractor shall report immediately to CDA in writing any incidents of alleged fraud and/or abuse by either the Contractor or subcontractors.

3. The Contractor shall maintain any records, documents, or other evidence of fraud and abuse until otherwise notified by CDA.

4. The Contractor agrees to timely execute any and all amendments to this Agreement or other required documentation relating to the Subcontractor's debarment/suspension status.

K. Agreement Authorization

1. If a public entity, the Contractor shall submit to CDA a copy of an approved resolution, order, or motion referencing this Agreement number authorizing execution of this Agreement. If a private nonprofit entity, the Contractor shall submit to CDA an authorization by the Board of Directors to execute this Agreement, referencing this Agreement number.

2. These documents, including minute orders, must also identify the action taken.

ARTICLE II. ASSURANCES (Continued)

3. Documentation in the form of a resolution, order, or motion by the Governing Board is required for the original and each subsequent amendment to this Agreement. This requirement may also be met by a single resolution from the Governing Board of the Contractor authorizing the Director or designee to execute the original and all subsequent amendments to this Agreement.

L. Contractor's Staff

1. The Contractor shall maintain adequate staff to meet the Contractor's obligations under this Agreement.

2. This staff shall be available to the State for training and meetings which the State may find necessary from time to time.

M. DUNS Number and Related Information

1. The DUNS number must be provided to CDA prior to the execution of this Agreement. Business entities may register for a DUNS number.

2. The Contractor must register the DUNS number and maintain an "Active" status within the federal System for Award Management.

3. If CDA cannot access or verify "Active" status the Contractor's DUNS information, which is related to this federal subaward on the Federal Funding Accountability and Transparency Act Subaward Reporting System (SAM.gov) due to errors in the Contractor's data entry for its DUNS number, the Contractor must immediately update the information as required.

N. Corporate Status

1. The Contractor shall be a public entity, private nonprofit entity, or Joint Powers Authority (JPA). If a private nonprofit corporation or JPA, the Contractor shall be in good standing with the Secretary of State of California and shall maintain that status throughout the term of this Agreement.

2. The Contractor shall ensure that any subcontractors providing services under this Agreement shall be of sound financial status.

3. Any subcontracting private entity or JPA shall be in good standing with the Secretary of State of California and shall maintain that status throughout the term of this Agreement.

ARTICLE II. ASSURANCES (Continued)

4. Failure to maintain good standing by the contracting entity shall result in suspension or termination of this Agreement with CDA until satisfactory status is restored. Failure to maintain good standing by a subcontracting entity shall result in suspension or termination of the subcontract by the Contractor until satisfactory status is restored.

O. Lobbying Certification

The Contractor, by signing this Agreement, hereby certifies to the best of its knowledge and belief, that:

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

2. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form-LLL, Disclosure Form to Report Lobbying, in accordance with its instructions.

3. The Contractor shall require that the language of this certification be included in the award documents for all subcontracts at all tiers (including contracts under grants, loans, and cooperative agreements which exceed $100,000) and that all subcontractors shall certify and disclose accordingly.

4. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into.

5. This certification is a prerequisite for making or entering into this transaction imposed by 31 USC 1352.

6. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

ARTICLE II. ASSURANCES (Continued)

P. The Contractor and its subcontractors/vendors shall comply with Governor's Executive Order 2-18-2011, which bans expenditures on promotional and marketing items colloquially known as "S.W.A.G." or "Stuff We All Get."

ARTICLE III. AGREEMENT

A copy of this executed Agreement is on file and available for inspection at the California Department of Aging, 2880 Gateway Oaks Drive, Suite 200, Sacramento, California 95833.

ARTICLE IV. COMMENCEMENT OF WORK

Should the Contractor or subcontractor begin work in advance of receiving notice that this Agreement is approved, that work may be considered as having been performed on a voluntary basis and may not be reimbursed or compensated.

ARTICLE V. SUBCONTRACTS

A. The Contractor is responsible for carrying out the terms of this Agreement, including the satisfaction, settlement, and resolution of all administrative, programmatic, and fiscal aspects of the program(s), including issues that arise out of any subcontracts, and shall not delegate or contract these responsibilities to any other entity. This includes, but is not limited to, disputes, claims, protests of award, or other matters of a contractual nature. The Contractor's decision is final, and the subcontractor(s) has no right of appeal to CDA.

B. The Contractor shall, in the event any subcontractor is utilized by the Contractor for any portion of this Agreement, retain the prime responsibility for all the terms and conditions set forth, including but not limited to, the responsibility for preserving the State's copyrights and rights in data in accordance with Article XIX of this Exhibit, for handling property in accordance with Article VII of this Exhibit, and ensuring the keeping of, access to, availability of, and retention of records of subcontractors in accordance with Article VI of this Exhibit.

C. The Contractor shall not obligate funds for this Agreement in any subcontracts for services beyond the ending date of this Agreement.

D. The Contractor shall have no authority to contract for, or on behalf of, or incur obligations on behalf of the State.

E. The Contractor shall maintain on file copies of subcontracts, memorandums and/or Letters of Understanding which shall be made available for review at the request of CDA.

ARTICLE V. SUBCONTRACTS (Continued)

F. The Contractor shall monitor the insurance requirements of its subcontractors in accordance with Article XI of this Exhibit.

G. The Contractor shall require language in all subcontracts to require all subcontractors to indemnify, defend, and save harmless the Contractor, its officers, agents, and employees from any and all claims and losses accruing to or resulting from any subcontractors, suppliers, laborers, and any other person, firm, or corporation furnishing or supplying work services, materials, or supplies in connection with any activities performed for which funds from this Agreement were used and from any and all claims and losses accruing or resulting to any person, firm, or corporation who may be injured or damaged by the Subcontractor(s) in the performance of this Agreement.

H. The Contractor shall require all subcontractors to maintain adequate staff to meet the subcontractors' agreement with the Contractor. This staff shall be available to the State for training and meetings which the State may find necessary from time to time.

I. If a private nonprofit corporation, the subcontractor(s) shall be in good standing with the Secretary of State of California and shall maintain that status throughout the term of the Agreement.

J. The Contractor shall refer to 2 CFR 200.330, Subpart D - Subrecipient and Contractor Determinations and 45 CFR 75.351, Subpart D - Subrecipient and Contractor Determinations in making a determination if a subcontractor relationship exists. If such a relationship exists, then the Contractor shall follow the procurement requirements in the applicable OMB Circular.

K. The Contractor shall utilize procurement procedures as follows:

The Contractor shall obtain goods and services through open and competitive awards. Each Contractor shall have written policies and procedures, including application forms, for conducting an open and competitive process, and any protests resulting from the process.

ARTICLE VI. RECORDS

A. The Contractor shall maintain complete records which shall include, but not be limited to, accounting records, contracts, agreements, a reconciliation of the "Financial Closeout Report" (CDA Closeout) to the audited financial statements, single audit report, and general ledgers. This includes the following: Letters of Agreement, insurance documentation, memorandums and/or Letters of Understanding, waiver participant records, and electronic files of its activities and expenditures hereunder in a form satisfactory to CDA. All records pertaining to this Agreement must be made available for inspection and audit by

ARTICLE VI. RECORDS (Continued)

pertaining to this the State or its duly authorized agents, at any time during normal business hours.

B. All such records, including confidential records, must be maintained, and made available by the Contractor: (1) until an audit of the July 1 through June 30 fiscal period of expenditures has occurred and an audit resolution has been issued or unless otherwise authorized in writing by CDA's or DHCS' Audit Branch, (2) for such longer period, if any, as is required by applicable statute, by any other clause of this Agreement, or by Sections A and C of this Article, and (3) for such longer period as CDA deems necessary.

C. If this Agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for the same periods as specified in Section A above. The Contractor shall ensure that any resource directories and all waiver participant records remain the property of CDA upon termination of this Agreement and are returned to CDA or transferred to another contractor as instructed by CDA.

D. In the event of any litigation, claim, negotiation, audit exception, or other action involving the records, all records relative to such action shall be maintained and made available until every action has been cleared to the satisfaction of CDA and DHCS and is so stated in writing to the Contractor.

E. Adequate source documentation of each transaction shall be maintained relative to the allowability of expenditures reimbursed by the DHCS under this Agreement. Source documentation includes, but is not limited to: vendor invoices, bank statements, cancelled checks, bank/credit card statements, contracts and agreements, employee time sheets, purchase orders, indirect cost allocation plans. If the allowability of expenditures cannot be determined because records or documentation of the Contractor are nonexistent or inadequate according to guidelines set forth in 2 CFR 200.302 and 45 CFR 75.302, the expenditures will be questioned in the audit and may be disallowed by CDA during the audit resolution process.

F. All records containing confidential information shall be handled in a confidential manner in accordance with the requirements for information integrity and security, and in accordance with guidelines set forth in this Article, and Article XVIII. After the authorized period has expired, confidential records shall be shredded and disposed of in a manner that will maintain confidentiality.

ARTICLE VII. PROPERTY

A. Unless otherwise provided for in this Article, property refers to all assets used in operation of this Agreement.

ARTICLE VII. PROPERTY (Continued)

1. Property includes land, buildings, improvements, machinery, vehicles, furniture, tools, and intangibles, etc.

2. Property does not include consumable office supplies such as paper, pencils, toner cartridges, file folders, etc.

3. Property, for the purpose of this MSSP Agreement, does not include any equipment or supplies acquired on behalf of the waiver participant.

B. Property acquired under this agreement, which meets any of the following criteria is subject to the reporting requirements:

1. Has a normal useful life of at least one (1) year and has a unit acquisition cost of at least $5,000 (a desktop or laptop setup, is considered a unit, if purchased as a unit).

2. All computing devices, regardless of cost (including but not limited to, workstations, servers, laptops, personal digital assistants, notebook computers, tablets, smartphones and cellphones).

3. All portable electronic storage media, regardless of cost (including but not limited to, thumb/flash drives and portable hard drives).

C. Additions, improvements, and betterments to assets meeting all of the conditions in Section B above must also be reported. Additions typically involve physical extensions of existing units. Improvements and betterments typically do not increase the physical size of the asset. Instead, improvements and betterments enhance the condition of an asset (e.g., extend life, increase service capacity, and lower operating costs). Examples of assets that might be improved and bettered include roads, bridges, curbs and gutters, tunnels, parking lots, streets and sidewalks, drainage, and lighting systems.

D. Intangibles are property which lack physical substance but give valuable rights to the owner. Examples of intangible property include patents, copyrights, leases, and computer software. By contrast, hardware consists of tangible equipment (e.g., computer printer, terminal, etc.). Costs include all amounts incurred to acquire and to ready the intangible asset for its intended use. Typical intangible property costs include the purchase price, legal fees, and other costs incurred to obtain title to the asset.

E. The Contractor shall keep track of property purchased with funds from this Agreement and submit to CDA a Property Acquisition Form (CDA 9023) for all property furnished or purchased by either the Contractor or the Subcontractor with funds awarded under the terms of this Agreement, as instructed by CDA. The Contractor shall certify their reported property inventory annually by completing the Program Property Inventory Certification (CDA 9024).

ARTICLE VII. PROPERTY (Continued)

The Contractor shall record, at minimum, the following information when property is acquired:

1. Date acquired.

2. Item description (include model number).

3. CDA tag number.

4. Serial number (if applicable).

5. Purchase cost or other basis of valuation.

6. Fund source.

F. Disposal of Property

1. Prior to disposal of any property purchased by the Contractor or the Subcontractor with funds from this Agreement or any predecessor Agreement, the Contractor must obtain approval from CDA for all reportable property as defined in Section B of this Article. Disposition, which includes sale, trade-in, discarding, or transfer to another agency may not occur until approval is received from CDA. The Contractor shall email to CDA the electronic version of the Request to Dispose of Property (CDA 248). CDA will then instruct the Contractor on disposition of the property. Once approval for disposal has been received from CDA and the Contractor has reported to CDA the Property Survey Report's (STD 152) Certification of Disposition, the item(s) shall be removed from the Contractor's inventory report.

2. The Contractor must remove all confidential, sensitive, or personal information from CDA property prior to disposal, including removal or destruction of data on computing devices with digital memory and storage capacity. This includes, but is not limited to magnetic tapes, flash drives, personal computers, personal digital assistants, cell or smart phones, multi-function printers, and laptops.

G. Any loss, damage, or theft of equipment shall be investigated, fully documented and the Contractor shall promptly notify CDA.

H. The State reserves title to all State-purchased or financed property not fully consumed in the performance of this Agreement, unless otherwise required by federal law or regulations or as otherwise agreed by the parties.

ARTICLE VII. PROPERTY (Continued)

I. The Contractor shall exercise due care in the use, maintenance, protection, and preservation of such property during the period of the project and shall assume responsibility for replacement or repair of such property during the period of the project, or until the Contractor has complied with all written instructions from CDA regarding the final disposition of the property.

J. In the event of the Contractor's dissolution or upon termination of this Agreement, the Contractor shall provide a final property inventory to the State. The State reserves the right to require the Contractor to transfer such property to another entity, or to the State.

K. To exercise the above right, no later than one hundred twenty (120) days after termination of this Agreement or notification of the Contractor's dissolution, the State will issue specific written disposition instructions to the Contractor.

L. The Contractor shall use the property for the purpose for which it was intended under the Agreement. When no longer needed for that use, the Contractor shall use it, if needed, and with written approval of the State for other purposes in this order:

1. For another CDA program providing the same or similar service.

2. For another CDA-funded program.

M. The Contractor may share use of the property and equipment or allow use by other programs, upon written approval from CDA. As a condition of the approval, CDA may require reimbursement under this Agreement for its use.

N. The Contractor or subcontractors shall not use equipment or supplies acquired under this Agreement with federal and/or State monies for personal gain or to usurp the competitive advantage of a privately-owned business entity.

O. If purchase of equipment is a reimbursable item, the equipment to be purchased will be specified in the Budget.

P. The Contractor shall include the provisions contained in this Article in all its subcontracts awarded under this Agreement.

ARTICLE VIII. ACCESS

The Contractor shall provide access to the federal or State contracting agency, the California State Auditor, the Comptroller, General of the United States, or any of their duly authorized

ARTICLE VIII. ACCESS (Continued)

federal or State representatives to any books, documents, papers, and records of the Contractor or subcontractor which are directly pertinent to this specific Agreement for the purpose of making an audit, examination, excerpts, and transcriptions. The Contractor shall include this requirement in its subcontracts.

ARTICLE IX. MONITORING AND EVALUATION

A. Authorized State representatives shall have the right to monitor and evaluate the Contractor's administrative, fiscal and program performance pursuant to this Agreement. Said monitoring and evaluation may include, but is not limited to, administrative processes, fiscal, data and procurement components. This will include policies, procedures, procurement, audits, inspections of project premises, interviews of project staff and participants, and when applicable, inspection of food preparation sites.

B. The Contractor shall cooperate with the State in the monitoring and evaluation processes, which include making any administrative, program and fiscal staff available during any scheduled process.

C. The Contractor shall monitor contracts and subcontracts to ensure compliance with laws, regulations, and the provisions of contracts that may have a direct and/or material effect on each of its CDA/DHCS funded programs.

D. The Contractor is responsible for maintaining supporting documentation including financial and statistical records, contracts, subcontracts, monitoring reports, and all other pertinent records until an audit has occurred and an audit resolution has been issued or unless otherwise authorized in writing by CDA.

ARTICLE X. AUDIT REQUIREMENTS

A. General

1. Any duly authorized representative of the federal or State government, which includes but is not limited to the State Auditor, CDA Staff, and any entity selected by State to perform inspections, shall have the right to monitor and audit Contractor and all subcontractors providing services under this Agreement through on-site inspections, audits, and other applicable means the State determines necessary. In the event that CDA is informed of an audit by an outside federal or State government entity affecting the Contractor, CDA will provide timely notice to Contractor.

2. Contractor shall make available all reasonable information necessary to substantiate that expenditures under this agreement are allowable and

ARTICLE X. AUDIT REQUIREMENTS (Continued)

allocable, including, but not limited to accounting records, vendor invoices, bank statements, cancelled checks, bank/credit card statements, contracts and agreements, employee time sheets, purchase orders, indirect cost allocation plans. Contractor shall agree to make such information available to the federal government, the State, or any of their duly authorized representatives, including representatives of the entity selected by State to perform inspections, for examination, copying, or mechanical reproduction, on or off the premises of the appropriate entity upon a reasonable request.

3. All agreements entered into by Contractor and subcontractors with audit firms for purposes of conducting independent audits under this Agreement shall contain a clause permitting any duly authorized representative of the federal or State government access to the supporting documentation of said audit firm(s).

4. The Contractor shall cooperate with and participate in any further audits which may be required by the State, including CDA fiscal and compliance audits.

B. CDA Fiscal and Compliance Audits

1. The CDA Audits and Risk Management Branch shall perform fiscal and compliance audits of Contractors in accordance with Generally Accepted Government Auditing Standards (GAGAS) to ensure compliance with applicable laws, regulations, grants, and contract requirements.

2. The CDA fiscal and compliance audits may include, but not be limited to, a review of:

a. Financial closeouts (2 CFR 200.1)

b. Internal controls (2 CFR 200.303)

c. Allocation of expenditures (2 CFR 200.1)

d. Allowability of expenditures (2 CFR 200.403)

e. Equipment expenditures and approvals, if required (2 CFR 200.439)

C. Single Audit Reporting Requirements (2 CFR 200 Subpart F and 45 CFR 75 Subpart F)

1. Contractor Single Audit Reporting Requirements

ARTICLE X. AUDIT REQUIREMENTS (Continued)

a. Contractors that expend $750,000 or more in federal funds shall arrange for an audit to be performed as required by the Single Audit Act of 1984, Public Law 98-502; the Single Audit Act Amendments of 1996, Public Law 104-156; and 2 CFR 200.501 to 200.521. A copy shall be submitted to the:

California Department of Aging
Attention: Audits and Risk Management Branch
2880 Gateway Oaks Drive, Suite 200
Sacramento, California 95833

b. The copy shall be submitted within thirty (30) days after receipt of the Auditor's report or nine (9) months after the end of the audit period, whichever occurs first, or unless a longer period is agreed to in advance by the cognizant or oversight agency.

c. For purposes of reporting, the Contractor shall ensure that State-funded expenditures are displayed discretely along with the related federal expenditures in the single audit report's "Schedule of Expenditures of Federal Awards" (SEFA) under the Catalog of Federal Domestic Assistance (CFDA) number.

d. For State contracts that do not have CFDA numbers, the Contractor shall ensure that the State-funded expenditures are discretely identified in the SEFA by the appropriate program name, identifying grant/contract number, and as passed through CDA.

2. The Contractor shall perform a reconciliation of the "Financial Closeout Report" to the audited financial statements, single audit, and general ledgers. The reconciliation shall be maintained and made available for CDA review.

3. Contract Resolution of Contractor's Subrecipients

The Contractor shall have the responsibility for resolving its contracts with subcontractors to determine whether funds provided under this Agreement are expended in accordance with applicable laws, regulations, and provisions of contracts or agreements. The Contractor shall, at a minimum, perform Contract resolution within fifteen (15) months of the "Financial Closeout Report."

4. The Contractor shall ensure that subcontractor single audit reports meet 2 CFR 200, Subpart F-Audit Requirements

ARTICLE X. AUDIT REQUIREMENTS (Continued)

5. Contract resolution includes:

   a. Ensuring that subcontractors expending $750,000 or more in federal awards during the subcontractor's fiscal year have met the audit requirements of 2 CFR 200.501 - 200.521.

   b. Issuing a management decision on audit findings within six (6) months after receipt of the Subcontractor's single audit report and ensuring that the Subcontractor takes appropriate and timely corrective action.

   c. Reconciling expenditures reported to the Contractor to the amounts identified in the single audit or other type of audit if the subcontractor was not subject to the single audit requirements. For a subcontractor who was not required to obtain a single audit and did not obtain another type of audit, the reconciliation of expenditures reported to CDA must be accomplished through performing alternative procedures (e.g., risk assessment [2 CFR 200.331], documented review of financial statements, and documented expense verification, including match, etc.).

6. When alternative procedures are used, the Contractor shall perform financial management system testing, which provides, in part, for the following:

   a. Accurate, current, and complete disclosure of the financial results of each federal award or program.

   b. Records that identify adequately the source and application of funds for each federally funded activity.

   c. Effective control over, and accountability for, all funds, property, and other assets to ensure these items are used solely for authorized purposes.

   d. Comparison of expenditures with budget amounts for each federal award.

   e. Written procedures to implement the requirements of 2 CFR 200.305.

   f. Written procedures for determining the allowability of costs in accordance with 2 CFR Part 200, Subpart E - Cost Principles. [2 CFR 200.302]

ARTICLE X. AUDIT REQUIREMENTS (Continued)

g. The Contractor shall document system and expense testing to show an acceptable level of reliability, including a review of actual source documents.

h. Determining whether the results of the reconciliations performed necessitate adjustment of the Contractor's own records.

7. The Contractor shall ensure that subcontractor single audit reports meet 2 CFR 200, Subpart F - Audit Requirements:

a. Performed timely – not less frequently than annually and a report submitted timely. The audit is required to be submitted within thirty (30) days after receipt of the Auditor's report or nine (9) months after the end of the audit period, whichever occurs first. [2 CFR 200 512]

b. Properly procured – use procurement standards for auditor selection. [2 CFR 200.509]

c. Performed in accordance with Generally Accepted Government Auditing Standards. [2 CFR 200.514]

d. All inclusive – includes an opinion (or disclaimer of opinion) of the financial statements; a report on internal control related to the financial statements and major programs; an opinion (or disclaimer of opinion) on compliance with laws, regulations, and the provisions of contracts; and the schedule of findings and questioned costs. [2 CFR 200.515]

e. Performed in accordance with provisions applicable to this program as identified in 2 CFR Part 200, Subpart F, Audit Requirements.

8. Requirements identified in Sections D and E of this Article shall be included in contracts with subcontractor(s). Further, the subcontractor(s) shall be required to include in its contract with the independent Auditor that the Auditor will comply with all applicable audit requirements/standards; CDA shall have access to all audit reports and supporting work papers, and CDA has the option to perform additional work, as needed.

ARTICLE X. AUDIT REQUIREMENTS (Continued)

9. The Contractor shall prepare a summary worksheet of results from the contract resolutions performed of all subcontractors. The summary worksheet shall include, but not be limited to, contract amounts; amounts resolved; amounts of match verified, resolution of variances; recovered amounts; whether an audit was relied upon or the Contractor performed an independent expense verification review (alternative procedures) of the Subcontractor in making a determination; whether audit findings were issued; and, if applicable, issuance date of the management letter; and any communication or follow-up performed to resolve the findings.

10. A reasonably proportionate share of the costs of audits required by, and performed in, accordance with the Single Audit Act Amendments of 1996, as implemented by requirements of this part, are allowable. However, the following audit costs are unallowable:

    a. Any costs when audits required by the Single Audit Act and 2 CFR 200, Subpart F – Audit Requirements have not been conducted or have been conducted but not in accordance therewith; and

    b. Any costs of auditing a non-federal entity that is exempted from having an audit conducted under the Single Audit Act and 2 CFR 200, Subpart F – Audit Requirements because its expenditures under federal awards are less than $750,000 during the non-federal entity's fiscal year.

        i. The costs of a financial statement audit of a non-federal entity that does not currently have a federal award may be included in the indirect cost pool for a cost allocation plan or indirect cost proposal.

        ii. Pass-through entities may charge federal awards for the cost of agreed-upon-procedures engagements to monitor subcontractors who are exempted from the requirements of the Single Audit Act and 2 CFR 200, Subpart F – Audit Requirements. This cost is allowable only if the agreed-upon procedures engagements are conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS) attestation standards, paid for and arranged by the pass-through entity, and limited in scope to one or more of the following types of compliance requirements: activities allowed or not allowed; allowable costs/cost principles; eligibility; and reporting.

        [2 CFR 200.425]

ARTICLE X. AUDIT REQUIREMENTS (Continued)

D. The Contractor shall cooperate with and participate in any further audits which may be required by the State.

ARTICLE XI. INSURANCE

A. Prior to commencement of any work under this Agreement, the Contractor shall provide for the term of this Agreement, the following insurance:

1. General liability of not less than $1,000,000 per occurrence for bodily injury and property damage combined. Higher limits may be required by the State in cases of higher than usual risks.

2. Automobile liability including non-owned auto liability, of not less than $1,000,000 for volunteers and paid employees providing services supported by this Agreement.

3. If applicable, or unless otherwise amended by future regulation, the Contractor and subcontractors shall comply with the Public Utilities Commission General Order No. 115-F which requires higher levels of insurance for charter-party carriers of passengers and is based on seating capacity as follows:

   a. $750,000 if seating capacity is under 8

   b. $1,500,000 if seating capacity is 8 – 15

   c. $5,000,000 if seating capacity is over 15

4. Professional liability of not less than $1,000,000 as it appropriately relates to the services rendered. Coverage shall include medical malpractice and/or errors and omissions. (All programs except Title V).

B. The insurance will be obtained from an insurance company acceptable to the Department of General Services, Office of Risk and Insurance Management (DGS, ORIM), or be provided through partial or total self-insurance acceptable to the Department of General Services (DGS).

C. Evidence of insurance shall be in a form and content acceptable to DGS, ORIM.

D. The Contractor shall notify the State within five (5) business days of any cancellation, non-renewal, or material change that affects required insurance coverage.

ARTICLE XI. INSURANCE (Continued)

E. Insurance obtained through commercial carriers shall meet the following requirements:

1. The Certificate of Insurance shall provide the statement: "The Department of Aging, State of California, its officers, agents, employees, and servants are included as additional insureds, with respect to work performed for the State of California under this Agreement." Professional liability coverage is exempt from this requirement.

2. CDA shall be named as the certificate holder and CDA's address must be listed on the certificate.

F. The insurance provided herein shall be in effect at all times during the term of this Agreement. In the event the insurance coverage expires during the term of this Agreement, the Contractor agrees to provide CDA, at least thirty (30) days prior to the expiration date, a new Certificate of Insurance evidencing insurance coverage as provided herein for a period not less than the remaining Agreement term or for a period not less than one (1) year. In the event the Contractor fails to keep in effect at all times said insurance coverage, CDA may, in addition to any other remedies it may have, terminate this Agreement.

G. The Contractor shall require its subcontractors under this Agreement, other than units of local government which are similarly self-insured, to maintain insurance appropriate to the work to be performed, in alignment with industry standards and the requirements set forth in the California Civil Code, California Public Contracting Code, and the relevant sections of the California Insurance Code. This insurance shall be for general liability, Worker's Compensation liabilities, and if appropriate, auto liability including non-owned auto and professional liability, and/or any other form of insurance as may be proper in the industry in which the Contractor is performing under this Agreement. Further, the Contractor shall require all of its subcontractors to hold the Contractor harmless. The subcontractor's Certificate of Insurance for general and auto liability shall also name the Contractor, not the State, as the certificate holder and additional insured. The Contractor shall maintain Certificates of Insurance for all of its subcontractors.

H. A copy of each appropriate Certificate of Insurance or letter of self-insurance, referencing this Agreement number shall be submitted to CDA with this Agreement.

I. The Contractor shall be insured against liability for Worker's Compensation or undertake self-insurance in accordance with the provisions of the Labor Code and the Contractor affirms to comply with such provisions before commencing the performance of the work under this Agreement. [Labor Code § 3700]

ARTICLE XII. TERMINATION

A. Termination Without Cause

CDA may terminate performance of work under this Agreement, in whole or in part, without cause, if CDA determines that a termination is in the State's best interest. CDA may terminate the Agreement upon ninety (90) days written notice to the Contractor. The Notice of Termination shall specify the extent of the termination and shall be effective ninety (90) days from the delivery of the Notice. The parties agree that if the termination of the Contract is due to a reduction or deletion of funding by the Department of Finance (DOF), Legislature or Congress, the Notice of Termination shall be effective thirty (30) days from the delivery of the Notice. The Contractor shall submit to CDA a Transition Plan as specified in Exhibit E of this Agreement. The parties agree that, apart from the terminated portion of the Agreement, the remainder of the Agreement shall be deemed to remain in effect and is not void.

B. Termination for Cause

CDA may terminate, in whole or in part, for cause the performance of work under this Agreement. CDA may terminate the Agreement upon thirty (30) days' written notice to the Contractor. The Notice of Termination shall be effective thirty (30) days from the delivery of the Notice of Termination unless the grounds for termination are due to threat to life, health, or safety of the public and in that case, the termination shall take effect immediately. The Contractor shall submit to CDA a Transition Plan as specified in Exhibit E of this Agreement. The grounds for termination for cause shall include, but are not limited to, the following:

1. A violation of the law or failure to comply with any condition of this Agreement.

2. Inadequate performance or failure to make progress so as to endanger performance of this Agreement.

3. Failure to comply with reporting requirements.

4. Evidence that the Contractor is in an unsatisfactory financial condition as determined by an audit of the Contractor or evidence of a financial condition that endangers performance of this Agreement and/or the loss of other funding sources.

5. Delinquency in payment of taxes or payment of costs for performance of this Agreement in the ordinary course of business.

ARTICLE XII. TERMINATION (Continued)

6. Appointment of a trustee, receiver, or liquidator for all or a substantial part of the Contractor's property, or institution of bankruptcy, reorganization, or the arrangement of liquidation proceedings by or against the Contractor.

7. Service of any writ of attachment, levy of execution, or commencement of garnishment proceedings against the Contractor's assets or income.

8. The commission of an act of bankruptcy.

9. Finding of debarment or suspension. [Article II J]

10. The Contractor's organizational structure has materially changed.

11. CDA determines that the Contractor may be considered a "high risk" agency as described in 2 CFR 200.205 and 45 CFR 75.205. If such a determination is made, the Contractor may be subject to special conditions or restrictions.

12. In case of threat of life, health, or safety of the public, termination of the Agreement shall be effective immediately.

C. Contractor's Obligation After Notice of Termination

After receipt of a Notice of Termination, and except as directed by CDA, the Contractor shall immediately proceed with the following obligations, as applicable, regardless of any delay in determining or adjusting any funds due under this clause.

The Contractor shall:

1. Stop work as specified in the Notice of Termination.

2. Place no further subcontracts for materials or services, except as necessary, to complete the continued portion of the Contract.

3. Terminate all subcontracts to the extent they relate to the work terminated.

4. Settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts, (the approval or ratification of which will be final for purposes of this clause).

ARTICLE XII. TERMINATION (Continued)

D. Effective Date

Termination of this Agreement shall take effect immediately in the case of an emergency such as threat to life, health, or safety of the public. The effective date for Termination with Cause or for funding reductions is thirty (30) days. Termination without Cause is ninety (90) days subsequent to written notice to the Contractor. The notice shall describe the action being taken by CDA, the reason for such action, and any conditions of the termination, including the date of termination.

E. Voluntary Termination of Area Plan Agreement (Title III Only)

Pursuant to 22 CCR 7210, the Contractor may voluntarily terminate its contract prior to its expiration either by mutual agreement with CDA or upon thirty (30) days written notice to CDA. In case of voluntary termination, the Contractor shall allow CDA up to one hundred eighty (180) days to transition services. The Contractor shall submit a Transition Plan in accordance with Exhibit E of this Agreement.

F. Notice of Intent to Terminate by Contractor (All other non-Title III Programs)

In the event the Contractor no longer intends to provide services under this Agreement, the Contractor shall give CDA Notice of Intent to Terminate. Such notice shall be given in writing to CDA at least one hundred eighty (180) days prior to the proposed termination date. Unless mutually agreed upon, the Contractor does not have the authority to terminate the Agreement. The Notice of Intent to Terminate shall include the reason for such action and the anticipated last day of work. The Contractor shall submit a Transition Plan in accordance with Exhibit E.

G. In the Event of a Termination Notice

CDA will present written notice to the Contractor of any condition, such as, but not limited to, transfer of waiver participants, care of waiver participants, return of unspent funds; and disposition of property, which must be met prior to termination.

ARTICLE XIII. REMEDIES

The Contractor agrees that any remedy provided in this Agreement is in addition to and not in derogation of any other legal or equitable remedy available to CDA as a result of breach of this Agreement by the Contractor, whether such breach occurs before or after completion of the project.

ARTICLE XIV. DISSOLUTION OF ENTITY

The Contractor shall notify CDA immediately of any intention to discontinue existence of the entity or to bring an action for dissolution.

ARTICLE XV. AMENDMENTS, REVISIONS OR MODIFICATIONS

A. No amendment or variation of the terms of this Agreement shall be valid unless made in writing, signed and approved through the State amendment process in accordance with the State Contract Manual. No oral understanding or agreement not incorporated in this Agreement is binding on any of the parties.

B. The State reserves the right to revise, waive, or modify the Agreement to reflect any restrictions, limitations, or conditions enacted by Congress or the Legislature or as directed by the Executive Branch of State government.

ARTICLE XVI. NOTICES

A. Any notice to be given hereunder by either party to the other may be effected by personal delivery in writing or by registered or certified mail, overnight mail, postage prepaid, return receipt requested, provided the Contractor retains receipt, and shall be communicated as of actual receipt.

B. The Contractor must notify CDA of any change of legal name, main address, or name of the Director. This notice shall be addressed to the MSSP Bureau Manager on the Contractor's letterhead.

1. The Contractor must notify CDA within thirty-five (35) days of relocation.
2. In addition, any change of address or name also requires an Agency Contract Representative form to be submitted to Business Management Bureau as stated in Exhibit D, Article XVII.

C. All other notices with the exception of those identified in Section B of this Article shall be addressed to the California Department of Aging, Multipurpose Senior Services Program Bureau, 2880 Gateway Oaks, Suite 200, Sacramento, California, 95833. Notices mailed to the Contractor shall be to the address indicated on the coversheet of this Agreement.

D. Either party may change its address by written notice to the other party in accordance with this Article.

ARTICLE XVII. DEPARTMENT CONTACT

A. The name of CDA's contact to request revisions, waivers, or modifications affecting this Agreement, will be provided by the State to the Contractor upon full execution of this Agreement.

ARTICLE XVII. DEPARTMENT CONTACT (Continued)

B. The Contractor shall, upon request from CDA, submit the name of its Agency Contract Representative (ACR) for this Agreement by submitting an Agency Contract Representative form to CDA's Business Management Bureau (BMB). This form requires the ACR's address, phone number, email address, and FAX number to be included on this form. For any change in this information, the Contractor shall submit an amended Agency Contract Representative form to the same address. This form may be requested from CDA's BMB.

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY

A. Information Assets

The Contractor, and its Subcontractors/Vendors, shall have in place operational policies, procedures, and practices to protect State information assets, including those assets used to store or access Personal Health Information (PHI), Personal Information (PI) and any information protected under the Health Insurance Portability and Accountability Act (HIPAA), (i.e., public, confidential, sensitive and/or personal identifying information) as specified in the State Administrative Manual, 5300 to 5365.3; Cal. Gov.
Code § 11019.9, DGS Management Memo 06-12; DOF Budget Letter 06-34; and CDA Program Memorandum 07-18 Protection of Information Assets and the Statewide Health Information Policy Manual.

Information assets may be in hard copy or electronic format and may include but is not limited to:

1. Reports
2. Notes
3. Forms
4. Computers, laptops, cellphones, printers, scanners
5. Networks (LAN, WAN, WIFI) servers, switches, routers
6. Storage media, hard drives, flash drives, cloud storage
7. Data, applications, databases

B. Encryption of Computing Devices

The Contractor, and its Subcontractors/Vendors, are required to use 128-Bit encryption for data collected under this Agreement that is confidential, sensitive, and/or personal information including data stored on all computing devices (including but not limited to, workstations, servers, laptops, personal digital assistants, notebook computers and backup media) and/or portable electronic

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY (Continued)

storage media (including but not limited to, discs, thumb/flash drives, portable hard drives, and backup media).

C. Disclosure

1. The Contractor, and its Subcontractors/Vendors, shall ensure that all confidential, sensitive and/or personal identifying information is protected from inappropriate or unauthorized access or disclosure in accordance with applicable laws, regulations, and State policies.

2. The Contractor, and its Subcontractors/Vendors, shall protect from unauthorized disclosure, confidential, sensitive and/or personal identifying information such as names and other identifying information concerning persons receiving services pursuant to this Agreement, except for statistical information not identifying any participant.

3. "Personal Identifying information" shall include, but not be limited to: name; identifying number; social security number; state driver's license or state identification number; financial account numbers; and symbol or other identifying characteristic assigned to the individual, such as finger or voice print or a photograph.

4. The Contractor, and its Subcontractors/Vendors, shall not use confidential, sensitive and/or personal identifying information above for any purpose other than carrying out the Contractor's obligations under this Agreement. The Contractor and its Subcontractors are authorized to disclose and access identifying information for this purpose as required by OAA.

5. The Contractor and its Subcontractors/Vendors, shall not, except as otherwise specifically authorized or required by this Agreement or court order, disclose any identifying information obtained under the terms of this Agreement to anyone other than CDA without prior written authorization from CDA. The Contractor may be authorized, in writing, by a participant to disclose identifying information specific to the authorizing participant.

6. The Contractor, and its Subcontractors/Vendors, may allow a participant to authorize the release of information to specific entities, but shall not request or encourage any participant to give a blanket authorization or sign a blank release, nor shall the Contractor accept such blanket authorization from any participant.

D. Security Awareness Training

1. The Contractor's employees, subcontractors/vendors, and volunteers handling confidential, sensitive and/or personal identifying information must complete the required CDA Security Awareness Training module within thirty (30) days of the start date of the Contract/Agreement, within

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY (Continued)

2. thirty (30) days of the start date of any new employee, subcontractor, vendor or volunteer's employment and annually thereafter.

3. The Contractor must maintain certificates of completion on file and provide them to CDA upon request.

E. Health Insurance Portability and Accountability Act (HIPAA)

The Contractor agrees to comply with the privacy and security requirements of HIPAA and ensure that subcontractors/vendors comply with the privacy and security requirements of HIPAA.

F. Information Integrity and Security Statement

The Contractor shall sign and return an Information Integrity and Security Statement (CDA 1024) form with this Agreement. This is to ensure that the Contractor is aware of, and agrees to comply with, their obligations to protect CDA information assets from unauthorized access and disclosure.

G. Security Incident Reporting

A security incident occurs when CDA information assets are or are reasonably believed to have been accessed, modified, destroyed, or disclosed without proper authorization, or are lost or stolen. The Contractor, and its subcontractors/vendors, must comply with CDA's security incident reporting procedure.

H. Security Breach Notifications

Notice must be given by the Contractor, and/or its subcontractors/vendors to anyone whose confidential, sensitive and/or personal identifying information could have been breached in accordance with HIPAA, the Information Practices Act of 1977, and State policy.

I. Software Maintenance

The Contractor, and its subcontractors/vendors, shall apply security patches and upgrades in a timely manner and keep virus software up to date on all systems on which State data may be stored or accessed.

J. Electronic Backups

The Contractor, and its subcontractors/vendors, shall ensure that all electronic information is protected by performing regular backups of files and databases and ensure the availability of information assets for continued business. The

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY (Continued)

Contractor, and its subcontractors/vendors, shall ensure that all data, files and backup files are encrypted.

K. Provisions of this Article

The provisions contained in this Article shall be included in all contracts of both the Contractor and its subcontractors/vendors.

ARTICLE XIX. COPYRIGHTS AND RIGHTS IN DATA

A. Copyrights

1. If any material funded by this Agreement is subject to copyright, the State reserves the right to copyright such material and the Contractor agrees not to copyright such material, except as set forth in Section B of this Article.

2. The Contractor may request permission to copyright material by writing to the Director of CDA. The Director shall grant permission or give reason for denying permission to the Contractor in writing within sixty (60) days of receipt of the request.

3. If the material is copyrighted with the consent of CDA, the State reserves a royalty-free, non-exclusive, and irrevocable license to reproduce, prepare derivative works, publish, distribute and use such materials, in whole or in part, and to authorize others to do so, provided written credit is given to the author.

4. The Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this contract for the acquisition, operation, or maintenance of computer software in violation of copyright laws.

B. Rights in Data

1. The Contractor shall not publish or transfer any materials, as defined in paragraph 2 below, produced or resulting from activities supported by this Agreement without the express written consent of the Director of CDA. That consent shall be given, or the reasons for denial shall be given, and any conditions under which it is given or denied, within thirty (30) days after the written request is received by CDA. CDA may request a copy of the material for review prior to approval of the request. This subsection is not intended to prohibit the Contractor from sharing identifying waiver participant information authorized by the participant or summary program information which is not waiver participant specific.

ARTICLE XIX. COPYRIGHTS AND RIGHTS IN DATA (Continued)

2. As used in this Agreement, the term "subject data" means writings, sound recordings, pictorial reproductions, drawings, designs or graphic representations, procedural manuals, forms, diagrams, workflow charts, equipment descriptions, data files and data processing or computer programs, and works of any similar nature (whether or not copyrighted or copyrightable) which are first produced or developed under this Agreement. The term does not include financial reports, cost analyses and similar information incidental to contract administration.

3. Subject only to other provisions of this Agreement, the State may use, duplicate, or disclose in any manner, and have or permit others to do so subject to State and federal law, all subject data delivered under this Agreement.

ARTICLE XX. BILINGUAL AND LINGUISTIC PROGRAM SERVICES

A. Needs Assessment

1. The Contractor shall conduct a cultural and linguistic group-needs assessment of the eligible waiver participant population in the Contractor's service area to assess the language needs of the population and determine what reasonable steps are necessary to ensure meaningful access to services and activities to eligible individuals. [22 CCR 98310, 98314]

   The group-needs assessment shall take into account the following four (4) factors:

   a. Number or proportion of persons with Limited English Proficiency (LEP) eligible to be served or encountered by the program.

   b. Frequency with which LEP individuals come in contact with the program.

   c. Nature and importance of the services provided.

   d. Local or frequently used resources available to the Contractor.

   This group-needs assessment will serve as the basis for the Contractor's determination of "reasonable steps" and provide documentary evidence of compliance with Cal. Gov. Code § 11135 et seq.; 2 CCR 11140, 2 CCR 11200 et seq., and 22 CCR98300 et seq.

2. The Contractor shall prepare and make available a report of the findings of the group-needs assessment that summarizes:

ARTICLE XX. BILINGUAL AND LINGUISTIC PROGRAM SERVICES (Continued)

a. Methodologies used.

b. The linguistic and cultural needs of non-English speaking or LEP groups.

c. Services proposed to address the needs identified and a timeline for implementation. [22 CCR 98310]

3. The Contractor shall maintain a record of the group-needs assessment on file at the Contractor's headquarters at all times during the term of this Agreement. [22 CCR 98310, 98313]

B. Provision of Services

1. The Contractor shall take reasonable steps, based upon the group-needs assessment identified in Section A of this Article, to ensure that "alternative communication services" are available to non-English speaking or LEP beneficiaries of services under this Agreement. [22 CCR 11162]

2. "Alternative communication services" include, but are not limited to, the provision of services and programs by means of the following:

a. Interpreters or bilingual providers and provider staff.

b. Contracts with interpreter services.

c. Use of telephone interpreter lines.

d. Sharing of language assistance materials and services with other providers.

e. Translated written information materials, including but not limited to, enrollment information and descriptions of available services and programs.

f. Referral to culturally and linguistically appropriate community service programs.

3. Based upon the findings of the group-needs assessment, the Contractor shall ensure that reasonable alternative communication services are available to meet the linguistic needs of identified eligible waiver participant population groups at key points of contact. Key points of contact include, but are not limited to, telephone contacts, office visits and in-home visits. [22 CCR 11162]

ARTICLE XX. BILINGUAL AND LINGUISTIC PROGRAM SERVICES (Continued)

The Contractor shall self-certify to compliance with the requirements of this section and shall maintain the self-certification record on file at the Contractor's office at all times during the term of this Agreement. [22 CCR 98310]

4. The Contractor shall notify its employees of waiver participants' rights regarding language access and the Contractor's obligation to ensure access to alternative communication services where determined appropriate based upon the needs assessment conducted by the Contractor. [22 CCR 98324]

5. Noncompliance with this section may result in suspension or termination of funds and/or termination of this Agreement. [22 CCR 98370]

C. Compliance Monitoring

1. The Contractor shall develop and implement policies and procedures for assessing and monitoring the performance of individuals and entities that provide alternative communication services to non-English and LEP waiver participants. [22 CCR 98310]

2. The Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. [22 CCR 98310]

3. The Contractor shall permit timely access to all records of compliance with this section. Failure to provide access to such records may result in appropriate sanctions. [22 CCR 98314]

D. Notice to Eligible Beneficiaries of Contracted Services

1. The Contractor shall designate an employee to whom initial complaints or inquiries regarding national origin can be directed. [22 CCR 98325]

2. The Contractor shall make available to ultimate beneficiaries of contracted services and programs information regarding CDA's procedure for filing a complaint and other information regarding the provisions of Cal. Gov. Code § 11135 et seq. [22 CCR 98326]

3. The Contractor shall notify CDA immediately of a complaint alleging discrimination based upon a violation of State or federal law. [2 CCR 11162, 22 CCR 98310, 98340]

ARTICLE I. SUBCONTRACTING PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. Contractor shall ensure that all subcontractors of Waiver Services complete a CDA-approved Vendor Application.

B. Contractor shall ensure that the subcontractor's selection process is based upon equitable criteria that provides for adequate publicity, screens out unqualified subcontractors who would not be able to provide the needed services and provide for awards to the lowest responsible and responsive bidder(s) as defined in California State Contracting Manuals.

C. Subcontracts for Purchased Waiver Services shall consist of standard format language consistent with this Agreement.

D. Subcontracts shall require all subcontractors to report immediately in writing to the Contractor any incidents of fraud or abuse to waiver participants, in the delivery of services, and/or in subcontractors' operations.

E. Contractor shall require all subcontractors to comply with the Health Insurance Portability and Accountability Act (HIPAA) Business Associate requirements in Exhibit F, as it appropriately relates to services rendered.

F. Contractors shall ensure all subcontractors comply with Electronic Visit Verification (EVV) requirements pursuant to federal and state law. Updated guidance may be obtained through DHCS, the state department overseeing EVV implementation.

G. The Contractor shall make timely payments to its subcontractors under this Agreement.

ARTICLE II. RECORDS PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

Waiver Participant records are to be kept as long as the case is open and active. Following case termination, waiver participant records will be maintained for a period of seven (7) years following case closure, or for a longer period if deemed necessary by CDA. A longer period of retention may be established by individual sites.

ARTICLE III. PROPERTY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A physical inventory of the property must be taken, and the results reconciled with the property records at least once every two (2) years.

ARTICLE IV. AUDIT REQUIREMENT PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. Unless prohibited by law, the cost of audits completed in accordance with provisions of Single Audit Act Amendments of 1996, are allowable charges to Federal Awards. The costs may be considered a direct cost, or an allocated indirect cost, as determined in accordance with provisions of applicable OMB cost principal circulars.

ARTICLE IV. AUDIT REQUIREMENT PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

B. The Contractor may not charge to federal awards the cost of any audit under the Single Audit Act Amendments of 1996 not conducted in accordance with the Act.

C. CDA and DHCS shall have access to all audit reports of Contractors and have the option to perform audits and/or additional work, as needed.

D. All audits shall be performed in accordance with and address all issues contained in any federal OMB Compliance Supplement that applies to this program.

E. The Contractor shall include in its contract with an independent auditor a clause permitting access by the State to the work papers of the independent auditor.

F. Audits to be performed shall be, minimally, financial and compliance audits, and may include economy and efficiency and/or program results audits.

G. The Contractor shall cooperate with, and participate in, any further audits which may be required by DHCS.

H. The Contractor agrees that CDA, DHCS, the Department of General Services, the California State Auditor, or their designated representative shall, at all times, have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment unless a longer period of records retention is required and until after CDA's Audits and Risk Management Branch has completed an audit. The Contractor agrees to provide CDA or its delegate with any relevant information requested and shall permit the awarding agency or its delegate access to its premises, upon reasonable notice, during normal business hours for the purpose of interviewing employees and inspecting and copying such books, records, accounts, and other material that may be relevant to a matter under investigation for the purpose of determining compliance with Government Code, Section 8546.7 et seq. Further, the Contractor agrees to include a similar right of CDA and DHCS to audit records and interview staff in any subcontract related to performance of this Agreement. [Cal. Gov. Code § 8546.7, Cal. Pub. Con. Code 10115 et seq.], [CCR Title 2, Section 1896]

I. The Catalog of Federal Domestic Assistance Number is 93.778, Grantor Medical Assistance Program.

ARTICLE V. TERMINATION OBLIGATIONS SPECIFIC TO THIS MSSP AGREEMENT

A. After CDA's Notice of Termination or the Contractor's Notice of Intent to Terminate (pursuant to Exhibit D, Article XII of this Agreement) and except as directed by CDA, the Contractor shall immediately proceed

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ARTICLE V. TERMINATION OBLIGATIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

with the following obligations, as applicable, regardless of any delay in determining or adjusting any funds due under this clause.

The Contractor shall:

1. Take immediate steps to ensure the health and safety of waiver participants in MSSP managed by the Contractor. Contractor agrees to refer MSSP waiver participants to other local resources.

2. Maintain staff to provide services to waiver participants during the course of waiver participant transition.

3. Deliver updated waiver participant records to the subsequent MSSP contractor or as directed by CDA.

4. With assistance from CDA, develop a written Transition Plan to locate alternative services for each waiver participant through another MSSP site or community agency in accordance with this Agreement.

5. Be responsible for providing all necessary waiver participant services until termination or expiration of the Contract and shall remain liable for the processing and payment of invoices and statements for covered services provided to waiver participants prior to such expiration or termination.

6. Submit a full accounting and closeout of the Contractor's existing budget.

7. Place no further subcontracts/vendor agreements for materials, or services, except as necessary to complete the continued portion of the Contract.

8. Settle all outstanding liabilities and termination settlement proposals arising from the termination of subcontracts/vendor agreements (the approval or ratification of which will be final for purposes of this clause).

9. Submit a Transition Plan as specified in Article VII of this Exhibit.

ARTICLE VI. INFORMATION INTEGRITY AND SECURITY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. Contractor acknowledges that it has been provided a copy of the Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement between CDA and DHCS ("Exhibit F"). Contractor, and its subcontractors/vendors, agrees that it must meet the requirements imposed on CDA, and all applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule, including the requirement to implement reasonable and appropriate administrative, physical, and

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ARTICLE VI. INFORMATION INTEGRITY AND SECURITY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

B. technical safeguards to protect Protected Health Information (PHI) and Personal Information (PI), as specified in Exhibit F.

C. Contractor, and its subcontractors/vendors, agrees that any security incidents or breaches of unsecured PHI or PI will be immediately reported to CDA as described in CDA's Security Incident Reporting Procedures and to DHCS in the manner described in Exhibit F.

ARTICLE VII. TRANSITION PLANS SPECIFIC TO THIS MSSP AGREEMENT

A. The Contractor shall submit a transition plan to CDA within fifteen (15) days of delivery of the written Notice to Terminate the Contract (pursuant to Exhibit D, Article XII of this Agreement). The Transition Plan must be approved by CDA and shall, at a minimum, include the following:

1. A current waiver participant count and identifying waiver participant information upon request.

2. A description of how waiver participants will be notified about the change in their MSSP provider.

3. A plan to communicate with other MSSP sites, local agencies and advocacy organizations that can assist in locating alternative services for MSSP waiver participants.

4. A plan to inform community referral sources of the pending termination of this MSSP contract and what alternatives, if any, exist for future referrals.

5. A plan to evaluate the health and safety of waiver participants in order to assure appropriate placement.

6. A plan to transfer confidential waiver participant records to a new contractor or care management agency.

7. A plan to maintain adequate staff to provide continued care to MSSP waiver participants through the term of the Contract.

8. A full inventory and plan to dispose or, transfer, or return to CDA all property purchased during the entire operation of the Contract.

9. Additional information as necessary to affect a safe transition of waiver participants to other MSSP or community care management programs.

ARTICLE VII. TRANSITION PLANS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

B. The Contractor shall implement the Transition Plan as approved by CDA. CDA will monitor the Contractor's progress in carrying out all elements of the Transition Plan.

C. If the Contractor fails to provide and implement a transition plan as required by Section A of this Article, the Contractor agrees to implement a transition plan submitted by CDA to the Contractor following the Contractor's Notice of Termination.

D. Phase-out Requirements for this Agreement:

1. Consist of the processing, payment, and monetary reconciliation necessary to pay claims for Waiver Services.

2. Consist of the resolution of all financial and reporting obligations of the Contractor. The Contractor shall remain liable for the processing and payment of invoices and other claims for payment for Waived Services and other services provided to waiver participants pursuant to this Contract prior to the expiration or termination. The Contractor shall submit to CDA all reports required.

3. Require all data and information provided by the Contractor to CDA to be accompanied by a letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT

A. The Contractor shall submit to the State written reports, on a format prescribed by the State, as follows:

1. Quarterly Status Reports

a. Reports are due no later than the 30th of the month, following the close of the quarter unless otherwise specified by CDA.

b. Reports are a snapshot of each quarter and shall include an overview of significant developments during the report period, identified problems, and solutions. The report narrative should be concise and informative. The subject areas to be addressed are:

- Care Management Staffing – Including the Full Time Equivalent (FTEs) for each position and staffing ratio. Also including staff exemptions and self-certification of staff meeting program requirements

- Care Management Activity – Including staff turnover, training, quality assurance, waiver participant grievances and Fair Hearings, Critical Incident reporting, internal/external program reviews and

corrective action plans, waiver participant satisfaction surveys, policy changes, and contract compliance regarding contracted caseload

ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

- Management Information System – Problems/issues with the Medi-Cal fiscal intermediary billing system and Medi-Cal fiscal intermediary technical support
- Monthly active waiver participant count
- Staff Roster
- Self-Certified Training
- Wait List – Including the number of potential MSSP Participants waiting for enrollment
- Critical Incident Reporting – Report is used for the entire fiscal year and is submitted quarterly for review by CDA. The report shall include all critical incidents, and the status should be updated in each quarter for any previously listed incidents. The comments section should be concise, but informative, and provide detail of the incident that occurred with actions or interventions placed with corresponding dates.
- Fiscal Reporting – Expenditure data by budget category and receivables by budget category

2. Ad Hoc Reports

The Contractor shall submit Ad Hoc Reports as may be required from time to time by CDA. Typical subject areas may include, but are not limited to:

a. General site operations
b. Facility and equipment
c. Emergency care and response
d. Availability of care
e. Waiver participant satisfaction
f. MIS operations
g. Administrative procedures
h. Database
i. Possible noncompliance with this Agreement
j. Fiscal year closeout

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ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

3. Fiscal Closeout Reports

   As part of the closeout procedures for this contract, the Contractor shall submit a closeout package which must include the following documents:

   a. Final Accounting Reconciliation
   b. Closeout Budget
   c. Fiscal Summary Report for the State

   CDA will transmit specific closeout instructions, including the Closeout Report due dates.

4. Monthly active waiver participant count

   Reports are due on the 5th working day of each month, unless otherwise specified by CDA.

B. The Contractor, at its discretion, may at any time prepare and submit reports and correspondence to CDA summarizing problems and concerns.

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Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act (IPA) at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS' behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA and/or the IPA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. Permitted Uses and Disclosures of PHI by Business Associate

Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA or other applicable laws if done by DHCS.

7.1 Specific Use and Disclosure Provisions

Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person. The person shall notify the Business Associate of any instances of which the person is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure

9.1.1 Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls and shall maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time. The current version of NIST SP 800-53, Revision 5, is available online at; updates will be available online through the Computer Security Resource Center website.

9.2.3 Business Associate shall employ FIPS 140-2 validated encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. FIPS 140-2 validation can be determined online through the Cryptographic Module Validation Program Search, with information about the Cryptographic Module Validation Program under FIPS 140-2. In addition, Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent

Business Associate shall ensure that any agents, subcontractors, sub awardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. Mitigation of Harmful Effects

Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. Access to PHI

Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. Amendment of PHI

Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. Accounting for Disclosures

Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. Compliance with DHCS Obligations

To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. Access to Practices, Books and Records

Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. Return or Destroy PHI on Termination; Survival

At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. Special Provision for SSA Data

If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. Breaches and Security Incidents

Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS

18.1.1 Business Associate shall notify DHCS immediately upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

18.1.2 Business Associate shall notify DHCS within 24 hours by email (or by telephone if Business Associate is unable to email DHCS) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential information affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information in Section 18.6.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at the DHCS Data Privacy webpage.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation

Business Associate shall immediately investigate such security incident or breach.

18.3 Complete Report

To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This “Final PIR” must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A “Supplemental PIR” may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate’s determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate’s corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals

If the cause of a breach is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS

If the cause of a breach of PHI is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 DHCS Contact Information

To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

18.6.1 DHCS Program Contract Manager

See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.

18.6.2 DHCS Privacy Office

Privacy Office
c/o: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413

Email: incidents@dhcs.ca.gov

Telephone: (916) 445-4646

18.6.3 DHCS Information Security Office

Information Security Office
DHCS Information Security Office
P.O. Box 997413, MS 6400
Sacramento, CA 95899-7413

Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS

DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 Termination for Cause

Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 Judicial or Administrative Proceedings

DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 Disclaimer

DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2 Amendment

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings

Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 No Third-Party Beneficiaries

Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 Interpretation

The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 No Waiver of Obligations

No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

MS-2425-41

Orange County Health Authority, dba CalOptima

Aliso Viejo	92653, 92656, 92698
Anaheim	92801- 92809, 92812, 92814 - 92817, 92825, 92850, 92899
Anaheim Hills	92807, 92808, 92809, 92817
Atwood	92811
Balboa	92661
Balboa Island	92662
Brea	92821, 92822, 92823
Buena Park	90620, 90621, 90622, 90623, 90624
Capistrano Beach	92624
Corona del Mar	92625
Costa Mesa	92626, 92627, 92628
Coto de Caza	92679
Cowan Heights	92705
Cypress	90630
Dana Point	92624, 92629
Dove Canyon	92679
East Lake	92686
East Tustin	92780
El Modena	92869
El Toro	92609, 92610, 92630
Emerald Bay	92718
Foothill Ranch	92610
Fountain Valley	92708, 92728
Fullerton	92831, 92832, 92833, 92834, 92835, 92836, 92837, 92838
Garden Grove	92840, 92841, 92842, 92843, 92844, 92845, 92846
Huntington Beach	92605, 92615, 92646, 92647, 92648, 92649
Irvine	92602 - 92604, 92606, 92612, 92614, 92616, 92618 - 92620, 92623, 92650, 92697, 92709, 92710
Ladera	92692
Ladera Ranch	92694
Laguna Beach	92607, 92637, 92651, 92652, 92653, 92654, 92656, 92677, 92698
Laguna Hills	92637, 92653, 92654, 92656
Laguna Niguel	92607, 92677, 92653, 92654
La Habra	90631, 90632, 90633
La Habra Heights	90631
Lake Forest	92609, 92630
La Plama	90623
Las Flores	92688
Lemon Heights	92705
Lido Isle	92663
Los Alamitos	90720, 90721
Midway City	92655
Mission Viejo	92675, 92690, 92691, 92692, 92694
Modjeska	92676
Monarch Beach	92629

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Orange County Health Authority, dba CalOptima

Newport Beach	92657, 92658, 92659, 92660, 92661, 92662, 92663
Newport Center	92660
Newport Coast	92657
Northwood	92629
Olinda	92621
Olive	92665
Orange	92856, 92857, 92859, 92861- 92869
Orange Park Acres	92869
Placentia	92870, 92871
Portola Hills	92679
Rancho Santa Margarita	92688
Red Hill	92705
Rossmoor	90720
San Clemente	92672, 92673, 92674
Santa Ana	92701- 92708, 92711, 92712, 92725, 92728, 92735, 92799
Santa Ana Heights	92707
San Juan Capistrano	92675, 92690, 92691, 92692, 92693, 92694
San Juan Hot Springs	92675
Seal Beach	90740
Silverado	92676
South Laguna	92651
Stanton	90680
Sunset Beach	90742
Surfside	90743
Three Acres Bay	92677
Trabuco Canyon	92678, 92679, 92688
Turtle Rock	92612
Tustin	92780, 92781, 92782
Villa Park	92861, 92867
Westminster	92683, 92684, 92685
Woodbridge	92714
Yorba Linda	92885, 92886, 92887

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Adopt Resolution No. 24-0606-02 Approving and Adopting Updated CalOptima Health Human Resources Policies

Contacts

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

Recommended Actions

Adopt Resolution No. 24-0606-02 approving updated CalOptima Health policies:

a. GA.8030: Background Check;
b. GA.8042: Supplemental Compensation;
c. GA.8050: Confidentiality; and
d. GA.8056: Paid Holidays

Background

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

Discussion

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

GA.8030: Background Check: This policy outlines the process by which CalOptima Health conducts background checks.

Policy Section	Proposed Change	Rationale	Impact
II.B	Adds "drug screenings (where applicable)" for external job applicants.	Aligns with practice of conducting both background checks and drug screenings for job applicants.	Provides transparency on comprehensive background check process for job applicants.
II.B.1	Moves section on "Pre-Employment Testing" from section II.G.3.	Aligns policy with process. This language pertains to pre-employment testing, which is done prior to	Reorganizes policy to reflect chronological steps in pre-employment screening process.

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Policy Section	Proposed Change	Rationale	Impact
		physical/medical exams.	
II.C	Adds "drug screening" to post-employment background check process for promotions and transfers.	Aligns policy with current process for internal promotions and transfers.	Increases transparency for current employees who are promoted or transferred internally.
II.D	Adds new language to address volunteers for CalOptima Health.	Volunteers are subjected to background checks when representing CalOptima Health.	Allows for background screening process for volunteers.
II.F	Adds "criminal records check" to list of what may be verified as part of the background check.	Aligns policy with current process.	Allows for more thorough screening process for employment.
II.F	Adds civil records check and debarment language regarding positions that may require additional screening.	Complies with CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring requiring civil records checks for some positions.	Ensures additional screening for certain job applicants in compliance with CalOptima Health policy.
II.G	Adds drug testing, occupational health services exam, and vaccination(s) to section describing physical examination for certain CalOptima Health positions.	Aligns policy with current process.	Provides clarity of current pre-employment process and ensures candidates for employment meet physical requirements of position consistent with business needs.
II.G.3	Moves section to II.B.1 as noted above.	Aligns policy with process. This pertains to pre-employment testing, which is done prior to physical/medical exams.	Reorganizes policy to reflect chronological steps in pre-employment screening process.

GA.8042: Supplemental Compensation: 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."

Policy Section	Proposed Change	Rationale	Impact
II.H	At the discretion of the CEO, the Commuter Allowance may be extended, paused, or resumed each fiscal year. Removes reference to initial implementation date.	Aligns policy with existing practice of CEO determining how the Commuter Allowance will be handled in the following fiscal year.	At the discretion of the CEO, maintains existing supplemental compensation per fiscal year for qualifying employees who commute to CalOptima Health.
II.L.1-2 and III.K.1-3	Effective July 1, 2024, expands and revises the Supplemental Compensation - Sales Incentive Program for OneCare to an Employee Sales and Enrollment Incentive Program for both of CalOptima Health's competitive programs, OneCare and PACE.	Aligns incentive plans to market best practices and grow a sustaining membership in both OneCare and PACE programs.	Adds incentives for employees to encourage member retention and updates the member sales and enrollment model for Sales Incentive Program.

GA.8050: Confidentiality: This policy outlines CalOptima Health's guidelines for protecting proprietary, private, and confidential information.

Policy Section	Proposed Change	Rationale	Impact
II.C, III.F, and III.G.2	Replaces references to "discipline" with "corrective action" to provide for consistent terminology.	Aligns with terminology used in CalOptima Health policy GA.8022 Performance and Behavior Standards.	Ensures consistency in policy language and clarity for employees and HR practitioners.
III.A.3	Adds three CalOptima Health policies to list of compliance and HIPPA-related policies.	Includes references to other CalOptima Health policies to which confidentiality guidelines applies.	Reflects all confidentiality related policies that employees must adhere to for consistent protecting of proprietary, private, and confidential information.

Policy Section	Proposed Change	Rationale	Impact
III.A.4	Updates Compliance and Ethics hotline telephone number.	Provides accurate Compliance and Ethics hotline contact information.	Ensures that employees have the accurate Compliance and Ethics hotline telephone number when reporting confidentiality issues.

GA.8056: Paid Holidays: This policy establishes the paid holiday schedule for CalOptima Health employees.

Policy Section	Proposed Change	Rationale	Impact
II.C	Adds language regarding an employee being in active status on December 31 in order to receive Flex Holiday on January 1.	Clarifies that employees must be in active status to receive Flex Holiday on January 1.	Ensures that inactive employees do not receive Flex Holiday on January 1.
II.C & IX Glossary	Removes duplicative language related to who is eligible to receive Flex Holiday and adds definition of Employee (for purposes of the policy) in the Glossary.	Simplifies language in this section and provides an accurate definition of the term Employees for purposes of the policy.	Improves clarity.
II.C.a	Adds language addressing how Flex Holiday will be administered for employees on a leave of absence and confirms that hours will be applied upon their return to active status.	Addresses how Flex Holiday will be applied upon return to active status for those on an approved leave of absence.	Aligns policy with practice in leave and Flex Holiday administration for those on a leave of absence.
II.C.b	Adds language addressing how Flex Holiday will be administered if an employee does not return to work after their approved leave of absence.	Clarifies that an employee will not be eligible to receive the Flex Holiday if they do not return to work after a leave of absence.	Aligns policy with practice in leave and Flex Holiday administration for those on a leave of absence.
III.C	Adds “base” to rate of pay that will apply if a non-exempt employee is required to work a scheduled holiday.	Aligns with practice and provides clarity.	Ensures that an employee’s base rate of pay is applied when working holidays.

Fiscal Impact

The recommended actions to update CalOptima Policies GA.8030, GA.8050 and GA.8056 are budget neutral.

The recommended action to update CalOptima Policy GA.8042 has no additional fiscal impact beyond what was included in the proposed Fiscal Year 2024-25 Operating Budget.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Adopt Resolution No. 24-0606-02 Approving and Adopting Updated CalOptima Health Human Resources Policies
2. Revised CalOptima Health Policy GA.8030: Background Check
3. Revised CalOptima Health Policy GA.8042: Supplemental Compensation
4. Revised CalOptima Health Policy GA.8050: Confidentiality
5. Revised CalOptima Health Policy GA.8056: Paid Holidays
6. OneCare and PACE Sales and Enrollment Incentive Program Agreement

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

RESOLUTION NO. 24-0606-02

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

APPROVE UPDATED CALOPTIMA HEALTH POLICIES

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

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

- GA.8030: Background Check;
- GA.8042: Supplemental Compensation;
- GA.8050: Confidentiality; and
- GA.8056: Paid Holidays.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima Health this 6th day of June 2024.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Clayton Corwin, Chair, CalOptima Health Board of Directors

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

Policy:	GA.8030
Title:	**Background Check**
Department:	Human Resources~~CalOptima Health Administrative~~
Section:	Not Applicable~~Human Resources~~
CEO Approval:	*/s/*
Effective Date:	04/01/2013
Revised Date:	06/06/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the process by which CalOptima Health conducts background checks.

II. POLICY

A. CalOptima Health is committed to protecting the health, well-being, and safety of its employees and Members. To accomplish these goals, a background check serves as an important part of the selection process and this policy provides directives and guidance in the administration of performing background checks in a systematic and fair manner. Through the background check process, CalOptima Health obtains additional applicant information that will help determine the applicant's overall employability and ensures the protection of the people, property, and information of the organization.

B. CalOptima Health shall conduct background checks and drug screenings (where applicable) on all external job applicants after a contingent offer of employment has been accepted by the applicant and prior to commencement of employment.

1. Pre-Employment Screening: All employees in Safety Sensitive classifications are required to pass a pre-employment drug screening as a condition of employment in the classification as defined in CalOptima Health Policy GA.8052: Drug-Free and Alcohol-Free Workplace.

C. For promotions or transfers of employees, a post-employment background check, including drug screening and criminal background, may be required depending on the job duties or if not conducted within the past twelve (12) months.

D. For any individual volunteering on behalf of CalOptima Health (employee or non-employee), a criminal background check may be required if not conducted within the past twelve (12) months.

~~D.~~E. Post-employment background checks will be conducted, typically every two (2) years or upon promotion into positions that have access to personal health information (PHI), direct ~~member~~Member access, provide healthcare services, any position that may have access to personally identifiable information (PII) for any ~~member~~Member or employee, any position authorized to enter into financial contracts on behalf of CalOptima Health, or any position with fiduciary responsibilities.

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~~E.~~F. Requirements specific to background checks are set out more fully in the Employment Related Background Check Guidelines. CalOptima Health may use a third-party agency to conduct the background checks and prepare a report.

~~F.~~G. The background check is conducted to verify the accuracy of the information provided by the applicant, including, but not limited to, the applicant's social security number, education obtained, employment experience, criminal records check, etc. Some positions may require additional background screening, which may include civil records check, depending on the job requirements, duties, and responsibilities. ~~-~~Background checks comply with federal suspension and debarment regulations pertaining to agency Principals, in accordance with CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring.

~~G.~~H. For positions that require physical examinations ~~drug testing,~~ and/or tuberculosis testing, CalOptima Health shall perform the background check and drug screening first, then may commence with ~~a~~occupational health services exam which may include physical examination, ~~drug testing,~~vaccination(s), and/or tuberculosis testing provided that:

1. The examination or inquiry is job-related and consistent with business necessity~~.~~; and

2. All new employees in the same job classification are subject to the same examination or screening.

~~3. Pre-Employment Testing: All employees in Safety Sensitive classifications are required to pass a pre-employment drug test as a condition of employment in the classification as defined in CalOptima Health Policy GA.8052: Drug-Free and Alcohol-Free Workplace.~~

~~H.~~I. The Human Resources Department shall also be responsible for conducting exclusion monitoring for all CalOptima Health employees upon hire and monthly thereafter as outlined in the Employment Related Background Check Guidelines.

~~I.~~J. Employees shall notify the Human Resources Department upon hire or immediately any time thereafter, if the employee knows, or has reason to know that the employee has 1) an arrest for which the employee is out on bail, or out on their own recognizance, and pending trial pursuant to Labor Code section 432.7(a)(1); or 2) post-hire felony criminal convictions that are not more than seven (7) years old and that have not been or are not in the process of being expunged, dismissed, pardoned or sealed by judicial order; or 3) is excluded from a federally funded healthcare program and/or may be listed on the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the General Services Administration's (GSA) System for Award Management (SAM), and the Medi-Cal Suspended & Ineligible (S&I) Website.

~~J.~~K. CalOptima Health shall ensure that all background checks are held confidentially by the Human Resources Department in compliance with all federal and state statutes, such as the California Investigative Consumer Reporting Act and the Fair Credit Reporting Act.

~~K.~~L. For positions that require an employee to drive as part of their work duties, CalOptima Health may check the applicant/employee's department of motor vehicles (DMV) records, which includes verification of car insurance and status of the driver's license. Employees shall notify the Human Resources Department upon hire or immediately any time thereafter, if the employee knows or has reason to know of any action to be taken on the employee's driver's license, including, but not limited to, suspension, revocation, restriction, or other action, or an event that occurs that could lead to such actions, including, but not limited to, accidents, citations for driving under the influence (DUI), etc. Employee's without a valid driver's license will be prohibited from driving CalOptima Health vehicles, driving for CalOptima Health business, and parking on CalOptima Health

premises. Failure to report such incidents to Human Resources may lead to corrective action, up to and including termination.

~~L.~~M. Falsification of information on the employment application or providing false information for the purpose of hiring may result in corrective action, up to and including termination of employment.

~~M.~~N. CalOptima Health follows Government Code section 12952, which requires that employers that intend to deny an applicant a position of employment solely or in in part because of the applicant's conviction history, must make an individualized assessment of whether the applicant's conviction history has a direct and adverse relationship with the specific duties of the job that justify denying the applicant the position. In making the assessment described in this paragraph, the employer shall consider all of the following:

1. The nature and gravity of the offense or conduct;

2. The time that has passed since the offense or conduct and completion of the sentence; and

3. The nature of the job held or sought.

~~N.~~O. The Human Resources Department will maintain all pre and post-employment background check documents and pre and post-employment drug screening documents as notated in CalOptima Health Policy GA.3201: Document Management Program.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Consumer Credit Reporting Agencies Act, California Civil Code §1785.1 *et seq*.
B. California Government Code, §12952
~~B.~~C. California Investigative Consumer Reporting Act, California Civil Code §1786 *et seq*.
~~C. California Government Code section 12952~~
~~D.~~ California Labor Code ~~section~~ , §§432.7
~~E.~~D. ~~California Labor Code, §~~ and 1024.5
~~F. CalOptima Employee Handbook~~
~~G.~~E. CalOptima Health Policy GA.3201: Document Management Program
~~H.~~F. CalOptima Health Policy GA.8052: Drug-Free and Alcohol-Free Workplace
G. CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring
~~I.~~H. Employment Related Background Check Guidelines
~~J.~~I. Fair Credit Reporting Act [15, USC, §1681 *et seq*.]
~~K. Equal Employment Opportunity Commission (EEOC) Regulation 29, C.F.R. Section §1602.14~~
~~L.~~J. Pre-Employment Background Authorization and Release
~~M.~~K. Sample Pre-Adverse Action Letter - Full Disclosure
~~N.~~L. Sample Adverse Action Notice – Denial and Withdrawal
~~O.~~M. Sample Background Check Disclosure, Authorization and Consent Form
N. Title 29, Code of Federal Regulations (C.F.R.), §1602.14, Equal Employment Opportunity Commission (EEOC)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
04/06/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2013	GA.8030	Background Check	Administrative
Revised	05/01/2014	GA.8030	Background Check	Administrative
Revised	10/01/2014	GA.8030	Background Check	Administrative
Revised	04/06/2017	GA.8030	Background Check	Administrative
Revised	12/01/2022	GA.8030	Background Check	Administrative
Revised	06/06/2024	GA.8030	Background Check	Administrative

IX. GLOSSARY

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Health program.
Principal	Employees in executive, director, manager, and supervisor level positions with responsibilities related to U.S. Department of Health and Human Services (HHS) covered transactions. Also includes consultants or other persons not employed by CalOptima Health paid with Federal funds who handle Federal funds, influence or control the use of those funds, or occupies a position capable of substantially influencing the development or outcome of an activity required to perform the covered transaction.
Safety Sensitive Employee	A position where the employee has the responsibility for their own safety or other people's safety, such as administering medication, handling of controlled substances and/or providing health care services or personal care services to CalOptima Health Members. This shall include any employee who operates a CalOptima Health owned or leased motor vehicle.

Policy:	GA.8030
Title:	**Background Check**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	04/01/2013
Revised Date:	06/06/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the process by which CalOptima Health conducts background checks.

II. POLICY

A. CalOptima Health is committed to protecting the health, well-being, and safety of its employees and Members. To accomplish these goals, a background check serves as an important part of the selection process and this policy provides directives and guidance in the administration of performing background checks in a systematic and fair manner. Through the background check process, CalOptima Health obtains additional applicant information that will help determine the applicant's overall employability and ensures the protection of the people, property, and information of the organization.

B. CalOptima Health shall conduct background checks and drug screenings (where applicable) on all external job applicants after a contingent offer of employment has been accepted by the applicant and prior to commencement of employment.

1. Pre-Employment Screening: All employees in Safety Sensitive classifications are required to pass a pre-employment drug screening as a condition of employment in the classification as defined in CalOptima Health Policy GA.8052: Drug-Free and Alcohol-Free Workplace.

C. For promotions or transfers of employees, a post-employment background check, including drug screening and criminal background, may be required depending on the job duties or if not conducted within the past twelve (12) months.

D. For any individual volunteering on behalf of CalOptima Health (employee or non-employee), a criminal background check may be required if not conducted within the past twelve (12) months.

E. Post-employment background checks will be conducted, typically every two (2) years or upon promotion into positions that have access to personal health information (PHI), direct Member access, provide healthcare services, any position that may have access to personally identifiable information (PII) for any Member or employee, any position authorized to enter into financial contracts on behalf of CalOptima Health, or any position with fiduciary responsibilities.

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F. Requirements specific to background checks are set out more fully in the Employment Related Background Check Guidelines. CalOptima Health may use a third-party agency to conduct the background checks and prepare a report.

G. The background check is conducted to verify the accuracy of the information provided by the applicant, including, but not limited to, the applicant's social security number, education obtained, employment experience, criminal records check, etc. Some positions may require additional background screening, which may include civil records check, depending on the job requirements, duties, and responsibilities. Background checks comply with federal suspension and debarment regulations pertaining to agency Principals, in accordance with CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring.

H. For positions that require physical examinations and/or tuberculosis testing, CalOptima Health shall perform the background check and drug screening first, then may commence with occupational health services exam which may include physical examination, vaccination(s), and/or tuberculosis testing provided that:

1. The examination or inquiry is job-related and consistent with business necessity; and

2. All new employees in the same job classification are subject to the same examination or screening.

I. The Human Resources Department shall also be responsible for conducting exclusion monitoring for all CalOptima Health employees upon hire and monthly thereafter as outlined in the Employment Related Background Check Guidelines.

J. Employees shall notify the Human Resources Department upon hire or immediately any time thereafter, if the employee knows, or has reason to know that the employee has 1) an arrest for which the employee is out on bail, or out on their own recognizance, and pending trial pursuant to Labor Code section 432.7(a)(1); or 2) post-hire felony criminal convictions that are not more than seven (7) years old and that have not been or are not in the process of being expunged, dismissed, pardoned or sealed by judicial order; or 3) is excluded from a federally funded healthcare program and/or may be listed on the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the General Services Administration's (GSA) System for Award Management (SAM), and the Medi-Cal Suspended & Ineligible (S&I) Website.

K. CalOptima Health shall ensure that all background checks are held confidentially by the Human Resources Department in compliance with all federal and state statutes, such as the California Investigative Consumer Reporting Act and the Fair Credit Reporting Act.

L. For positions that require an employee to drive as part of their work duties, CalOptima Health may check the applicant/employee's department of motor vehicles (DMV) records, which includes verification of car insurance and status of the driver's license. Employees shall notify the Human Resources Department upon hire or immediately any time thereafter, if the employee knows or has reason to know of any action to be taken on the employee's driver's license, including, but not limited to, suspension, revocation, restriction, or other action, or an event that occurs that could lead to such actions, including, but not limited to, accidents, citations for driving under the influence (DUI), etc. Employee's without a valid driver's license will be prohibited from driving CalOptima Health vehicles, driving for CalOptima Health business, and parking on CalOptima Health premises. Failure to report such incidents to Human Resources may lead to corrective action, up to and including termination.

M. Falsification of information on the employment application or providing false information for the purpose of hiring may result in corrective action, up to and including termination of employment.

N. CalOptima Health follows Government Code section 12952, which requires that employers that intend to deny an applicant a position of employment solely or in in part because of the applicant's conviction history, must make an individualized assessment of whether the applicant's conviction history has a direct and adverse relationship with the specific duties of the job that justify denying the applicant the position. In making the assessment described in this paragraph, the employer shall consider all of the following:

1. The nature and gravity of the offense or conduct;

2. The time that has passed since the offense or conduct and completion of the sentence; and

3. The nature of the job held or sought.

O. The Human Resources Department will maintain all pre and post-employment background check documents and pre and post-employment drug screening documents as notated in CalOptima Health Policy GA.3201: Document Management Program.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Consumer Credit Reporting Agencies Act, California Civil Code §1785.1 *et seq.*
B. California Government Code, §12952
C. California Investigative Consumer Reporting Act, California Civil Code §1786 *et seq.*
D. California Labor Code, §§432.7 and 1024.5
E. CalOptima Health Policy GA.3201: Document Management Program
F. CalOptima Health Policy GA.8052: Drug-Free and Alcohol-Free Workplace
G. CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring
H. Employment Related Background Check Guidelines
I. Fair Credit Reporting Act [15, USC, §1681 *et seq.*]
J. Pre-Employment Background Authorization and Release
K. Sample Pre-Adverse Action Letter - Full Disclosure
L. Sample Adverse Action Notice – Denial and Withdrawal
M. Sample Background Check Disclosure, Authorization and Consent Form
N. Title 29, Code of Federal Regulations (C.F.R.), §1602.14, Equal Employment Opportunity Commission (EEOC)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors

04/06/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2013	GA.8030	Background Check	Administrative
Revised	05/01/2014	GA.8030	Background Check	Administrative
Revised	10/01/2014	GA.8030	Background Check	Administrative
Revised	04/06/2017	GA.8030	Background Check	Administrative
Revised	12/01/2022	GA.8030	Background Check	Administrative
Revised	06/06/2024	GA.8030	Background Check	Administrative

IX. GLOSSARY

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Health program.
Principal	Employees in executive, director, manager, and supervisor level positions with responsibilities related to U.S. Department of Health and Human Services (HHS) covered transactions. Also includes consultants or other persons not employed by CalOptima Health paid with Federal funds who handle Federal funds, influence or control the use of those funds, or occupies a position capable of substantially influencing the development or outcome of an activity required to perform the covered transaction.
Safety Sensitive Employee	A position where the employee has the responsibility for their own safety or other people's safety, such as administering medication, handling of controlled substances and/or providing health care services or personal care services to CalOptima Health Members. This shall include any employee who operates a CalOptima Health owned or leased motor vehicle.

Policy:	GA.8042
Title:	**Supplemental Compensation**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2011
Revised Date:	06/06/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ 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 Health considers the following as Special Compensation pursuant to Title 2, California Code of Regulations (CCR), Section 571:

1. Bilingual Pay/Bilingual Premium;
2. Holiday Premium Pay;
3. Night Shift Premium/Shift Differential;
4. Active Certified Case Manager (CCM) Pay/Educational Incentive;
5. Executive Incentive Program/Bonus Pay; and
6. Temporary Upgrade Pay.

B. Overtime Pay: As a public agency, CalOptima Health follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all time worked in excess of forty (40) in any one (1) federal Fair Labor Standards Act (FLSA) Workweek at the rate of one and one half (1.5) times the employee's regular rate of pay, as defined by 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 Health 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

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considered Holiday Pay pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation.

D. Bilingual Pay: CalOptima Health provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima Health'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 Health 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 Health 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 Health 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 Health 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 Health 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 Health 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 Health 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,~~ With approval of the Chief Executive Officer (CEO), the Commuter Allowance may be offered each fiscal year to provide ~~CalOptima Health 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. The Commuter Allowance may be paused and resumed at the discretion of the CEO. ~~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. Internet Stipend: CalOptima Health shall provide an Internet Stipend in the amount of twenty-five dollars ($25.00) per pay period to full-time employees designated as Full Teleworkers, Partial Teleworkers or Community Workers. The Internet Stipend begins the first full pay period as a Full or Partial Teleworker or Community Worker. Eligible full-time employees will continue to receive the stipend until the first, full pay period in which an employee is not assigned to full or partial telework or community work. The Internet Stipend will be provided only for full pay periods and will not be prorated for a change in designation for a portion of a pay period. Executive Level Positions and Full Office Workers are not eligible for the Internet Stipend.

J. Active Certified Case Manager (CCM) Pay: CalOptima Health 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.

K. 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.

~~L. Sales Incentive Program: The OneCare 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 program.~~

~~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 program in accordance with the table in Paragraph II.L.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 ($165.00), plus (from tier fifty-one (51) – sixty-five (65)) three (3) members multiplied by one hundred seventy-five ($175.00), 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 program 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 Sales and Enrollment Incentive Program. Changes to this plan will be effective July 1, 2024. The purpose of the Program is to provide incentives for qualified and eligible staff whose primary job responsibility is to enroll new members in CalOptima Health's competitive programs, OneCare, and Program for All-Inclusive Care for the Elderly (PACE). Employees eligible for the Program must be employed by CalOptima Health, in good standing. Eligible employees must also individually sign a Sales and Enrollment Incentive Program Agreement, which does not alter the at-will nature of their relationship with CalOptima Health. The Sales and Enrollment Incentive Program may be modified or withdrawn, at any time, with five days' advance written notice.

1. OneCare Program: The OneCare Manager Member Outreach and Education; OneCare Supervisor Member Outreach and Education; OneCare Community Partner and Community Partner Sr staff in the Marketing and Sales Department must have an active Resident Insurance Producer license to enroll eligible members into the OneCare program. These licensed employees may be eligible to receive an incentive payment based on the number of new enrollments produced and retained in the OneCare program on a monthly basis in accordance with the OneCare Sales and Enrollment Incentive Program Agreement signed by each eligible employee.

2. PACE Program: The Supervisor Member Outreach and Education and Enrollment Coordinators staff are eligible for the Sales and Enrollment Incentive Program and may receive incentive payments based on the number of new enrollments produced and retained in the PACE Program on a monthly basis in accordance with the PACE Sales and Enrollment Incentive Program Agreement signed by each eligible employee.

M. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima Health's business needs and mission, vision, and values.

N. 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 Health may, at the discretion of the CEO, and on an exception basis, award a retention incentive.

O. 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 Health. Recruitment incentives of up to a maximum of fifty thousand dollars ($50,000) may be offered for Executive Level Positions and require informing the Board of Directors after approved.

P. 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 Health.

Q. Employer-Paid Member Contribution (EPMC): CalOptima Health contributes seven percent (7%) of compensation earnable, on behalf of eligible employees who hold management staff positions as identified in the CalOptima Health 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.

R. 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.N.~~J~~ of this Policy, provided that their performance meets the goals and objectives set forth by their managers.

S. Automobile Allowance: CalOptima Health 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 Health business.

T. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima Health'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 Health 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.

U. Work Life Balance Stipend: CalOptima Health shall provide an annual Work Life Balance Stipend of five hundred dollars ($500.00) to full-time employees and two hundred fifty dollars ($250.00) to part-time employees. The stipend is intended to promote employee wellness through enhanced work life balance and may be used for any wellness-related purchases, such as dependent care, gym memberships, yoga classes, art therapy, dietician services, athletic gear, personal development courses, and more. The stipend is taxable and paid in two (2) increments of two hundred fifty dollars ($250.00) to full-time employees and one hundred twenty-five dollars ($125.00) to part-time employees on the pay periods that include November 01, and May 01 each year.

V. Benefit Income: CalOptima Health shall provide a bi-monthly taxable medical stipend as a cost savings measure to CalOptima Health and incentive for employees who have medical coverage outside of CalOptima Health. Employees must submit proof of outside coverage in order to be eligible for this benefit. The amount of the bi-monthly stipend is approved by the Board of Directors on an annual basis.

W. Temporary Upgrade Pay: An employee who is appointed for a limited duration to a job having a higher pay grade is eligible for Temporary Upgrade Pay. The employee must meet the minimum requirements of the position and be performing all essential job functions and responsibilities of the upgraded position without performing duties of their current job to qualify for Temporary Upgrade Pay. Temporary Upgrade Pay will be the minimum of the new pay rate or a five percent (5%) of base pay increase, whichever is greater. Temporary Upgrade Pay will be eliminated when the temporary assignment ends. The temporary assignment shall not exceed nine hundred and sixty (960) hours. Temporary Upgrade Pay is considered premium pay pursuant to Title 2 CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS Classic Members.

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 Health 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. Actual hours worked on a holiday will be used for purposes of calculating 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, 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 3:00 p.m. and 8:00 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 Health'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 Health may periodically audit and validate employee Office/Telework designations.

H. Internet Stipend

1. Internet Stipend is automatically calculated for eligible employees based on system designation of Full Teleworker, Partial Teleworker, or Community Worker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Telework designation changes require a request and approval per the Telework Program Guidelines. Community Worker designation is determined by the position. CalOptima Health may periodically audit and validate employee Office/Telework designations.

I. 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.

J. Incentive Compensation

1. The Board of Directors approves CalOptima Health'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 Health 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 Health 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.

K. Employee Sales and Enrollment Incentive Program

1. The Executive Director, Medicare Programs or designee will review the Employee Sales and Enrollment Incentive structure for the OneCare and PACE Programs on an annual basis and will submit any required changes to the incentive structure and the OneCare and PACE Employee Sales and Enrollment Incentive Agreements for review and approval by the CEO, or designee.

2. OneCare:

a. Employees with the job titles of OneCare Manager Member Outreach and Education; Supervisor Member Outreach and Education; OneCare Community Partner and Community Partner Sr ~~staff, in the Member Outreach & Education Department, shall have an active Resident Insurance Producer license to enroll~~are eligible ~~members into~~for the ~~OneCare~~Sales and Enrollment Incentive Program~~.~~ and will be required to sign a OneCare Sales and Enrollment Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific each eligible employee job title.

~~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 Program. Sales incentive pay for the Manager, Member Outreach & Education, shall be based on the number of members enrolled into the OneCare Program by the Community Partner and Sr. Community Partner as described in Section II.I.2 of this Policy.~~

b. ~~CalOptima Health shall follow the Medicare~~ The OneCare Manager Outreach and Education will be responsible for calculating monthly payments for employees who are eligible for the OneCare Sales and Enrollment Incentive Program based on the number of enrollments produced each month according to the terms of the OneCare Sales and Enrollment Incentive Agreement effective at the time the enrollments are produced. The Manager will submit a detailed report of enrollments produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

3. PACE:

a. Employees with the job titles of PACE Supervisor Member Outreach and Education and PACE Enrollment Coordinator are eligible for the Sales and Enrollment Incentive Program and will be required to sign a PACE Sales Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific to their job title.

~~a.~~ The PACE Manager 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 Health policies.~~

~~3. CalOptima Health 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~~ & Enrollment will be responsible for calculating monthly incentive payments for employees who are eligible ~~employee enrolled~~for the PACE Sales and Enrollment Incentive Program based on the number of enrollments produced each month according to the ~~new member. However,~~ terms of the ~~sales incentive is not earned until~~PACE Sales and Enrollment Incentive Program Agreement effective at the ~~member has been enrolled in~~time the ~~respective program for ninety-one (91) days.~~

~~a. In~~enrollments are produced. The Manager will submit a detailed report of enrollments produced and payments due for approval by the ~~event a OneCare member disenrolls from their respective program within ninety (90) calendar days for reasons other than the exceptions specified under the guidelines and applicable CalOptima Health 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.~~

~~a.~~b. ~~The Director, Network Management,~~ Executive Director ~~of Network Operations~~, Medicare Programs, and the Chief ~~Operations~~Financial Officer ~~will review the sales incentive structure on an annual basis.~~ .

L. 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 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.

M. 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 Health. Recruitment incentives of up to a maximum of fifty thousand dollars ($50,000) may be offered for Executive Level Positions and require informing the Board of Directors after approved. 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 Health within twenty-four (24) months of the date of hire.

N. 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 Health to be eligible to receive the lump sum bonus payments.

O. 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.

P. Work Life Balance Stipend: Work Life Balance Stipend is automatically calculated for eligible employees.

Q. Benefit Income: Once enrolled in Benefit Income, the participating employee's election to waive CalOptima Health medical insurance will remain in effect for the entire, or remaining, plan year (January 1 through December 31) unless the employee has a qualifying event.

R. Temporary Upgrade Pay: Human Resources will calculate Temporary Upgrade Pay for eligible employees who are authorized and appointed for a limited duration to assume the duties of a position with a higher pay grade.

IV. ATTACHMENT(S)

A. Executive Incentive Program
B. Performance Review of Executives Template

V. REFERENCE(S)

A. CalOptima Health Employee Handbook
B. Compensation Administration Guidelines
C. Government Code, §20636 and 20636.1
D. Telework Program Guidelines
E. Title 2, California Code of Regulations (CCR), §571
F. PACE Sales and Enrollment Incentive Program Agreement: Supervisor Member Outreach and Education
G. PACE Sales and Enrollment Incentive Program Agreement: Enrollment Coordinator
H. OneCare Sales and Enrollment Incentive Program Agreement: Community Partner and Community Partner Sr
I. OneCare Sales and Enrollment Incentive Program Agreement: Supervisor Member Outreach and Education
J. OneCare Sales and Enrollment Incentive Program Agreement: Manager Member Outreach & Education

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
06/02/2022	Regular Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors

12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health 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
Revised	06/02/2022	GA.8042	Supplemental Compensation	Administrative
Revised	05/04/2023	GA.8042	Supplemental Compensation	Administrative
Revised	12/07/2023	GA.8042	Supplemental Compensation	Administrative
Revised	06/06/2024	GA.8042	Supplemental Compensation	Administrative

IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima Health's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process	Prospective staff translators are identified by the Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima Health'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 the 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 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.
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.
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Central Worksite	CalOptima Health's primary physical location of business applicable to the employee, which is either CalOptima Health's administration building at 505 City Parkway West, the PACE building or other CalOptima Health operated location.
Community Worker	An employee in a position that performs fifty-one percent (51%) or more of their duties in field locations such as provider offices, members' homes, and at community outreach events.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
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.

Term	Definition
Leave of Absence (LOA)	A term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.
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 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

Policy:	GA.8042
Title:	**Supplemental Compensation**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2011
Revised Date:	06/06/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ 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 Health considers the following as Special Compensation pursuant to Title 2, California Code of Regulations (CCR), Section 571:

1. Bilingual Pay/Bilingual Premium;
2. Holiday Premium Pay;
3. Night Shift Premium/Shift Differential;
4. Active Certified Case Manager (CCM) Pay/Educational Incentive;
5. Executive Incentive Program/Bonus Pay; and
6. Temporary Upgrade Pay.

B. Overtime Pay: As a public agency, CalOptima Health follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all time worked in excess of forty (40) in any one (1) federal Fair Labor Standards Act (FLSA) Workweek at the rate of one and one half (1.5) times the employee's regular rate of pay, as defined by 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 Health 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

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considered Holiday Pay pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation.

D. Bilingual Pay: CalOptima Health provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima Health'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 Health 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 Health 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 Health 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 Health 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 Health 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 Health 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 Health 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: With approval of the Chief Executive Officer (CEO), the Commuter Allowance may be offered each fiscal year to provide 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. The Commuter Allowance may be paused and resumed at the discretion of the CEO.

I. Internet Stipend: CalOptima Health shall provide an Internet Stipend in the amount of twenty-five dollars ($25.00) per pay period to full-time employees designated as Full Teleworkers, Partial Teleworkers or Community Workers. The Internet Stipend begins the first full pay period as a Full or Partial Teleworker or Community Worker. Eligible full-time employees will continue to receive the stipend until the first, full pay period in which an employee is not assigned to full or partial telework or community work. The Internet Stipend will be provided only for full pay periods and will not be prorated for a change in designation for a portion of a pay period. Executive Level Positions and Full Office Workers are not eligible for the Internet Stipend.

J. Active Certified Case Manager (CCM) Pay: CalOptima Health 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.

K. 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.

L. Employee Sales and Enrollment Incentive Program. Changes to this plan will be effective July 1, 2024. The purpose of the Program is to provide incentives for qualified and eligible staff whose primary job responsibility is to enroll new members in CalOptima Health's competitive programs, OneCare, and Program for All-Inclusive Care for the Elderly (PACE). Employees eligible for the Program must be employed by CalOptima Health, in good standing. Eligible employees must also individually sign a Sales and Enrollment Incentive Program Agreement, which does not alter the at-will nature of their relationship with CalOptima Health. The Sales and Enrollment Incentive Program may be modified or withdrawn, at any time, with five days' advance written notice.

1. OneCare Program: The OneCare Manager Member Outreach and Education; OneCare Supervisor Member Outreach and Education; OneCare Community Partner and Community Partner Sr staff in the Marketing and Sales Department must have an active Resident Insurance Producer license to enroll eligible members into the OneCare program. These licensed employees may be eligible to receive an incentive payment based on the number of new enrollments produced and retained in the OneCare program on a monthly basis in accordance with the OneCare Sales and Enrollment Incentive Program Agreement signed by each eligible employee.

2. PACE Program: The Supervisor Member Outreach and Education and Enrollment Coordinators staff are eligible for the Sales and Enrollment Incentive Program and may receive incentive payments based on the number of new enrollments produced and retained in the PACE Program on a monthly basis in accordance with the PACE Sales and Enrollment Incentive Program Agreement signed by each eligible employee.

M. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima Health's business needs and mission, vision, and values.

N. 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 Health may, at the discretion of the CEO, and on an exception basis, award a retention incentive.

O. 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 Health. Recruitment incentives of up to a maximum of fifty thousand dollars ($50,000) may be offered for Executive Level Positions and require informing the Board of Directors after approved.

P. 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 Health.

Q. Employer-Paid Member Contribution (EPMC): CalOptima Health contributes seven percent (7%) of compensation earnable, on behalf of eligible employees who hold management staff positions as identified in the CalOptima Health 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.

R. 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.N. of this Policy, provided that their performance meets the goals and objectives set forth by their managers.

S. Automobile Allowance: CalOptima Health 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 Health business.

T. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima Health'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 Health 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.

U. Work Life Balance Stipend: CalOptima Health shall provide an annual Work Life Balance Stipend of five hundred dollars ($500.00) to full-time employees and two hundred fifty dollars ($250.00) to

part-time employees. The stipend is intended to promote employee wellness through enhanced work life balance and may be used for any wellness-related purchases, such as dependent care, gym memberships, yoga classes, art therapy, dietician services, athletic gear, personal development courses, and more. The stipend is taxable and paid in two (2) increments of two hundred fifty dollars ($250.00) to full-time employees and one hundred twenty-five dollars ($125.00) to part-time employees on the pay periods that include November 01, and May 01 each year.

V. Benefit Income: CalOptima Health shall provide a bi-monthly taxable medical stipend as a cost savings measure to CalOptima Health and incentive for employees who have medical coverage outside of CalOptima Health. Employees must submit proof of outside coverage in order to be eligible for this benefit. The amount of the bi-monthly stipend is approved by the Board of Directors on an annual basis.

W. Temporary Upgrade Pay: An employee who is appointed for a limited duration to a job having a higher pay grade is eligible for Temporary Upgrade Pay. The employee must meet the minimum requirements of the position and be performing all essential job functions and responsibilities of the upgraded position without performing duties of their current job to qualify for Temporary Upgrade Pay. Temporary Upgrade Pay will be the minimum of the new pay rate or a five percent (5%) of base pay increase, whichever is greater. Temporary Upgrade Pay will be eliminated when the temporary assignment ends. The temporary assignment shall not exceed nine hundred and sixty (960) hours. Temporary Upgrade Pay is considered premium pay pursuant to Title 2 CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS Classic Members.

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 Health 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. Actual hours worked on a holiday will be used for purposes of calculating 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, 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 3:00 p.m. and 8:00 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 Health'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 Health may periodically audit and validate employee Office/Telework designations.

H. Internet Stipend

1. Internet Stipend is automatically calculated for eligible employees based on system designation of Full Teleworker, Partial Teleworker, or Community Worker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Telework designation changes require a request and approval per the Telework Program Guidelines. Community Worker designation is determined by the position. CalOptima Health may periodically audit and validate employee Office/Telework designations.

I. 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.

J. Incentive Compensation

1. The Board of Directors approves CalOptima Health'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 Health 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 Health 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.

K. Employee Sales and Enrollment Incentive Program

1. The Executive Director, Medicare Programs or designee will review the Employee Sales and Enrollment Incentive structure for the OneCare and PACE Programs on an annual basis and will submit any required changes to the incentive structure and the OneCare and PACE Employee Sales and Enrollment Incentive Agreements for review and approval by the CEO, or designee.

2. OneCare:

   a. Employees with the job titles of OneCare Manager Member Outreach and Education; Supervisor Member Outreach and Education; OneCare Community Partner and Community Partner Sr are eligible for the Sales and Enrollment Incentive Program and will be required to sign a OneCare Sales and Enrollment Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific each eligible employee job title.

   b. The OneCare Manager Outreach and Education will be responsible for calculating monthly payments for employees who are eligible for the OneCare Sales and Enrollment Incentive Program based on the number of enrollments produced each month according to the terms of the OneCare Sales and Enrollment Incentive Agreement effective at the time the enrollments are produced. The Manager will submit a detailed report of enrollments produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

3. PACE:

   a. Employees with the job titles of PACE Supervisor Member Outreach and Education and PACE Enrollment Coordinator are eligible for the Sales and Enrollment Incentive Program and will be required to sign a PACE Sales Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific to their job title.

   b. The PACE Manager Marketing & Enrollment will be responsible for calculating monthly incentive payments for employees who are eligible for the PACE Sales and Enrollment Incentive Program based on the number of enrollments produced each month according to the terms of the PACE Sales and Enrollment Incentive Program Agreement effective at the time the enrollments are produced. The Manager will submit a detailed report of enrollments produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

L. 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 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.

M. 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 Health. Recruitment incentives of up to a maximum of fifty thousand dollars ($50,000) may be offered for Executive Level Positions and require informing the Board of Directors after approved. 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 Health within twenty-four (24) months of the date of hire.

N. 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 Health to be eligible to receive the lump sum bonus payments.

O. 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.

P. Work Life Balance Stipend: Work Life Balance Stipend is automatically calculated for eligible employees.

Q. Benefit Income: Once enrolled in Benefit Income, the participating employee's election to waive CalOptima Health medical insurance will remain in effect for the entire, or remaining, plan year (January 1 through December 31) unless the employee has a qualifying event.

R. Temporary Upgrade Pay: Human Resources will calculate Temporary Upgrade Pay for eligible employees who are authorized and appointed for a limited duration to assume the duties of a position with a higher pay grade.

IV. ATTACHMENT(S)

A. Executive Incentive Program
B. Performance Review of Executives Template

V. REFERENCE(S)

A. CalOptima Health Employee Handbook

B. Compensation Administration Guidelines
C. Government Code, §20636 and 20636.1
D. Telework Program Guidelines
E. Title 2, California Code of Regulations (CCR), §571
F. PACE Sales and Enrollment Incentive Program Agreement: Supervisor Member Outreach and Education
G. PACE Sales and Enrollment Incentive Program Agreement: Enrollment Coordinator
H. OneCare Sales and Enrollment Incentive Program Agreement: Community Partner and Community Partner Sr
I. OneCare Sales and Enrollment Incentive Program Agreement: Supervisor Member Outreach and Education
J. OneCare Sales and Enrollment Incentive Program Agreement: Manager Member Outreach & Education

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
06/02/2022	Regular Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health 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
Revised	06/02/2022	GA.8042	Supplemental Compensation	Administrative
Revised	05/04/2023	GA.8042	Supplemental Compensation	Administrative
Revised	12/07/2023	GA.8042	Supplemental Compensation	Administrative
Revised	06/06/2024	GA.8042	Supplemental Compensation	Administrative

IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima Health's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process	Prospective staff translators are identified by the Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima Health'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 the 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 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.
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.
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Central Worksite	CalOptima Health's primary physical location of business applicable to the employee, which is either CalOptima Health's administration building at 505 City Parkway West, the PACE building or other CalOptima Health operated location.
Community Worker	An employee in a position that performs fifty-one percent (51%) or more of their duties in field locations such as provider offices, members' homes, and at community outreach events.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
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.

Term	Definition
Leave of Absence (LOA)	A term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.
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 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 HEALTH EXECUTIVE INCENTIVE PROGRAM

The Executive Incentive Plan is an annual plan for the members of CalOptima Health'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 Health'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 attainment
- Consistency in approach across 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			

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, YYYY, through March 31, YYYY.

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 Health 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 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 procedures 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 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
List specific examples or details of past performance and self-development	
STRATEGIC THINKING: • Applies the SWOT analysis to CalOptima Health'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.	☐ 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.8050
Title:	**Confidentiality**
Department:	Human Resources~~CalOptima Administrative~~
Section:	Not Applicable~~Human Resources~~
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	06/06/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ~~☐ OneCare Connect~~ ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines ~~CalOptima's~~CalOptima Health's guidelines for protecting proprietary, private, and confidential information.

II. POLICY

A. CalOptima Health Board members, executive staff, employees, interns, volunteers, temporary employees, and applicable contractors, consultants, and agents (referred to herein collectively as "Employees") shall not disclose, divulge, or make accessible proprietary, private, and/or confidential information belonging to, or obtained through the Employee's affiliation with, CalOptima Health to any person, including, but not limited to, relatives, friends, and business and professional associates, other than to persons who have a legitimate business need for such information and to whom CalOptima Health has authorized disclosure in writing. This obligation includes making sure proprietary, private, and/or confidential information is secure (whether maintained in electronic or other format), taking precautions to secure files, and following all federal, state, and local laws and regulations.

B. Proprietary information is all information owned by CalOptima Health, obtained, or created by Employees during the course of their work with or at CalOptima Health, including, but not limited to, intellectual property, computer software, and provider identification numbers. Private information is any personal information for which an individual, group, or entity would reasonably expect to be restricted from public access, including, but not limited to, any information related to a person's health, member file, personnel file, recruitment and application records, workers' compensation file, date of birth, and social security number. Confidential information is any information that is not known generally to the public~~,~~ and is accessible only to those for whom it is intended or directed, including, but not limited to, provider rates, the Department of Health Care Services (DHCS) reimbursement rates, Protected Health Information (PHI), procurement requests, vendor proposals or bids, contracts, administrative files, computer records, computer programs, and financial data. Information may be one or more of proprietary, private, and/or confidential in nature.

C. Inappropriate use, unauthorized copy or transfer, attempted destruction, or the destruction or disclosure of proprietary, private, and/or confidential information obtained through the Employee's

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affiliation with CalOptima Health will subject an Employee to ~~discipline~~corrective action, up to and including termination, and possible legal recourse.

III. PROCEDURE

A. Employees shall:

1. Use proprietary, private, and/or confidential information solely for the purpose of performing services as a trustee or Employee of CalOptima Health;

2. Exercise good judgment and care at all times to avoid unauthorized or improper disclosures of proprietary, private, and/or confidential information; and

3. Adhere to all CalOptima Health compliance and Health Insurance Portability and Accountability Act (HIPAA) policies, including, but not limited to, CalOptima Health Policies ~~IS~~, GA.5005a: Acceptable Use of Technology Resources, HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls, HH.3011: Use and Disclosure of Protected Health Information for Treatment, Payment, and Health Care Operations, HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI), ITS.1201: ~~EPHI~~ Technical Safeguards - Access Controls, ~~IS~~ITS.1202: ~~EPHI~~ Technical Safeguards - Data Controls, ~~GA.5005a: Use of Technology Resources, and IS~~and ITS.1301: Security ~~of Workforce Access to EPHI~~Awareness Training.

4. Employees are expected to report confidentiality~~Confidentiality~~ issues under this policy and can do so anonymously to the Compliance and Ethics hotline at 1-~~877-837-4417~~855-507-1805.

B. Conversations in public places, such as restaurants, elevators, restrooms, hallways, lobbies, and while traveling via public transportation, should be limited to matters that do not pertain to information of a sensitive, proprietary, private, and/or confidential nature. In addition, Employees must be sensitive to the risk of inadvertent disclosure and should refrain from leaving proprietary, private, and/or confidential information on desks, workspaces, personal computers, cars, or otherwise in plain view of unauthorized persons, and Employees shall refrain from the use of speaker phones to discuss proprietary, private, and/or confidential information if the conversation could be heard by unauthorized persons.

C. Employees may be subject to more specific legal, regulatory, and contractual requirements regarding proprietary, private, and/or confidential information. In brief summary, Employees and individuals affiliated with CalOptima Health are subject to various confidentiality provisions such as:

1. Public Assistance Recipients: The identity of an individual receiving public services/assistance is protected by state and federal law. Medi-Cal is a form of public assistance and providing information regarding an individual's eligibility is limited only to purposes of service delivery. Only those designated individuals responsible for verifying eligibility to providers should be providing such information and only to authorized recipients.

2. Medical Records: Medical condition and treatment records are confidential between the treating healthcare Provider and Member. Such information is protected under California and federal law. When authorized, such records may be subject to review by qualified professionals involved in ~~CalOptima's~~CalOptima Health's responsibilities related to such functions as claims,

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utilization review, quality assurance, grievance appeals, etc. Any information obtained in this regard must be kept confidential and may not be disclosed to unauthorized persons.

3. Special Health Conditions: Information related to the identity of individuals receiving treatment with certain health conditions carry further confidentiality protection, e.g., AIDS, substance abuse, mental illness, or venereal disease.

4. Special Categories: Other conditions, or circumstances, are covered by special confidentiality provisions, e.g., minors, victims of abuse~~, etc~~.

5. Rates: The rates paid to CalOptima Health by the Department of Health Care Services (DHCS) and the rates CalOptima Health pays to its contractors/providers are confidential under state and federal law.

D. HIPAA requires CalOptima Health, its Employees, and its agents to comply with the following standards to protect the privacy of an individual's PHI. PHI is any individually identifiable health information, including demographic information. CalOptima Health is committed to ensuring the privacy and security of Member information, and Employees shall comply with applicable laws and CalOptima Health policies and procedures to protect and maintain the confidentiality of PHI as outlined below:

1. General Use: PHI pertaining to Members may only be used to perform functions, activities, or services for the purpose of treatment, payment, or health care operations, unless otherwise authorized by the Member, or required by law. In addition, use or disclosure of PHI should be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

2. Unacceptable Use: PHI shall not be used for personal benefit or for the benefit of any other person or entity. Divulging the Medi-Cal status or other PHI of a Member to unauthorized recipients is prohibited.

3. Privacy and Security Safeguards: CalOptima Health is required to have in place administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI. These safeguards may include, but are not limited to, physically securing PHI in paper form and encrypting PHI in electronic form.

E. At the end of a Board member's term in office, or upon the termination of an Employee's relationship with CalOptima Health, he or she shall immediately return all documents, papers, electronic files, and other materials, regardless of medium, which may contain or be derived from proprietary, private and/or confidential information in his or her possession.

F. Any individual covered by this policy who violates its provisions shall be subject to ~~discipline~~corrective action up to and~~/or~~ including separation from service~~,~~ or affiliation~~,~~ with CalOptima Health, as well as possible civil and/or criminal liability. The restrictions of this policy also pertain to any disclosure or use of proprietary, private, and/or confidential information after leaving affiliation with CalOptima Health.

G. CalOptima Health shall provide new hires with this policy.

1. All Employees are required to sign an acknowledgment that they have received and read, and understand, this policy and agree to comply with it.

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2. Failure to sign such acknowledgment may result in ~~disciplinary~~corrective action~~,~~ up to and including termination.

H. CalOptima Health welcomes new ideas related to the security of our proprietary, private, and/or confidential information and encourages Employees to share them with their supervisors and managers to continually improve existing practices. If any Employee would like to remain anonymous when sharing such ideas, that Employee may contact the Human Resources Employee Relations unit.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources
D. CalOptima Health Policy ~~IS.1201: Electronic~~ HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information ~~(EPHI)~~ and Document Controls
E. CalOptima Health Policy HH.3011: Use and Disclosure of Protected Health Information for Treatment, Payment, and Health Care Operations
F. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
~~D.~~G. CalOptima Health Policy ITS.1201: Technical Safeguards - Access Controls
~~E.~~H. CalOptima Health Policy ~~IS~~ITS.1202: ~~Electronic Protected Health Information (EPHI)~~ Technical Safeguards - Data Controls
~~F.~~I. CalOptima Health Policy ~~IS~~ITS.1301: Security ~~of Workforce Access to Electronic Protected Health Information (EPHI)~~Awareness Training
~~G.~~J. Confidentiality Statement

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Regulatory Agency
12/01/2016	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8050	Confidentiality	Administrative
Revised	12/01/2016	GA.8050	Confidentiality	Administrative

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Action	Date	Policy	Policy Title	Program(s)
Revised	10/04/2018	GA.8050	Confidentiality	Administrative
Revised	06/02/2022	GA.8050	Confidentiality	Administrative
Revised	06/06/2024	GA.8050	Confidentiality	Administrative

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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 Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127) for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.~~ Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members

	less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima

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	Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. ~~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).~~ PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.
Employee	For purposes of this policy, CalOptima Health Board members, executive staff, employees, contractors, interns, volunteers, temporary employees, and applicable contractors, consultants, and agents.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Medical Record	Any single or complete record kept or required to be kept, that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy.
Member	A beneficiary enrolled in a CalOptima Health program.

Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future payment for the provision of health care to a Member.
Provider	~~A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.~~Med-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.

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Policy:	GA.8050
Title:	**Confidentiality**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	06/06/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines CalOptima Health's guidelines for protecting proprietary, private, and confidential information.

II. POLICY

A. CalOptima Health Board members, executive staff, employees, interns, volunteers, temporary employees, and applicable contractors, consultants, and agents (referred to herein collectively as "Employees") shall not disclose, divulge, or make accessible proprietary, private, and/or confidential information belonging to, or obtained through the Employee's affiliation with, CalOptima Health to any person, including, but not limited to, relatives, friends, and business and professional associates, other than to persons who have a legitimate business need for such information and to whom CalOptima Health has authorized disclosure in writing. This obligation includes making sure proprietary, private, and/or confidential information is secure (whether maintained in electronic or other format), taking precautions to secure files, and following all federal, state, and local laws and regulations.

B. Proprietary information is all information owned by CalOptima Health, obtained, or created by Employees during the course of their work with or at CalOptima Health, including, but not limited to, intellectual property, computer software, and provider identification numbers. Private information is any personal information for which an individual, group, or entity would reasonably expect to be restricted from public access, including, but not limited to, any information related to a person's health, member file, personnel file, recruitment and application records, workers' compensation file, date of birth, and social security number. Confidential information is any information that is not known generally to the public and is accessible only to those for whom it is intended or directed, including, but not limited to, provider rates, the Department of Health Care Services (DHCS) reimbursement rates, Protected Health Information (PHI), procurement requests, vendor proposals or bids, contracts, administrative files, computer records, computer programs, and financial data. Information may be one or more of proprietary, private, and/or confidential in nature.

C. Inappropriate use, unauthorized copy or transfer, attempted destruction, or the destruction or disclosure of proprietary, private, and/or confidential information obtained through the Employee's affiliation with CalOptima Health will subject an Employee to corrective action, up to and including termination, and possible legal recourse.

III. PROCEDURE

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A. Employees shall:

1. Use proprietary, private, and/or confidential information solely for the purpose of performing services as a trustee or Employee of CalOptima Health;

2. Exercise good judgment and care at all times to avoid unauthorized or improper disclosures of proprietary, private, and/or confidential information; and

3. Adhere to all CalOptima Health compliance and Health Insurance Portability and Accountability Act (HIPAA) policies, including, but not limited to, CalOptima Health Policies, GA.5005a: Acceptable Use of Technology Resources, HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls, HH.3011: Use and Disclosure of Protected Health Information for Treatment, Payment, and Health Care Operations, HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI), ITS.1201: Technical Safeguards - Access Controls, ITS.1202: Technical Safeguards - Data Controls, and ITS.1301: Security Awareness Training.

4. Employees are expected to report confidentiality issues under this policy and can do so anonymously to the Compliance and Ethics hotline at 1-855-507-1805.

B. Conversations in public places, such as restaurants, elevators, restrooms, hallways, lobbies, and while traveling via public transportation, should be limited to matters that do not pertain to information of a sensitive, proprietary, private, and/or confidential nature. In addition, Employees must be sensitive to the risk of inadvertent disclosure and should refrain from leaving proprietary, private, and/or confidential information on desks, workspaces, personal computers, cars, or otherwise in plain view of unauthorized persons, and Employees shall refrain from the use of speaker phones to discuss proprietary, private, and/or confidential information if the conversation could be heard by unauthorized persons.

C. Employees may be subject to more specific legal, regulatory, and contractual requirements regarding proprietary, private, and/or confidential information. In brief summary, Employees and individuals affiliated with CalOptima Health are subject to various confidentiality provisions such as:

1. Public Assistance Recipients: The identity of an individual receiving public services/assistance is protected by state and federal law. Medi-Cal is a form of public assistance and providing information regarding an individual's eligibility is limited only to purposes of service delivery. Only those designated individuals responsible for verifying eligibility to providers should be providing such information and only to authorized recipients.

2. Medical Records: Medical condition and treatment records are confidential between the treating healthcare Provider and Member. Such information is protected under California and federal law. When authorized, such records may be subject to review by qualified professionals involved in CalOptima Health's responsibilities related to such functions as claims, utilization review, quality assurance, grievance appeals, etc. Any information obtained in this regard must be kept confidential and may not be disclosed to unauthorized persons.

3. Special Health Conditions: Information related to the identity of individuals receiving treatment with certain health conditions carry further confidentiality protection, e.g., AIDS, substance abuse, mental illness, or venereal disease.

4. Special Categories: Other conditions, or circumstances, are covered by special confidentiality provisions, e.g., minors, victims of abuse.

5. Rates: The rates paid to CalOptima Health by the Department of Health Care Services (DHCS) and the rates CalOptima Health pays to its contractors/providers are confidential under state and federal law.

D. HIPAA requires CalOptima Health, its Employees, and its agents to comply with the following standards to protect the privacy of an individual's PHI. PHI is any individually identifiable health information, including demographic information. CalOptima Health is committed to ensuring the privacy and security of Member information, and Employees shall comply with applicable laws and CalOptima Health policies and procedures to protect and maintain the confidentiality of PHI as outlined below:

1. General Use: PHI pertaining to Members may only be used to perform functions, activities, or services for the purpose of treatment, payment, or health care operations, unless otherwise authorized by the Member, or required by law. In addition, use or disclosure of PHI should be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

2. Unacceptable Use: PHI shall not be used for personal benefit or for the benefit of any other person or entity. Divulging the Medi-Cal status or other PHI of a Member to unauthorized recipients is prohibited.

3. Privacy and Security Safeguards: CalOptima Health is required to have in place administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI. These safeguards may include, but are not limited to, physically securing PHI in paper form and encrypting PHI in electronic form.

E. At the end of a Board member's term in office, or upon the termination of an Employee's relationship with CalOptima Health, he or she shall immediately return all documents, papers, electronic files, and other materials, regardless of medium, which may contain or be derived from proprietary, private and/or confidential information in his or her possession.

F. Any individual covered by this policy who violates its provisions shall be subject to corrective action up to and including separation from service or affiliation with CalOptima Health, as well as possible civil and/or criminal liability. The restrictions of this policy also pertain to any disclosure or use of proprietary, private, and/or confidential information after leaving affiliation with CalOptima Health.

G. CalOptima Health shall provide new hires with this policy.

1. All Employees are required to sign an acknowledgment that they have received and read, and understand, this policy and agree to comply with it.

2. Failure to sign such acknowledgment may result in corrective action up to and including termination.

H. CalOptima Health welcomes new ideas related to the security of our proprietary, private, and/or confidential information and encourages Employees to share them with their supervisors and

managers to continually improve existing practices. If any Employee would like to remain anonymous when sharing such ideas, that Employee may contact the Human Resources Employee Relations unit.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources
D. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls
E. CalOptima Health Policy HH.3011: Use and Disclosure of Protected Health Information for Treatment, Payment, and Health Care Operations
F. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
G. CalOptima Health Policy ITS.1201: Technical Safeguards - Access Controls
H. CalOptima Health Policy ITS.1202: Technical Safeguards - Data Controls
I. CalOptima Health Policy ITS.1301: Security Awareness Training
J. Confidentiality Statement

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Regulatory Agency
12/01/2016	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8050	Confidentiality	Administrative
Revised	12/01/2016	GA.8050	Confidentiality	Administrative
Revised	10/04/2018	GA.8050	Confidentiality	Administrative
Revised	06/02/2022	GA.8050	Confidentiality	Administrative
Revised	06/06/2024	GA.8050	Confidentiality	Administrative

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IX. GLOSSARY

Term	Definition
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health

	is responsible for all Covered Services as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. <u>PACE</u>: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.

Employee	For purposes of this policy, CalOptima Health Board members, executive staff, employees, contractors, interns, volunteers, temporary employees, and applicable contractors, consultants, and agents.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.
Medical Record	Any single or complete record kept or required to be kept, that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy.
Member	A beneficiary enrolled in a CalOptima Health program.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future payment for the provision of health care to a Member.
Provider	Med-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.

1

CalOptima Health, Program for All Inclusive Care of the Elderly (PACE)

SALES AND ENROLLMENT INCENTIVE PROGRAM AGREEMENT

Job Title: **Supervisor Member Outreach and Education**

This PACE Sales and Enrollment Incentive Program Agreement ("Agreement") is entered into by and between CalOptima Health, and, _____(Employee Name) who is currently employed by CalOptima Health as a PACE Supervisor Member Outreach and Education ("Employee") and is eligible to participate in the Employee Sales and Enrollment Incentive Program according to CalOptima Health Policy GA.8042, Supplemental Compensation. This Agreement shall be effective as of _____ ("Effective Date") through December 31, _____.

I. Obligations of Employee

1.1 Employee must meet requirements as defined in CalOptima Health policy PA.2010, Enrollment and Intake.

II. CalOptima Health Incentive Payment Procedure

2.1 The Enrollment and Sales Incentive for the Supervisor Member Outreach and Education is based on PACE's total enrollment net growth for the calendar year (CY) measurement period. The CY measurement period will begin on January1st and end on December 31st of the current year. The incentive will be [redacted] per Net Gained Member.

2.2 The number of Net Gained Members is calculated based on PACE's total enrollment net growth for the CY measurement period, produced by all Employees in the PACE Marketing and Enrollment Department including Enrollment Coordinators.

2.3 Employee will receive an Incentive based on the net increase of PACE's monthly total enrollment during the CY measurement period. Net enrollment growth will be tracked monthly. Employee will earn and be paid fifty percent (50%) of the total incentive tracked each month. The remaining fifty percent (50%) of the Incentive will be earned and paid only if PACE's total enrollment at the end of the CY measurement period increased compared to the previous CY measurement period.

2.4 The final total net negative or net positive enrollment calculation for the CY measurement period will be calculated in the month of March of the following calendar year to adjust for any retroactive changes in actual net enrollment.

2.5 After the final true-up of actual net enrollment, Employee will receive any remaining earned incentive for the CY measurement period according to CalOptima Health's monthly incentive compensation payment schedule.

2.4 If Employee leaves CalOptima Health employment and is thereafter rehired into the same position, the Incentive for net enrollment will reset to zero (0) at the time of rehire.

Policy:	GA.8056
Title:	**Paid Holidays**
Department:	~~CalOptima Health Administrative~~Human Resources
Section:	~~Human Resources~~Not Applicable
CEO Approval:	*/s/*
Effective Date:	04/01/2014
Revised Date:	06/06/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ~~☐ OneCare Connect~~ ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes the paid holiday schedule for CalOptima Health Employees.

II. POLICY

A. The following holidays shall be observed by CalOptima Health:

1. New Year's Day
2. Martin Luther King Jr's Birthday
3. Lincoln's Birthday
4. Washington's Birthday
5. Memorial Day
6. Independence Day
7. Labor Day
8. Indigenous Peoples' Day
9. Veterans Day
10. Thanksgiving Day
11. Day after Thanksgiving
12. Christmas Day
13. One Flex Holiday (credited on January 1)

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B. A holiday that falls on a Saturday or Sunday can be observed on the preceding Friday or the following Monday. ~~-~~Holiday observances will be noted on the annual payroll schedule.~~-~~ Employees will be provided notice of any changes to the published schedule.

C. ~~Regular full-time and regular part-time Employees who are regularly scheduled to work twenty (20) or more hours per week.~~ Employees in active status on December 31st are eligible to receive a maximum of one (1) Flex Holiday (maximum of eight (8) hours, prorated based on scheduled work hours) each calendar year on January 1st. Limits are imposed on the number of Flex Holiday hours that can be maintained in an Employee's Flex Holiday account. A maximum of twelve (12) hours, prorated based on scheduled work hours, may be maintained in an Employee's Flex Holiday account as of January 1st of each year. In the event that available Flex Holiday hours are not used by the last pay period of the calendar year, Employees may carry unused Flex Holiday hours into subsequent years and may accrue additional hours up to the maximum of eight (8) hours, prorated based on scheduled work hours. If an Employee reached the maximum amount of twelve (12) hours on January 1st, prorated based on scheduled work hours, the Employee will stop accruing Flex Holiday hours. Flex Holiday hours are not eligible for annual cash out applicable to Paid Time Off (PTO) hours. The Chief Executive Officer (CEO) may assign a specific date for the Flex Holiday for business reasons and/or needs. Assignment of the Flex Holiday will be announced in advance. Otherwise, Employees may take the Flex Holiday on any day elected by the Employee, subject to approval by the Employee's manager. If an Employee separates from CalOptima Health and has unused Flex Holiday hours, the unused Flex Holiday hours will be paid out at the same time and in the same manner as unused PTO hours upon termination.

a. Employees on an approved leave of absence on December 31st will be eligible to receive a maximum of one (1) Flex Holiday (maximum of eight (8) hours, prorated based on scheduled work hours) upon their return to active status.

b. If the Employee does not return to work after their approved leave of absence, and instead separates from employment with CalOptima Health, the employee will not be eligible to receive the Flex Holiday.

D. Regular full-time and regular part-time Employees shall be paid their regular base rate of pay for the holidays specified in this Policy.

E. CalOptima Health may, in its discretion, amend the list of paid holidays and/or require an Employee to work on one or more of the observed holidays.

F. From time to time, at the discretion of the CEO, the CEO, or their Designee, may authorize managers, at their discretion, to release Employees early, up to a maximum of two (2) hours, with pay, on the workday immediately preceding a holiday, as long as departments ensure critical areas are covered for the entire business day.~~-~~ The release of Employees early as provided herein is intended to benefit only those Employees who are working on the workday immediately preceding a holiday. Employees who are on PTO on the day Employees are permitted to leave early are not entitled to any credit or future early release.

III. PROCEDURE

A. CalOptima Health will note holiday observances annually on its payroll schedule. ~~-~~In the event of a change to the published schedule, CalOptima Health will provide prompt notice to all Employees.

B. When a holiday falls on a regular nine (9) hour workday for a full-time non-exempt Employee on a 9/80 schedule pursuant to CalOptima Health Policy GA.8020: 9/80 Work Schedule, the Employee has the option of using one (1) hour of accrued PTO or making up the time if approved by their

supervisor. For Employees on the 9/80 Work Schedule, should a holiday fall on an Employee's scheduled day off, the Employee will be permitted to take another day off in the same workweek.

C. All regular, non-exempt, full-time employees who are eligible for paid holidays but who may be required to work on a holiday observed by CalOptima Health will receive Holiday Premium Pay in accordance with CalOptima Health Policy GA.8042: Supplemental Compensation. If a regular, non-exempt part-time Employee is required to work a scheduled holiday, they will receive their regular base rate of pay for the holiday, in addition to their regular compensation for the hours of actual work performed.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8020: 9/80 Work Schedule
B. CalOptima Health Policy GA.8042: Supplemental Compensation

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
04/07/2016	Regular Meeting of the CalOptima Board of Directors
04/05/2018	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2014	GA.8056	Paid Holidays	Administrative
Revised	04/07/2016	GA.8056	Paid Holidays	Administrative
Revised	04/05/2018	GA.8056	Paid Holidays	Administrative
Revised	02/01/2021	GA.8056	Paid Holidays	Administrative
Revised	12/01/2022	GA.8056	Paid Holidays	Administrative
Revised	06/06/2024	GA.8056	Paid Holidays	Administrative

IX. GLOSSARY

Term	Definition
Employee	For the purposes of this policy, employees include regular full-time and regular part-time ~~employees of~~ CalOptima Health employees who are regularly scheduled to work twenty (20) or more hours per week.

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Policy:	GA.8056
Title:	**Paid Holidays**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	04/01/2014
Revised Date:	06/06/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes the paid holiday schedule for CalOptima Health Employees.

II. POLICY

A. The following holidays shall be observed by CalOptima Health:

1. New Year's Day
2. Martin Luther King Jr's Birthday
3. Lincoln's Birthday
4. Washington's Birthday
5. Memorial Day
6. Independence Day
7. Labor Day
8. Indigenous Peoples' Day
9. Veterans Day
10. Thanksgiving Day
11. Day after Thanksgiving
12. Christmas Day
13. 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.

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C. Employees in active status on December 31st are eligible to receive a maximum of one (1) Flex Holiday (maximum of eight (8) hours, prorated based on scheduled work hours) each calendar year on January 1st. Limits are imposed on the number of Flex Holiday hours that can be maintained in an Employee's Flex Holiday account. A maximum of twelve (12) hours, prorated based on scheduled work hours, may be maintained in an Employee's Flex Holiday account as of January 1st of each year. In the event that available Flex Holiday hours are not used by the last pay period of the calendar year, Employees may carry unused Flex Holiday hours into subsequent years and may accrue additional hours up to the maximum of eight (8) hours, prorated based on scheduled work hours. If an Employee reached the maximum amount of twelve (12) hours on January 1st, prorated based on scheduled work hours, the Employee will stop accruing Flex Holiday hours. Flex Holiday hours are not eligible for annual cash out applicable to Paid Time Off (PTO) hours. The Chief Executive Officer (CEO) may assign a specific date for the Flex Holiday for business reasons and/or needs. Assignment of the Flex Holiday will be announced in advance. Otherwise, Employees may take the Flex Holiday on any day elected by the Employee, subject to approval by the Employee's manager. If an Employee separates from CalOptima Health and has unused Flex Holiday hours, the unused Flex Holiday hours will be paid out at the same time and in the same manner as unused PTO hours upon termination.

a. Employees on an approved leave of absence on December 31st will be eligible to receive a maximum of one (1) Flex Holiday (maximum of eight (8) hours, prorated based on scheduled work hours) upon their return to active status.

b. If the Employee does not return to work after their approved leave of absence, and instead separates from employment with CalOptima Health, the employee will not be eligible to receive the Flex Holiday.

D. Regular full-time and regular part-time Employees shall be paid their regular base rate of pay for the holidays specified in this Policy.

E. CalOptima Health may, in its discretion, amend the list of paid holidays and/or require an Employee to work on one or more of the observed holidays.

F. From time to time, at the discretion of the CEO, the CEO, or their Designee, may authorize managers, at their discretion, to release Employees early, up to a maximum of two (2) hours, with pay, on the workday immediately preceding a holiday, as long as departments ensure critical areas are covered for the entire business day. The release of Employees early as provided herein is intended to benefit only those Employees who are working on the workday immediately preceding a holiday. Employees who are on PTO on the day Employees are permitted to leave early are not entitled to any credit or future early release.

III. PROCEDURE

A. CalOptima Health will note holiday observances annually on its payroll schedule. In the event of a change to the published schedule, CalOptima Health will provide prompt notice to all Employees.

B. When a holiday falls on a regular nine (9) hour workday for a full-time non-exempt Employee on a 9/80 schedule pursuant to CalOptima Health Policy GA.8020: 9/80 Work Schedule, the Employee has the option of using one (1) hour of accrued PTO or making up the time if approved by their supervisor. For Employees on the 9/80 Work Schedule, should a holiday fall on an Employee's scheduled day off, the Employee will be permitted to take another day off in the same workweek.

C. All regular, non-exempt, full-time employees who are eligible for paid holidays but who may be required to work on a holiday observed by CalOptima Health will receive Holiday Premium Pay in

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accordance with CalOptima Health Policy GA.8042: Supplemental Compensation. If a regular, non-exempt part-time Employee is required to work a scheduled holiday, they will receive their regular base rate of pay for the holiday, in addition to their regular compensation for the hours of actual work performed.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8020: 9/80 Work Schedule
B. CalOptima Health Policy GA.8042: Supplemental Compensation

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
04/07/2016	Regular Meeting of the CalOptima Board of Directors
04/05/2018	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2014	GA.8056	Paid Holidays	Administrative
Revised	04/07/2016	GA.8056	Paid Holidays	Administrative
Revised	04/05/2018	GA.8056	Paid Holidays	Administrative
Revised	02/01/2021	GA.8056	Paid Holidays	Administrative
Revised	12/01/2022	GA.8056	Paid Holidays	Administrative
Revised	06/06/2024	GA.8056	Paid Holidays	Administrative

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IX. GLOSSARY

Term	Definition
Employee	For the purposes of this policy, employees include regular full-time and regular part-time CalOptima Health employees who are regularly scheduled to work twenty (20) or more hours per week.

III. Termination of Employment

3.1 To earn and receive Incentive payments, Employee must be employed by CalOptima Health as a Supervisor Member Outreach and Education at the time any applicable Incentive payment is due and payable. If Employee moves to a position within CalOptima Health that is not eligible for Sales and Enrollment Incentive payments or is terminated or quits before an Incentive payment is made, Employee will not earn or be paid the Incentive payment following the date of such transfer or termination.

IN WITNESS WHEREOF, by signing below, Employee agrees to abide by the terms of this Agreement and CalOptima Health's policies and procedures.

_____

Employee (Signed Name and Date)

_____

PACE Manager, Marketing and Enrollment (Approval and Date)

_____

Executive Director, Medicare Programs (Approval and Date)

_____

Chief Financial Officer (Approval and Date)

CalOptima Health, Program for All Inclusive Care of the Elderly (PACE)

SALES AND ENROLLMENT INCENTIVE PROGRAM AGREEMENT

Job Title: **PACE Enrollment Coordinator**

This PACE Sales and Enrollment Incentive Program Agreement ("Agreement") is entered into by and between CalOptima Health, and, _____(Employe Name) who is currently employed by CalOptima Health as an Enrollment Coordinator ("Employee") and is eligible to participate in the Employee Sales and Enrollment Incentive Program according to CalOptima Health Policy GA.8042, Supplemental Compensation. This Agreement shall be effective as of _____ ("Effective Date") through December 31, _____.

I. Obligations of Employee

1.1 Employee must meet requirements as defined in CalOptima Health policy PA.2010, Enrollment and Intake.

II. CalOptima Health Incentive Payment Procedure

2.1 New Sales and Enrollment Incentive:

2.1.1 Employee is eligible to earn and be paid a Sales Enrollment Incentive based on the number of new enrollments produced by Employee into the PACE program each month.

2.1.2 Incentives for new enrollments will be paid out monthly in the month following the effective date of enrolment.

2.1.3 Incentive payments for new enrollments are subject to retroactive enrollment adjustments.

2.1.4 Employee will receive a flat Enrollment and Sales Incentive of [redacted] based on the number of new members enrolled by Employee in the PACE program.

2.1.5 An Enrolled Member is defined as an individual who is enrolled for three (3) consecutive months, starting on their effective date of enrollment coverage.

2.1.6 If an Enrolled Member voluntarily disenrolls and does not meet the minimum consecutive three-month (3) continuous enrollment period, a chargeback will occur for the month the PACE Enrollment and Sales Incentive was paid out. Employee's PACE Enrollment and Sales Incentive will be reassessed and recalculated for that month. The chargeback will be deducted from Employee's total monthly Incentive payment following the PACE member enrollment status change.

2.1.7 No Chargeback will be deducted if the Enrolled Member involuntarily disenrolls before the minimum three-month (3) continuous enrollment period is satisfied. Involuntary disenrollment reasons include death, loss of Medi-Cal eligibility, loss of Medicare eligibility, or if the Enrolled Member moves out of Orange County.

2.1.8 Employee must be employed by CalOptima Health as an Enrollment Coordinator at the time the Incentive payment is due in order to earn and be paid the Incentive payment. Incentive payments will not be made following the termination of Employee's employment with CalOptima Health or following Employee's transfer to a position within CalOptima Health other than Enrollment Coordinator..

2.4 If the total Incentive payments in any given month are insufficient to cover a Chargeback, the amount of the Chargeback will be carried over to the next month's Incentive payment.

2.5 If Employee leaves CalOptima Health employment and is thereafter rehired as an Enrollment Coordinator, any Incentive payment that was not previously earned or paid due to Employee's termination of employment will not be paid.

III. Termination of Employment

3.1 To earn and receive an Incentive payment, Employee must be employed by CalOptima Health as an Enrollment Coordinator at time any applicable Incentive payment is due. If Employee moves to a position within CalOptima Health that is not eligible for incentives or is terminated or quits, Employee will not earn or be paid an Incentive after the date of such transfer or termination.

IN WITNESS WHEREOF, by signing below, Employee agrees to abide by the terms of this Agreement and CalOptima Health's policies and procedures.

_____

Employee (Signed Name and Date)

_____

Manager, Marketing and Enrollment (Approval and Date)

_____

Executive Director, Medicare Programs (Approval and Date)

_____

Chief Financial Officer (Approval and Date)

CalOptima Health, OneCare Program

SALES AND ENROLLMENT INCENTIVE PROGRAM AGREEMENT

Job Title: **Community Partner and Community Partner Sr**

This PACE Sales and Enrollment Incentive Program Agreement ("Agreement") is entered into by and between CalOptima Health, and, _____(Employee Name) who is currently employed by CalOptima Health as a Community Partner or Community Partner Sr ("Employee") and is eligible to participate in the Employee Sales and Enrollment Incentive Program according to CalOptima Health Policy GA.8042, Supplemental Compensation. This Agreement shall be effective as of _____ ("Effective Date") through December 31, _____.

I. Obligations of Employee

1.1 Employee must meet requirements as defined in CalOptima Health policy MA.2012, Training and Oversight of CalOptima Health-Employed Community Partners.

1.2 Employee must have an active Resident Insurance Producer license ("Producer License") issued by the California Department of Insurance throughout the term of this Agreement. Should the employee's Producer License expire, no incentives will be earned until the license is reactivated. Under no circumstances will Employee earn an incentive for a sale made during the period of an expired license.

II. CalOptima Health Incentives for Community Partner and Community Partner Sr

2.1 New Sales and Enrollment Incentive:

2.1.1 Employee will receive a Sales and Enrollment Incentive based on the number of new enrollments produced into the OneCare program each month in accordance with the monthly new enrollment incentive schedule in section 2.1.5 below.

2.1.2 Incentives for new enrollments will be paid out monthly in the month following the effective date of the enrollment.

2.1.3 Incentive payments for new enrollments are subject to retroactive enrollment adjustments as described in sections 2.1.7 and 2.1.8, below.

2.1.4 Community Partners and Community Partners Sr are required to produce a **minimum of thirty-seven (37) enrollments each month**. No incentive will be paid for the first thirty-six (36) enrollments each month. Failure to meet the 37 minimum monthly enrollment production goal for three (3) consecutive months may result in the employee being

placed on a Performance Improvement Plan (PIP) according to CalOptima Health Human Resources policy.

2.1.5 The OneCare Sales and Enrollment Incentive is paid per "Enrolled Member" based on the member's effective date of enrollment coverage at the rate specified within the table below.

Tier	Minimum	Maximum	Incentive per Enrollment
1	1	36	N/A
2	37	50	[redacted]
3	51	60	[redacted]
4	61 +	-	[redacted]

2.1.6 An Enrolled Member is defined as an individual who is enrolled for three (3) consecutive months, starting on their effective date of enrollment coverage.

2.1.7 If an Enrolled Member voluntarily disenrolls and does not meet the minimum three-month (3) continuous enrollment period, a "Chargeback" will occur for the month the Sales and Enrollment Incentive was paid out. Employee's OneCare Enrollment and Sales Incentive will be reassessed and recalculated for that month. The Chargeback will be deducted from Employee's total monthly incentive payout(s) in the month following the Enrolled Member's enrollment status change.

2.1.8 No Chargeback will be deducted if the Enrolled Member involuntarily disenrolls before the minimum three-month (3) continuous enrollment period is satisfied. Involuntary disenrollment reasons include member's death, loss of Medi-Cal eligibility, loss of Medicare eligibility, or if the Enrolled Member moves out of Orange County.

2.2 Residual (Retention) Incentive:

2.2.1 Each month, Employee will receive a monthly Residual or Retention Incentive based on any Enrolled Member who was most recently enrolled in OneCare by Employee. This Residual Incentive is compensated at a rate of [redacted] **per member per month (PMPM)**.

2.2.2 A monthly review of continuous eligibility of Enrolled Members will be conducted. If a Residual Incentive payment was paid out in any given month for an Enrolled Member who subsequently disenrolled, for any reason, a Chargeback of previously paid Residual Incentives for Enrolled Members will be deducted from Employee's total Incentive Payout for any future month.

Example of review of continuous eligibility: If a Residual Incentive payment was paid out for an Enrolled Member in January, a look-back will be conducted in February to confirm the member remained enrolled during the month of January.

2.3 Incentive for Referrals to PACE:

2.3.1 If Employee submits a referral to CalOptima Health's PACE Program of an individual eligible to enroll in PACE, and the referred individual successfully enrolls in the Program, the Employee is eligible to receive a one-time $200 Referral Incentive for each successful referral.

III. CalOptima Health Incentive Payout Procedures

3.1 The total monthly Incentive Payout is defined as Employee's incentive payment due for the month for all incentives, including any eligible OneCare Sales and Enrollment Incentive, Residual (Retention) Incentive and Referrals to the Program for All-Inclusive Care for the Elderly (PACE) in the measured month.

3.2 Employee must be employed by CalOptima Health as a Community Partner or Senior Community Partner at the time the Incentive Payout is due in order to earn and be paid the Incentive Payout. Incentive Payouts will not be made following the termination of Employee's employment with CalOptima Health or following Employee's transfer to a position within CalOptima Health other than Community Partner or Senior Community Partner.

3.3 If the total Incentive Payout in any given month is insufficient to cover a Chargeback, the amount of the Chargeback will be carried to the next month's Incentive Payout.

3.4 If the Community Partner or Community Partner Sr leaves CalOptima Health employment and is rehired into a position eligible for the Incentive Payout thereafter, any Incentive Payout that was not previously earned or paid due to Employee's termination of employment will not be paid.

IV. Termination of Employment

4.1 To earn and receive an Incentive Payout, Employee must be employed by CalOptima Health as a Community Partner or Community Partner Sr at the time any applicable Incentive Payout is due. If Employee transfers to a position within CalOptima Health that is not eligible for the Incentive Payout or is terminated or quits, Employee will not earn or be paid any Incentive Payout following the date of such transfer or termination.

IN WITNESS WHEREOF, by signing below, Employee agrees to abide by the terms of this Agreement and CalOptima Health's policies and procedures. Nothing in this Agreement is intended to alter the at-will nature of Employee's Employment with CalOptima Health.

_____

Employee (Signed Name and Date)

_____

Manager, Member Outreach & Education (Approval and Date)

_____

Executive Director, Medicare Programs (Approval and Date)

_____

Chief Financial Officer (Approval and Date)

CalOptima Health, OneCare Program

SALES AND ENROLLMENT INCENTIVE PROGRAM AGREEMENT

Job Title: **Supervisor Member Outreach and Education**

This OneCare Sales and Enrollment Incentive Program Agreement ("Agreement") is entered into by and between CalOptima Health, and, _____(Employee Name) who is currently employed by CalOptima Health as a Supervisor Member Outreach and Education ("Employee") and is eligible to participate in the Employee Sales and Enrollment Incentive Program according to CalOptima Health Policy GA.8042, Supplemental Compensation. This Agreement shall be effective as of _____ ("Effective Date") through December 31, _____.

I. Obligations of Employee

1.1 The employee must meet requirements as defined in CalOptima Health policy MA.2012, Training and Oversight of CalOptima Health-Employed Community Partners.

1.2 Employees must have an active Resident Insurance Producer license ("Producer License") issued by the California Department of Insurance throughout the term of this agreement. Should the employee's Producer License expire, incentives will not be earned until the license is reactivated. Under no circumstances will an employee receive an incentive for a sale made during the period of the expired license.

II. CalOptima Health Incentive Payment Procedure

2.1 Employee is eligible to receive a residual or retention incentive based on the net member growth in the OneCare program for a calendar year (CY) measurement period. The CY measurement period will begin on January1st and end on December 31st of the current year.

2.2 The Residual (retention) Incentive Amount for the Supervisor Member Outreach and Education is [redacted] per Net Gained Member.

2.3 The number of Net Gained Members is calculated based on OneCare's total enrollment net growth for the CY measurement period, produced by all Employees of the OneCare Marketing and Sales Department including Community Partner, Community Partner Sr, Manager Member Outreach & Education and Supervisor Member Outreach and Education.

2.4 Employee will receive an incentive based on the net increase of OneCare's monthly total enrollment during the CY measurement period. Net enrollment growth will be tracked monthly. Employee will earn and be paid fifty percent (50%) of the total incentive tracked each month. The remaining fifty percent (50%) of the incentive will be earned and paid only if OneCare's total enrollment at the end of the CY measurement period increased compared to the previous CY measurement period.

2.5 The total enrollment increase for the measurement period will be calculated in March of the subsequent year by CalOptima Health's Finance Department and paid in April of that year.

2.6 If Employee leaves CalOptima Health employment and is thereafter rehired into the same position, the incentive for net enrollment will reset to zero (0).

III. Termination of Employment

3.1 To receive incentive payments, Employee must be employed by CalOptima Health as a Supervisor Member Outreach and Education at the time any applicable incentive payment is paid. If Employee moves to a position within CalOptima Health that is not eligible for incentives or is terminated at the time an incentive payment is due to be paid, Employee will not be eligible to receive the incentive payment.

IN WITNESS WHEREOF, by signing below, Employee agrees to abide by the terms of this Agreement and CalOptima Health's policies and procedures.

_____

Employee (Signed Name and Date)

_____

Director, OneCare Marketing and Enrollment (Approval and Date)

_____

Executive Director, Medicare Programs (Approval and Date)

_____

Chief Financial Officer (Approval and Date)

CalOptima Health, OneCare Program

SALES AND ENROLLMENT INCENTIVE PROGRAM AGREEMENT

Job Title: **Manager Member Outreach & Education**

This OneCare Sales and Enrollment Incentive Program Agreement ("Agreement") is entered into by and between CalOptima Health, and, _____(Employee Name) who is currently employed by CalOptima Health as a Manager Member Outreach & Education ("Employee") and is eligible to participate in the Employee Sales and Enrollment Incentive Program according to CalOptima Health Policy GA.8042, Supplemental Compensation. This Agreement shall be effective as of _____ ("Effective Date") through December 31, _____.

I. Obligations of Employees

1.1 Employee must meet requirements as defined in CalOptima Health policy MA.2012, Training and Oversight of CalOptima Health-Employed Community Partners.

1.2 Employee must have an active Resident Insurance Producer license ("Producer License") issued by the California Department of Insurance throughout the term of this agreement. Should Employee's Producer License expire, incentives will not be earned until the license is reactivated. Under no circumstances will Employee receive an incentive for a sale made during the period of the expired license.

II. CalOptima Health Incentive Payment Procedure

2.1 Employee is eligible to receive a residual or retention incentive based on the net member growth in the OneCare program for the calendar year (CY) measurement period. The CY measurement period will begin on January 1st and end on December 31st of the current year.

2.2 The Residual (retention) Incentive Amount for the Manager Member Outreach & Education Incentive is [redacted] per Net Gained Member.

2.3 The number of Net Gained Members is calculated based on OneCare's total enrollment net growth for the CY measurement period, produced by all Employees of the OneCare Marketing and Sales Department including Community Partner, Community Partner Sr, Manager Member Outreach & Education and Supervisor Member Outreach and Education.

2.4 Employee will receive an incentive based on the net increase of OneCare's monthly total enrollment during the CY measurement period. Net enrollment growth will be tracked monthly. Employee will earn and be paid fifty percent (50%) of the total incentive tracked each month. The remaining fifty percent (50%) of the incentive will be earned and paid only if OneCare's total

enrollment at the end of the CY measurement period increased compared to the previous CY measurement period.

2.5 The total enrollment increase will be calculated in March of the subsequent year by CalOptima Health's Finance Department and paid in April of that year.

2.6 If Employee leaves CalOptima Health employment and is thereafter rehired into the same position, the incentive for net enrollment will reset to zero ($0).

III. Termination of Employment

3.1 To receive incentive payments, Employee must be employed by CalOptima Health as a Manager Member Outreach & Education at the time any applicable incentive payment is paid. If Employee moves to a position within CalOptima Health that is not eligible for incentives or is terminated at the time the incentive payment is due to be paid, Employee will not be eligible to receive the incentive payment.

IN WITNESS WHEREOF, by signing below, Employee agrees to abide by the terms of this Agreement and CalOptima Health's policies and procedures.

_____

Employee (Signed Name and Date)

_____

OneCare Director, OneCare Marketing and Enrollment (Approval and Date)

_____

Executive Director, Medicare Programs (Approval and Date)

_____

Chief Financial Officer (Approval and Date)

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Authorize Actions Related to CalOptima Health's Supplemental Retirement Plan

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

1. Authorize staff to develop a scope of work and release the request for proposals for a Supplemental Retirement Plan administrator.
2. Authorize the Chief Executive Officer to select a vendor and negotiate and execute a contract with the selected vendor.

Background

On January 5, 1999, the CalOptima Health Board of Directors (Board) approved the establishment of a Supplemental Retirement Plan (SRP) for CalOptima Health employees, appointed members to an SRP Committee, authorized the SRP Committee to take necessary actions to adopt and implement an SRP plan document, appointed the Director of Human Resources as the plan administrator, authorized the Chair of the Board and/or the Chief Executive Officer (CEO) to appoint and/or remove members of the SRP Committee, and authorized the CEO to determine the employer contribution to the SRP consistent with the previous authority given to set employee compensation and benefits within the limits of the budget. CalOptima Health contracted with the Public Agency Retirement Services (PARS) in 1999 to implement and administer the SRP, a 401(a) tax-qualified multiple employer trust. PARS has been the administrator of the SRP since that time.

The SRP is currently funded by an employer contribution of four percent (4%) of employee base earnings. The SRP Committee reviews the plan's asset allocations and the performance of the plan's investment alternatives on a quarterly basis. Total plan assets as of March 31, 2024, are $64,453,661.42.

Discussion

For the SRP, PARS serves as the Trust Administrator and is responsible for plan accounting, coordinating distributions, and communicating plan provisions. John Hancock Retirement Services serves as custodian of plan assets and the record keeper of the plan. Through John Hancock, PARS participants have the ability to self-direct investments by selecting a variety of no-load mutual funds. However, CalOptima Health's SRP Committee cannot direct changes to the PARS/Hancock 401(a) plan investment menu because the plan is structured as a multiple employer arrangement and all participating employers must maintain the same investment menu.

As a public employer, CalOptima Health needs to perform its fiducial responsibilities to ensure investment diversification and performance. Understanding that there are benefits in investment control, the SRP Committee recommends that CalOptima Health develop a scope of work and initiate a request

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for proposal (RFP) process for the SRP administrator. Staff recommend that the CEO be granted authority to select the vendor and execute the contract for services.

Fiscal Impact
Funding for the SRP administrator contract is a budgeted item in the proposed Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation
These actions ensure that CalOptima Health maintains its fiduciary responsibility in how its supplemental retirement benefits are managed.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
8. Approve Amended Policy for Election of Officers

Contacts
Michael Hunn, Chief Executive Officer, (714) 246-8570
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Action
Approve amended policy for election of officers.

Background
At the September 7, 2023, Board of Directors (Board) meeting, Chair Clayton Corwin established the Governance Ad Hoc (Ad Hoc) Committee for the purposes of drafting the initial Board Rules of Procedures and a formal process for electing officers. Chair Corwin appointed Vice Chair Blair Contratto as the Ad Hoc Committee Chair, along with Director Isabel Becerra and Supervisor Vicente Sarmiento to the Ad Hoc Committee.

CalOptima Health's bylaws require the Board to elect one Director to serve as the Board's Chair and another Director to serve as the Board's Vice Chair. The Board adopted the Election of Officers policy in November of 2023, as recommended by the Ad Hoc Committee, that established a procedure by which the Board elects Directors to serve as Board Officers.

Discussion
A clarifying revision is recommended at this time to clearly stipulate that Directors may also submit nominations when the item is called at the organizational meeting in addition to the nomination process outlined in the policy.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended action will revise the formalized process for electing officers of the Board.

Concurrence
James Novello, Outside General Counsel, Kennady Levitt

Attachments
1. Redlined Election of Officers Policy

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

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Title: **Board of Directors' Officer Election Policy**
Department: Board of Directors
Section: Not Applicable

Effective Date: ~~10/XX/2023~~06/06/2024

Board-Proposed Draft Policy

I. BACKGROUND

CalOptima Health's bylaws require the Board to elect one Director to serve as the Board's Chair and elect another Director to serve as the Board's Vice Chair.[1] The Board Officers' terms commence on the first day of the month after the Organizational or Regular Meeting at which the Board Officer was elected and continue for a one (1)-year term, unless the Board Officer sooner resigns or is removed from office.[2] Board Officers may continue beyond the one (1)-year term if a successor has not yet been elected. In that instance, the Board Officer's term would end upon the election of a successor.[3] These elections must take place at an Organizational Meeting of the Board, unless the election is to replace a Board Officer who resigned or was removed prior to the completion of the term as a Board Officer.

II. PURPOSE

This policy establishes the procedures by which the Board elects Directors to serve as Board Officers.

III. POLICY

A. Definitions. The terms used below shall have the following definitions in this Policy.

Term	Definition
Board	The Board of Directors for CalOptima Health.
Board Officer	A Director who holds the position of either Chair of the Board or Vice Chair of the Board.
Director	A voting member of the Board.
Organizational Meeting	The Board's annual organizational meeting, as designated by the Board under § 5.2(b) of CalOptima Health's bylaws.
Regular Meeting	The regular meetings scheduled by the Board under § 5.2 of CalOptima Health's bylaws.

B. Nominations. In the thirty (30) days prior to the Organizational Meeting or Regular Meeting at which an election for Board Officers will take place, CalOptima Health Legal Counsel will survey all Directors to determine which Directors have an interest in serving as a Board Officer. CalOptima Health Legal Counsel then will circulate that list of potential Board Officer nominees for each Officer position to all Directors. From that list of potential nominees, Directors may nominate other Directors or themselves for a Board Office position by submitting their nominations to CalOptima Health Legal Counsel. Directors ~~must~~ may submit all nominations for a Board Officer to CalOptima Health Legal Counsel at least ten (10) days prior to any Organizational Meeting or Regular Meeting at which the election will take place. Directors may also submit nominations when the item is called at the organizational meeting.

[1] CalOptima Health Bylaws §§ 8.1, 8.2.
[2] CalOptima Health Bylaws § 8.3.
[3] *Id*.

C. Elections.

1. *Requirements*. The election of Board Officers requires at least seven (7) Directors present at the Organizational or Regular Meeting at which the election takes place. The election of a Board Officer requires the vote of at least five (5) Directors for each Board Office.
2. *Procedure*. The Chair shall call the agenda item and turn the Board Officer election process over to CalOptima Health Legal Counsel. The Clerk of the Board (Clerk) will conduct the election for Board Officers with the assistance of CalOptima Health Legal Counsel. All Directors nominated under Section III.B shall appear on the initial ballot for the respective Board Officer position or be nominated at the meeting. The Clerk will distribute the ballots immediately prior to the vote, collect the ballots once completed by the Directors, count the ballots, and announce the results on the record. Voting shall be repeated as many times as necessary to obtain the required majority vote for any nominee for the Board Officer position. The Clerk will read the result of each vote and the vote of every Director into the record. If an election does not result in a nominee receiving the required five (5) votes after three (3) ballots, for each subsequent vote, the nominee with the fewest number of votes from the previous tally shall be removed from the ballot prior to the next vote at that same meeting. This procedure shall continue until there are only two (2) nominees remaining. In no event shall a name be struck from the ballot that leaves the ballot with only one (1) remaining nominee. If both the Board Chair and Vice Chair are elected at the same meeting, the Board Chair election shall take place first. If a nominee for Board Chair does not receive enough votes to become Chair, that Director shall automatically be placed on the ballot for the Vice Chair election.

D. Term Limits. The Chair and Vice Chair will each serve a limit of two (2) terms if re-elected after the first term. The two term limit shall apply regardless if the Chair or Vice Chair is elected prior to the Organizational Meeting due to the early resignation or removal of the previous Chair or Vice Chair. If the Chair is not re-elected the Vice Chair would presumptively ascend to the position of Chair, unless the Board votes to deny the Vice Chair's ascension to Chair. A Board Officer who reaches the term limit under this Section III.D may not hold the same Board Officer position again for a period of four (4) years. The Vice Chair shall automatically become Chair at the Chair's resignation or the end of the Chair's term under this section, unless (i) the Vice Chair notifies the Board prior to the end of the Chair's term that the Vice Chair does not wish to serve as the Chair, or (ii) the Vice Chair will not be a Director for the upcoming Board Officer term; in which case, the Board will elect a Chair and Vice Chair in accordance with the procedures in Sections III.B and III.C.

E. Interim Officers. If at least (7) Directors are not present for the Organizational or Regular Meeting, the current Board Officers will remain in place as interim Board Officers until the Board holds another election to select the Board Officers' replacements.

F. Records. After any election, the Clerk shall retain the election ballots for four (4) years. The Clerk will update and file with the California Secretary of State the "Statement of Facts: Roster of Public Agencies" form and any other filing required by government agencies each time there is a new Board Officer.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Approve Actions Related to a Contract with Infomedia Group, Inc. dba Carenet Healthcare Services

Contacts

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

Recommended Actions

Authorize the Chief Executive Officer to execute a contract with Infomedia Group, Inc. dba Carenet Healthcare Services (Carenet) for a three (3)-year term effective July 1, 2024, with two (2) additional one-year extension options, each exercisable at CalOptima Health's sole discretion, to provide Nurse Advice Line and after hours support for customer service and behavioral health, and member engagement services.

Background

Nurse Advice Line and after hours support for customer service and behavioral health are regulatory requirements. As part of CalOptima Health's compliance with this regulatory requirement, staff contracted with Carenet through a request for proposal (RFP) process in 2019.

CalOptima Health entered into a three-year (3) contract with Carenet, effective July 1, 2019, through June 30, 2022. Additionally, CalOptima Health obtained Board approval for two (2) one-year extensions with Carenet. The current agreement will terminate as of June 30, 2024.

As part of CalOptima Health's standard procurement process, in July 2023, CalOptima Health issued an RFP for a vendor that provides:

- Nurse Triage/Advice Line Services;
- After-hours customer service support for Call Center;
- After-hours customer service and clinical support for Behavioral Health Line; and
- Member Engagement Strategies.

Discussion

The RFP closed on September 7, 2023, and CalOptima Health received a total of four (4) proposals. All proposals were reviewed by CalOptima Health staff and evaluated based on the following criteria:

- Overall organization and completeness of response;
- Proper qualifications and capacity;
- Related experience;
- Service team qualifications; and
- Price/cost.

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Upon completing the RFP evaluation process, the following scores were given to each applicant:

Proposal

Name	Score	Rank
Infomedia Group, Inc. dba Carenet Healthcare Services	3.95	1
Call 4 Health	3.92	2
AnswerNet	3.56	3
Fonemed LLC	3.52	4

Interview/Presentation Results

Name	Score	Rank
Infomedia Group, Inc. dba Carenet Healthcare Services	4.02	1
Fonemed LLC	3.89	2
Call 4 Health	3.72	3
AnswerNet	2.36	4

Based on standard procurement processes and in conjunction with CalOptima Health Policy GA.5002: Purchasing, the evaluation team identified Carenet as the vendor that best meets CalOptima Health member needs.

The targeted effective date of the new contract with Carenet will be July 1, 2024. The contract will be for a three (3)-year term with two (2) additional one-year extension options, each exercisable at CalOptima Health's sole discretion.

Fiscal Impact
The estimated annual cost for the contract with Carenet is $2.4 million. Management will include operating expenses in the proposed Fiscal Year 2024-25 Operating Budget and future operating budgets.

Rationale for Recommendation
Based on the review of the possible vendors, staff recommends contracting with Carenet to provide a twenty-four hours, seven days per week Nurse Triage/Advice Line, customer services and behavioral health after-hours support, and member outreach services.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Proposed Carenet Ancillary Services Contract

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Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 3, 2021	Consider Authorizing Amendment to Contract with Infomedia Group, Inc., dba Carenet Healthcare Services to Support Member Outreach Calls	July 1, 2019 – June 30, 2022	
August 4, 2022	Ratify Amendment to the Ancillary Services Contract with Infomedia Group Inc., dba Carenet Healthcare Services	June 30, 2022 – June 30, 2023	
June 1, 2023	Authorize Extending Contract with Infomedia Group, Inc., dba Carenet Healthcare Services for one year.	June 30, 2023 – June 30, 2024	

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

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

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ANCILLARY SERVICES CONTRACT
NON-MEDICAL PROVIDER

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

RECITALS

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

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

C. CalOptima has entered into a contract with the Department of Health and Human Services ("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 the California Department of Health Care Services (DHCS).

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

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

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

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

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

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

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

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

1.2 "California Children Services (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 defined in Title 22 CCR Section 41515.2 – 41518.9.

1.4 "CCS Providers" or "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.

1.5 "California Children's Services (CCS) Program" means the public health program which 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.

1.6 "CDA" means the California Department of Aging.

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

1.7.1 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.

1.7.2 "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.

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

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

1.10 "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.

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

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

1.13 "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.

1.14 "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.

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

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 "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).

1.19 "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.

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

1.21 "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.

1.22 "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.

1.23 "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).

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

1.25 "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.

1.26 "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.

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

1.28 "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.

1.29 "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.

1.30 "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.

1.31 "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.

1.32 "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.

1.33 "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.

1.34 "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 2.20 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 fully and accurately complete the disclosure form in Attachment D and submit the disclosure form to CalOptima prior to the Effective Date. Provider shall promptly notify CalOptima of any changes to the information contained in the disclosure form in Attachment D and submit an updated disclosure form to CalOptima within thirty (30) days of any such change.

2.11 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 and cooperate 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.

2.12 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.

2.13 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.

2.14 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, fostering 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.

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

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

2.16 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.

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

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

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

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

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

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

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

2.18 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.

2.19 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.

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

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute prohibited discrimination: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services. Provider and its Subcontractors agree to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. Provider and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

2.21 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 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.

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

2.22.1 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.

2.22.2 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.

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

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

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

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

2.23 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.

2.24 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:

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

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.

2.24.2 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.

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

2.24.4 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.

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

2.26 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.

2.27 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.

2.28 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.

2.29 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.

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

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

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

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

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

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

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

2.31.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Sub provision 13.1.2 herein; and

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

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

2.31.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that

essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

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

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

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

2.32 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 E.

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

2.32.2 Certification and Disclosure Requirements

2.32.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment E, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 2.30.3 of this provision.

2.32.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment E-1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 2.30.3 of this provision if paid for with appropriated funds.

2.32.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 2.30.2.2 herein. An event that materially affects the accuracy of the information reported includes:

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

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

2.32.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

2.32.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 2.30.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

2.32.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 2.30.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

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

any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

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

2.34 Health Networks. Provider acknowledges and agrees that CalOptima has delegated financial responsibility to Health Networks for certain Covered Services rendered to Members enrolled in Health Networks. Provider agrees to extend to Health Networks the same terms contained in this Contract, including rates, for Covered Services provided to Members enrolled in Health Networks and to contract with a Health Network under the same terms as this Contract, at the request of a Health Network. Regardless of whether Provider is contracted with a Health Network, Provider also agrees to look to the applicable Health Network for payment for Covered Services rendered by Provider that are the financial responsibility of the Health Network pursuant to the Health Network's contract with CalOptima.

2.35 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.

2.36 CCS Provider Compliance.

2.36.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

2.36.2 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.

2.36.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Provider shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.36.2.2 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.

2.37 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.

2.38 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.

2.39 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.

2.40 Hospital Referrals. Provider shall refer Members to providers that have hospital privileges at CalOptima contracted facilities, whenever possible.

2.41 Information and Cyber Security. Provider must have policies, procedures, and practices that address its information and cyber security measures, safeguards, and standards, including at least the following:

2.41.1 Access Controls. Access controls, including Multi-Factor Authentication, to limit access to Provider's information systems and any CalOptima information that Provider maintains or can access.

2.41.2 Encryption. Use of encryption to protect any CalOptima information, in transit and at rest, that Provider maintains or can access.

2.41.3 Security. Safeguards for the security of the information systems and CalOptima information that Provider maintains or can access, including hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

2.41.4 Software Maintenance. Software maintenance, support, updates, upgrades, third-party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable industry standards.

2.41.5 Network Security. Network security that conforms to generally recognized industry standards and best practices.

For the purpose of this Section 2.41, "**Multi-Factor Authentication**" means authentication through verification of at least two (2) of the following types of authentication factors: (i) knowledge factors, such as a password; (ii) possession factors, such as a token or text message on a mobile phone; (iii) inherence factors, such as a biometric characteristic; or (iv) any other industry standard and commercially accepted authentication factors.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

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

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

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

ARTICLE 4
PAYMENT PROCEDURES

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

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

4.3 Claim Completion and Accuracy. Provider shall be responsible for the completion and accuracy of all Claims submitted whether on paper forms or electronically including claims submitted for the Provider

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

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

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

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

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

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

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

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

4.6 Overpayments and CalOptima Right to Recover. Provider has an obligation to report any overpayment identified by Provider, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Provider, or of receipt of notice of an overpayment identified by CalOptima. Provider acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Provider, CalOptima shall have the right to recover such amounts from Provider by recoupment or offset from current or future amounts due from CalOptima to Provider, after giving Provider notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Provider to CalOptima, including, but not limited to, amounts due because of:

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

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

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this

Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Insurance Requirements

5.2.1 Professional Liability:

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

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

5.2.2 Commercial General Liability/Commercial Automobile Liability:

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

Commercial General Liability: $1,000,000 per occurrence/$2,000,000 aggregate

(Including Personal Injury)

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

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

*(Charter-party carriers of passengers:)

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

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

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

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

5.2.3 Workers' Compensation:

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

Employers' Liability Insurance:

$1,000,000 Bodily injury each accident

$1,000,000 Bodily injury policy limit

$1,000,000 Bodily injury each employee

Waiver of Subrogation wording is required and to include:

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

5.2.4 Commercial Crime:

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

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

5.2.5 Cyber Liability Insurance: Provider at its sole cost and expense shall maintain cyber lability insurance with the minimum limits listed below covering first and third-party claims involving

privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion, and network security. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

Cyber Liability Insurance requirements: $1,000,000 each occurrence/claim and $1,000,000 aggregate.

5.2.6 Bonding:

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

5.3 Insurer Ratings.

Such insurance shall be provided by an insurer:

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

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

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

5.4 Captive Risk Retention Group/Self Insured:

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

5.5 Cancellation or Material Change:

The 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. Thirty (30) days prior written notice be given to CalOptima in the event of cancellation.

5.6 Certificates of Insurance:

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

5.7 Subcontractors:

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

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

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

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1 Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Provider and its Subcontractors shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, contracts, documents, electronic systems for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Provider's premises. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Provider shall maintain records in chronological sequence, and in an

immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. If DHCS, CMS, CDA or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, CDA or the DHHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider and its Subcontractors from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and Provider's contract may be terminated due to fraud.

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

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

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

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

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

6.4.3 Declaration of Confidentiality. If Provider 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.

6.5 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. This Contract shall become effective on the Effective Date and continue in effect for three (3) years ("Initial Term"). This Contract may be renewed at CalOptima's option for two (2) consecutive one-year terms (each a "Renewal Term").

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

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

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

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

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

7.6 Termination Without Cause. Either party may terminate this Contract, without cause, upon one-hundred eighty days (180) days' prior written notice to the other party as provided herein after the Initial Term.

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

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

ARTICLE 8

GRIEVANCES AND APPEALS

8.1 Provider Grievances. 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 may not assign this Contract, either in whole or in part, without the prior written consent of CalOptima, which may be withheld in CalOptima's sole and absolute discretion. For purposes of this Section 9.1, assignment includes: (i) the change of more than fifty percent (50%) 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 fifty percent (50%) of the directors or trustees of Provider; (iii) the merger, reorganization, or consolidation of Provider with another entity when Provider is not the surviving entity; 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 or entity.

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

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

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, 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 on Notice_es_:signer1: }}

Name

{{*Title on Notice_es_:signer1: }}

Title

{{*Address on Notice_es_:signer1 }}

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.

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 Exclusive Remedy. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 9.15.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

9.15.4 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.

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**
{{_es_:signer1:signature}}	{{_es_:signer2:signature}}
Signature	Signature
{{*Name_es_:signer1 }}	{{N_es_:signer2:fullname }}
Print Name	Print Name
{{*_es_:signer1:title }}	{{*_es_:signer2:title }}
Title	Title
{{*_es_:signer1:date }}	{{*_es_:signer2:date }}
Date	Date

ATTACHMENT A

CONTRACTED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

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

__X__ Medi-Cal Program

__X__ Medicare Advantage Program (OneCare)

_____ PACE Program

_____ Multipurpose Senior Services Program (MSSP)

ARTICLE 2
SERVICES

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

2.1.1 CUSTOMER SERVICE, NURSE ADVICE AND BEHAVIORAL HEALTH LINE

Provider shall provide the following services:

1. Customer service call center support for Members and providers.
2. Customer service and clinical support for behavioral health line to Members and providers.
3. Nurse advice line services to Members.
4. Engagement strategies may include support with outbound welcome calls, program reminders, gaps in care outreach campaigns, notifications, member assessments, and to receive inbound calls to enhance engagement and education to Members and providers.

2.1.2 SERVICE LEVEL GUARANTEES

Provider shall uphold the same level of professional customer service as CalOptima staff provides and shall provide the following service levels:

a. Answer eighty percent (80%) of calls within thirty (30) seconds.
b. Maintain an abandoned call ("ABD") rate of five percent (5%) or less.
c. Maintain an Average Speed of Answer ("ASA") of two (2) minutes or less.

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

2.1.3 REQUIREMENTS

2.1.3.1 CalOptima has multiple product lines and business processes, each requiring different scripting and support. For CalOptima Programs listed in Section 1.1 of this Attachment A, Provider shall perform the following but not limited to:

a. Customer Service Support:

- **Call Center** requires customer service support.

- **Behavioral Health Line** requires customer service support to verify eligibility, and triage for clinical support.
- **Nurse Advice Line** requires customer service support to verify eligibility, and triage for clinical support.

b. Clinical Support:

- **Behavioral Health Line** requires customer clinical support from a licensed clinician (LCSW, LPCC or LMFT) or registered nurse (RN) with behavioral health experience.
- **Nurse Advice Line** requires customer clinical support from a registered nurse (RN) for all LOBs for members.

c. Engagement Strategies:

- Capabilities to support CalOptima with outbound welcome calls, program reminders, gaps in care outreach campaigns, notifications, member assessments, and to receive inbound calls to enhance engagement and education to Members and providers.

All calls shall be answered by an individual employed by Provider, and Provider shall be transparent to the callers. The Service Level Guarantees shall be maintained throughout the term of the Contract. Provider's staffing levels shall be adequate to handle the volume of calls received from Members and providers.

Provider's staff must be Health Insurance Portability and Accountability Act (HIPAA) trained and understand the importance of confidentiality. Provider's staff must also be trained in telephone answering etiquette which shall consistently provide timely, courteous and quality service to Members and providers. CalOptima reserves the right to conduct "blind" calls, without prior notice to the Provider, for quality customer service monitoring. Provider shall provide ongoing training to their staff to ensure the highest "level of service" possible. Provider shall train their staff to handle CalOptima's calls. This training shall include a thorough review of CalOptima's policies and procedures when handling all incoming calls. CalOptima shall not pay to train new hires after the initial implementation period.

2.1.3.2 Customer Service Support

1. Provider to provide "live answer" telephone answering services during the following:
   a. After Hours
      i. Medi-Cal: 5:30 pm-8:00 am
      ii. OneCare: 8:00 pm-8:00 am
      iii. Behavioral Health: 5:00 pm-8:00 am
   b. Business Hours, as needed (refer to 2.1.3.2 Section 2.)
      i. Medi-Cal: 8:00 am-5:30 pm
      ii. OneCare: 8:00 am-8:00 pm
      iii. Behavioral Health: 8:00 am-5:00 pm
   c. 24/7 support, including holidays
      i. Nurse Advice Line
   d. Holidays (24-hour support)
      i. Martin Luther King Day
      ii. Lincoln's Birthday
      iii. Washington's Birthday
      iv. Memorial Day
      v. Independence Day
      vi. Labor Day
      vii. Indigenous Peoples' Day
      viii. Veteran's Day
      ix. Thanksgiving Day
      x. Friday after Thanksgiving Day
      xi. Christmas Day
      xii. New Year's Day

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2. Provider shall also be available to answer calls during CalOptima's regular business hours, as needed (i.e., call overflow, meetings, trainings, emergency). If CalOptima is aware in advance, of this additional requirement, CalOptima may provide Provider with a minimum of 3 business days advanced notice. If CalOptima experiences high call volume or an emergency, an example such as an electrical power outage, Provider shall answer calls as required, without prior notification from CalOptima.
3. Call inquiries received by the Provider may consist of clinical, pharmacy, administrative, call center monitoring timeliness and accessibility test calls, or eligibility (Customer Service) questions. Calls requiring further assistance by CalOptima staff shall be documented and reported for next business day response and shall be forwarded to CalOptima. If the call is considered to be of an urgent nature, the CalOptima on-call staff shall be notified and given the Member's immediate callback information. Member shall be informed that their call will be returned by an on-call CalOptima clinical staff member within 24 hours or less.
4. Utilization Management Calls
    a. Call inquiries received by the Provider from providers regarding claim submission and status, payment information and pre-authorizations (non-emergency department), will be advised to contact CalOptima during normal business hours.
    b. Call inquiries received by the Provider from providers regarding post stabilization care and hospital discharge will be transferred to the CalOptima On-Call Nurse and provided the On-Call Nurse number.
    c. Call inquiries received by the Provider from providers regarding utilization.
5. Provider shall ensure a secure and encrypted communication between current service provider and CalOptima.
6. Provider's automated system shall have the capability of receiving simultaneous incoming calls from Members and providers to ensure Service Level Guarantees are met. Said system shall also be capable of receiving outside calls from Members at a time and be capable of accepting a third call from a CalOptima staff member.
7. Provider's staff must be trained in handling Center for Medicare and Medicaid Services (CMS) Call Center Monitoring - Timeliness and Accessibility Studies test calls.
8. Provider's staff must be capable of screening calls and have the ability to qualify the Member's needs for further CalOptima assistance, as specified in CalOptima's written procedures and script. Provider's staff must be able to refer the Member to another number or resource, as per CalOptima's written procedures.
9. CalOptima shall have the option to modify any script and/or policy and procedure as deemed necessary. Urgent requests shall be completed in less than 3 business days, and non-urgent requests within 10 business days.
10. Provider shall use call scripts as provided by CalOptima and shall accurately respond to calls in accordance with those scripts. Provider shall report back specific information gathered during certain calls, based on scripts that require it, e.g., a Member filing a grievance, or provider filing a Provider Grievance, or a Member requesting to opt out of the program and shall report all information back to CalOptima within the next business day. An example of such service may include the following:
    a. for Member Eligibility questions, refer Member to the Medi-Cal eligibility telephone number, Automated Eligibility Verification System (AEVS), CalOptima Website, or Interactive Voice Response (IVR) line.
    b. the Member may have an urgent need to speak with a CalOptima nurse regarding hospital discharge appeals. After qualifying the Member by asking written procedural questions provided by CalOptima, Provider may be required to contact CalOptima's on-call nurse. The Provider shall inform the Member that CalOptima's on-call nurse will be given their immediate contact information, and the on-call nurse will return their call within 24 hours or less.
    c. for any medical or behavioral health support, triage call to Providers clinical team. See 2.1.3.1 section b.
11. CalOptima shall have the option to request call recording(s) as deemed necessary and Provider shall provide the requested call recording(s) to CalOptima within 3 business days.

12. Record Retention.
    a. Provider shall maintain and retain all records in accordance with article 6.2 of this agreement, CalOptima Policy HH.2022 Record Retention and Access, and attachment E of this agreement. Records shall include all items pertaining to the services provided to Members including but not limited to books, documents, records, encounter data and recordings..
    b. Call Recordings
        i. Provider shall record 100% of voice calls.
        ii. Provider shall retain call recordings for six (6) months.

2.1.3.3 Clinical Support – Behavioral Health Line and Nurse Advice Line

1. Provider shall ensure the Nurse Advice Line is staffed by a registered nurse (RN) 24 hours a day, 7 days a week, and 365 days per year.
2. Provider shall ensure the Behavioral Health line is staffed by a licensed clinician (LMFT, LPCC or LCSW) or a RN with behavioral health experience. Behavioral health hours of support are noted in section 2.1.3.2.
3. The Behavioral Health Line may be answered by a customer service support staff to verify eligibility, and triage to nurse for medical or behavioral health support, if appropriate.
4. Provider's RN or clinicians must:
    a. Be licensed to practice in the State of California.
    b. Provide safety screenings, symptom assessment and clinical triage to Members and to navigate them to the most appropriate level of care by using evidence-based, industry-standard clinical guidelines.
    c. Spend as much time with Members as needed to deliver quality service.
    d. Document the call which includes the Member's presenting problem, assessment guideline used, outcome of safety screening, recommended disposition and care advice.
    e. Serve as a key navigational hub to seamlessly integrate a broad spectrum of health management tools. During the triage call with the Member, the nurse or clinician shall identify the referral opportunity. As appropriate, make referrals to designated Participating Providers, facilities, support groups and community, state and national resources. and inform CalOptima's Utilization Management staff of the referral. In the event a referring provider is in contact for treatment authorizations the Provider will follow the script provided by CalOptima.
    f. Provider shall provide follow-up calls to include, but not limited to, contacting Members on specific cases if required after a triage call. This shall be dependent on program guidelines.
5. CalOptima shall have the option to modify any script and/or policy and procedure as deemed necessary. If CalOptima requests changes to the scripting or any procedure, urgent requests shall be completed in less than 3 business days, and non-urgent requests within 10 business days.
6. Secure Electronic Communication:
    a. Allow Members to communicate health related questions in a HIPAA compliant manner through email with Provider's licensed nurses or clinicians. This service shall be integrated into CalOptima's website and/or Member portal allowing the Member to access only one website for their healthcare questions. Provider shall include implementation tasks requirement as part of the standard set-up.
    b. Email services shall be a confidential, web inquiry service allowing Members to ask a licensed nurse or clinician health information questions. A response to Members' questions via secure email within 24 hours is required.
7. Audio Health Library (phone accessible self-help library)
    a. Provide Members with phone access to an audio health library for supplemental health and education materials to support the clinical conversation Members have with the licensed nurse or clinician.
8. Records Retention.
    a. Provider shall maintain and retain all records in accordance with article 6.2 of this agreement, CalOptima Policy HH.2022 Record Retention and Access, and attachment E of this agreement.

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Records shall include all items pertaining to the services provided to Members including but not limited to books, documents, records, encounter data, and recordings.

2.1.3.4 Member Engagement Strategies – Interactive Voice Recording (IVR) Technology and Live Outbound Calls

1. To assist CalOptima with member engagement and education, Provider shall have an IVR telephone system that can support various call campaigns and deliver automated outbound messages to Members. The IVR telephone system must be able to: 1) connect caller to a live person, if desired, by pressing a key tone (i.e. "0"), 2) provide immediate opt-out option, and 3) track and report automated responses at Member level, or anonymously, if desired.
2. Provider shall have staff available to assist with live outbound and inbound call campaigns to Members to execute initiatives on items such as welcome/onboarding calls, Telephonic Health Assessments, Appointment facilitation to address HEDIS measures, Risk Adjustment, or other gaps in care, post-discharge, program enrollment, retention, surveys, or other outreach initiatives, etc.
3. Appointment Scheduling
   a. When applicable, determine the appropriate provider(s) needed to assist in closing the gaps in care. With Member's agreement and consent, an Engagement Specialist will perform a three-way call to the Participating Provider to schedule an appointment.
   b. Follow-up calls can be made to Members 24-48 hours after the scheduled appointment date to capture appointment status. For multiple scheduled appointments, the 24-48 hour period will be based off the date of the last appointment scheduled.
   c. Should a Member not keep their appointment, the Engagement Specialist can make one (1) attempt to reschedule the appointment with the same Participating Provider that the original appointment was scheduled with.
4. Provider will attempt to reach each Member a maximum of three (3) times. If available, a voicemail message can be left on the Member's voicemail or answering machine.
5. All call campaign content must be approved by CalOptima. Member Engagement Strategy campaigns may include the following:

Campaign Name	**# of Members Contacted**	**Details**
Initial Health Assessment (IHA) and Health Information Form (HIF) Initial Reminder	~13,000	Monthly, ongoing (automated call)
IHA and HIF Follow-up Reminder	~13,000	Monthly, ongoing (automated call)
Whole Child Model	~14,500	Once (automated call)
Flu Reminder	~15,000	Yearly, as-needed (automated call)
Diabetes Prevention	~47,000	Biannual, Ongoing (automated call)
Diabetes Prevention	~47,000	Once, (live outbound calls)
IHA Live Welcome Call	~2,000	Once (live outbound call)
Cancer Screening (CCS, BCS, COL)	~460,000	Biannual, Ongoing (automated call)
Women's Cancer Screening (CCS, BCS)	~228,000	Once (live outbound call)
Controlling Blood Pressure	~47,000	Biannual, Ongoing (automated call)
Annual Wellness Visit Live Call Campaign	~200,000 (~185,000 MC + ~15,000 OC)	Once (live outbound call)
Annual Wellness Visit IVR	~200,000 (~185,000 MC + ~15,000 OC)	Yearly, as-needed (automated call)

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Pediatric Live Call Campaign	~24,000	Quarterly, ongoing (live outbound call)
Well-Child Visits-First 15 Months IVR	~9,000	Biannual, ongoing (automated call)
Well-Child Visits-15 to 30 Months IVR	~12,000	Biannual, ongoing (automated call)
Adolescent (3-17 Years) IVR	~245,000	Biannual, ongoing (automated call)
Young Adult (18-21 Years) IVR	~75,000	Biannual, ongoing (automated call)
Postpartum Care Call Campaign	~5,000	Ongoing (live outbound call)
Member Health Rewards	~15,000 OC	Twice a year, live outbound call campaign.
Blood Lead Testing IVR	~5,100	Twice a year, automated call.

2.1.4 MEMBER SATISFACTION SURVEY

2.1.4.1 Provider shall conduct CalOptima member satisfaction survey calls on a routine ongoing basis to assess the general satisfaction with the services performed.

2.1.4.2 Content of such survey must be approved by CalOptima and can be modified at any time, if needed.

2.1.4.3 Summary of the feedback shall be provided to CalOptima quarterly.

2.1.5 LANGUAGE INTERPRETER SERVICES

2.1.5.1 Provider shall have Bilingual staff and be able to speak with Members in one or more of CalOptima's threshold languages (Spanish, Vietnamese, Farsi, Korean, Chinese, Arabic). Providers staff must be trained and able to support Members through 711, if needed.

2.1.5.2 For calls other than English that cannot be answered by a bilingual staff, Provider shall utilize an interpreter service which shall include a full suite of interpretation services for various languages and dialects. Must include Spanish, Vietnamese, Farsi, Korean, Chinese, and Arabic, at minimum.

2.1.5.3 Any interpreter used for Nurse Triage and Advice to a Member shall be available to Members 24 hours per day, 7 days a week, and 365 days a year.

2.1.6 DATA EXCHANGE AND SYSTEM INTERFACE/REQUIREMENTS

2.1.6.1 Provider shall have the ability to handle eligibility files and to download from CalOptima's FTP site. It shall also have the ability to take the eligibility files and set-up a system load, allowing their staff to research member information and eligibility to respond to CalOptima's Members and providers.

2.1.7 REPORTING

2.1.7.1 Reports shall be parsed out for all dedicated toll-free numbers that Provider will be supporting.

- Medi-Cal Customer Services Call Center
- OneCare Customer Services Call Center
- Behavioral Health Line

- Nurse Advice Line

Provider shall provide a standard performance reporting to CalOptima, as applicable to the services. Modifications to Provider's standard reports or requests by CalOptima for new custom/ad hoc reporting are an additional cost and are priced in Professional Services Rates in Attachment C**.** If Provider updates the standard reporting and it disrupts CalOptima's standard reports, CalOptima shall not pay to have the report customized. These standard aggregate level reports will be sent monthly for services provided by Attachment A.

2.1.7.2 Call Center Reports

1. Daily call log reports of CalOptima incoming calls received by the Provider must be produced and maintained by the Provider. The required daily call log reports shall include the information/data listed below. The information/data listed within this paragraph shall be sent to CalOptima via web portal or SFTP and received by 9:30 a.m., every business day, Monday through Friday. Provider shall provide the information/data for calls received on Saturday, Sunday and holidays, on the next regular business day before 9:30 a.m. to CalOptima. Each daily report shall provide the total number of seconds expended.
2. Date and time of call, name of caller, name of Member, Member's CalOptima Client Index Number (CIN) number, date of birth, language spoken (if other than English) and phone number.
3. Nature of Member's request and exact action taken by Provider according to written procedures provided by CalOptima, including but not limited to, telephone numbers dialed on behalf of caller, use of a Language Line Service, or Transfer Bridge Conference Call services performed, list of CalOptima staff contacted, duration of call time until customer needs were escalated to next level per written instructions, and/or time duration until CalOptima staff returned Provider's contact.
4. Total length of call time, including number of times on-call nurse was contacted, Transfer Bridge Conference Calling, and on-hold minutes.
5. Information listed below must be included as part of the report which shall accompany each monthly invoice. The dates on the report must coincide with the invoice dates.
    a. Specify the total quantity of calls; list separately by toll-free numbers (i.e., Medi-Cal, OneCare, Behavioral Health, Nurse Advice) the calls received from a Member; list separately by CalOptima's threshold languages; list separately the calls received from a Participating Provider; specify the number of total minutes expended for the month; the number of incoming calls; the number of outgoing calls; the description of service provided; the description for each call sorted by reason; the time period covered by the invoice and the amount of payment requested.
    b. As part of the monthly report, Provider shall list as one line item, each day including the total seconds and minutes that CalOptima is charged for.
    c. Provider shall populate the line of business code from the member's eligibility file into the messages. When a Member is found in the CalOptima eligibility file, it shall be these codes the Provider shall populate into its call record.
    d. As part of the monthly report, Provider shall provide a report with total number of inbound calls, number of calls answered/serviced, number of calls abandoned, percent of calls with an average speed of answer within 30, 60, 120, and 600 seconds, abandonment rates and service levels for each toll-free number/dedicated line (i.e., Medi-Cal, OneCare, Behavioral Health, Nurse Advice).

2.1.7.3 Behavioral Health and Nurse Advice Line Reports

1. A triage call report shall be provided to CalOptima real time (i.e., via fax or portal access) at the end of each call. Report shall include caller information (name, phone

number, address, gender, DOB, CIN, Health Network & PCP information, language spoken), date and time of call, presenting problem, assessment, triage notes, guideline used, recommended care disposition, original inclination of call, intended action, and reason for disposition. The behavioral health triage call report shall include additional information such as call back number, service requested, follow-up request, and urgency of call.

2. Monthly reports shall measure performance and outcomes on all Member encounters and shall include, but not limited to:
   a. Guideline Report – A summary of the guidelines and the frequency of use during triage calls.
   b. Disposition Report -A summary of triage calls showing the total number of times recommended dispositions were used.
   c. Call Volume Report – Statistics collected on all incoming calls and reported monthly on the data collected and reported includes average speed of answer, average abandonment rate and service level.
   d. Usage Report – An analysis of callers by age, gender, ethnicity, and geographic location.
   e. Disposition vs Original Inclination – A summary of triage calls displaying the caller's original inclination compared to the recommendation for care.
   f. Triage Call Report – A detailed summary provided after each triage call and include the Member's presenting problem, assessment guideline used, recommended disposition and care advice, and patient demographic information. The report must be generated real-time via HIPAA compliant electronic fax.

2.1.8 ACCOUNT MANAGEMENT

Provider shall provide a CalOptima Account Manager (CAM) that will serve as the main point-of-contact and program manager for the Services. The CAM will manage the CalOptima program implementation from beginning to end. They will assemble the necessary Provider subject matter experts, such as clinical and information technology teams. During the implementation, the CAM will partner with CalOptima to carry out project deliverables.

ATTACHMENT B

PROCEDURES FOR REQUESTING INTERPRETATION SERVICE

1. CALOPTIMA DIRECT MEMBERS AND PACE PARTICIPANTS

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

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

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

1.3 Provider's Responsibilities.

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

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

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

2. HEALTH NETWORK MEMBERS

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

ATTACHMENT C
COMPENSATION

Provider will comply with payment procedures as outlined in Article 4 of the Contract. CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. Customer Service, Nurse Advice and Behavioral Health Line:

The monthly invoice will be paid according to the following:

Program Per Call Fee:	Customer Service: $[redacted] per non-clinician call answered Nurse Advice: $[redacted] per clinical call Behavioral Health: $[redacted] per non-clinical call, not transferred to clinical staff $[redacted] per non-clinical call, transfer to clinical staff
Total call volume:	Pricing is based on a minimum [redacted] clinician calls answered per month, and [redacted] non-clinician calls answered per month
Language Interpretation Services	$[redacted] per minute for live agent language line usage

II. Member Engagement Strategies:

A. Interactive Voice Recording (IVR).

IVR/Automated messaging technologies include complementary allotment of up to 750,000 IVR calls per CalOptima's fiscal year (July – June). These 750,000 IVR calls shall be limited to three (3) unique scripts per year. Additional unique scripts will be billed in accordance with the Provider Services Rates in Section III of this Attachment C. For IVR campaign requests over the 750,000 allotments, Provider will submit a work order to CalOptima approval, prior to commencement of the work. Approved work orders will be paid by invoice.

Additional messaging beyond the 750,000 is billed at [redacted] per message. Set up for additional campaigns is billed at $[redacted]/hour as per the Professional Services Rates matrix in section III of this Attachment C.

B. Live Outbound and Inbound Calls:

Live outbound and inbound call campaigns shall include calls to Members on items such as welcome calls, member service support, quality initiatives, gaps in care outreach, health risk assessment (HRA), member assessments, ongoing check-ins, etc.

$[redacted] per hour per staff

Per hour per staff pricing will be billed based on a minimum monthly staff of 15 Engagement Specialist Full Time Employee (FTE). For Engagement Specialists one FTE equals 160 hours worked per month. Live Outbound and Inbound Calls under this SOW, unless otherwise stated and budgeted for in a Work Order Form, shall not exceed $[redacted] annually between July 1 – June 30 per CalOptima's fiscal year. For custom work orders that may deviate from the rate listed above Provider will submit a work order to CalOptima for approval, prior to commencement of the work. Approved work orders will be paid by invoice.

CX Analytics – Two complimentary CX analytics project. Additional projects beyond the two complimentary projects are priced at $[redacted] per project.

III. Professional Services Rates:

Professional Services	Hourly Rate
Application Development/Programming/IT Professional Services and launching/delivery of a new campaign or modification to an existing campaign.	$[redacted]
Marketing and Creative Services	$[redacted]
Client Relationship Manager	$[redacted]
Program Support – Any maintenance and support services requested by CalOptima that are outside Provider's standard service described in this SOW	$[redacted]
Curriculum and Training Materials Development	$[redacted]
Compliance/Auditing Support (>5 hours per/annum)	$[redacted]
Clinical Employee Program Training	$[redacted]/per person
Non-Clinical Employee Program Training	Included in hourly rate
CalOptima-Requested Travel	At Cost, as Prior Approved by CalOptima

CalOptima may request Professional Services from Provider for business performance, business intelligence and/or business integration or other purposes. For Professional Services not listed above or a rate that deviates from the rate listed above, Provider will provide a work order to CalOptima for approval, prior to commencement of the work.

IV. Payment Procedures:

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

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

ATTACHMENT D

DISCLOSURE FORM

Infomedia Group, Inc. dba Carenet Healthcare Services

Name of Provider

Pursuant to DHCS APL 23-006, Medi-Cal managed care plans like CalOptima must comply with the ownership and control disclosure requirements as set forth in 42 CFR § 455.104 by collecting information on whether their Subcontractors are persons with ownership or control interest or managing employees. Provider shall complete and return this form to CalOptima prior to the Effective Date and submit updates to this form to CalOptima within thirty (30) days of any change to this form.

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):

Individuals with an Ownership or Control Interest owning more than five percent (5%) of the Provider's stock: Please list all individuals with an ownership or control interest. Include each person's name, address, date of birth (DOB), and Social Security Number (SSN). Indicate the title (*e.g.* chief executive officer, owner) and if an owner, the percentage of ownership.

Name	Title	% Ownership	DOB	SSN

Corporation with and Ownership or Controlling Interest holding more than five percent (5%) of the Provider's debt: Please list all corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, the P.O. Box address(es). Attach additional pages as needed.

Name of Corporation	TIN	% Ownership	P.O. Box

Dated:

Signature:

Name:
(Please type or print)

Title:
(Please type or print)

ATTACHMENT E

REGULATORY REQUIREMENTS

This Attachment E sets forth the Program requirements and other statutory and regulatory provisions applicable to this Contract. In the event of a conflict between this Attachment E and any other provision in the Contract, the provisions in this Attachment E control.

I. Medi-Cal Program Addendum

1. Definitions.

   1.1. "**Downstream Subcontractor**" means an individual or an entity that has an agreement with a Subcontractor or a Downstream Subcontractor that includes a delegation of Provider's and Subcontractor's duties and obligations under the Contract.

   1.2. "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following: (i) placing the Member's health in serious jeopardy; (ii) serious impairment of bodily functions; (iii) serious dysfunctions to any bodily organ or part; or (iv) death.

   1.3. "**Health Equity**" means the reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations.

   1.4. "**HSC**" means the California Health & Safety Code.

   1.5. "**Laws**" means, without limitation, federal, state, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Attachment E.

   1.6. "**Quality Improvement and Health Equity Transformation Program**" or "**QIHETP**" means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in Laws, Government Program Requirements.

2. Compliance with Laws. This Contract shall be governed by and construed in accordance with all Laws and applicable regulations governing the DHCS Contract, including the Knox Keene Act, HSC §§ 1340 *et seq*., unless otherwise excluded under the DHCS Contract; 28 CCR §§ 1300.43 *et seq*; Welfare & Institutions ("**W&I**") Code §§ 14000 and 14200 *et seq*.; and 22 CCR §§ 53800 *et seq*., 53900 *et seq*. Provider will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including all applicable requirements specified in the DHCS Contract, Laws, sub-regulatory guidance, and DHCS All Plan Letters ("**APLs**") and policy letters, and CalOptima Policies. Provider shall comply with all monitoring requirements of the Contract, the DHCS Contract, and any other monitoring requests by DHCS and CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.4), (A.5), (A.11), (B.7), (B.8), and (B.11)]

3. Provider Data. As applicable, Provider and its Subcontractors will submit to CalOptima complete, accurate, reasonable, and timely provider data, Program Data, Template Data, and any other reports or data as requested by CalOptima to meet its reporting requirements to DHCS. Provider shall submit all provider data to CalOptima in the form, format, and timeframe requested by CalOptima.

Provider will make corrections to provider data as requested by CalOptima. Provider data shall include all data required under the Contract – including reports and provider rosters. For purposes of this section, (1) "**Program Data**" means data that includes but is not limited to: Grievance data, Appeals data, medical exemption request denial reports and other continuity of care data, out-of-network request data, and PCP assignment data as of the last calendar day of the reporting month; and (2) "**Template Data**" means data reports submitted to DHCS by CalOptima, which includes, but is not limited to: data of Member populations, health care benefit categories, or program initiatives. [DHCS Contract, Exhibit A, Attachment III, §§ 1.2.5, 2.1.4, 2.1.5, 2.1.6, 3.1.5(A.6) and (B.10)]

4. Encounter Data. As applicable, Provider will submit to CalOptima complete, accurate, reasonable, and timely Encounter Data needed by CalOptima in order to meet its reporting requirements to DHCS in compliance with applicable DHCS APLs, including APL 14-020 and any superseding or amendment APLs. All Encounter Data shall be submitted to CalOptima no later than ninety (90) days from the Date of Service in the form and format as designated by CalOptima. Provider will cooperate as requested by CalOptima if corrections to Encounter Data are required for CalOptima to comply with reporting requirements to DHCS. [DHCS Contract, Exhibit A, Attachment III, §§ 2.1.2, 3.1.5(A.6) and (B.10)]

5. Reports. Provider and its Subcontractors agree to submit all reports required and requested by CalOptima to comply with applicable laws in a form acceptable to CalOptima. [DHCS APL 19-001, Attachment A, Requirement 6]

6. California Health and Human Services ("**CalHHS**") Data Exchange. Provider shall (i) execute the CalHHS Data Sharing Agreement ("**DSA**"); (ii) comply with the DSA requirements, including the CalHHS policies and procedures incorporated into the DSA; and (iii) participate in the real-time exchange of, or provision of access to, health information between and among other DSA participants, including CalOptima and any other Participating Providers providing services to Members. [HSC § 130290]

7. Additional Subcontracting Requirements. If Provider is allowed to subcontract services under this Contract and does so subcontract, then Provider shall, upon request, provide copies of such Subcontracts to CalOptima and/or DHCS.

    7.1 Subcontracts for Provision of Covered Services. Provider shall maintain copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Contract. Provider will ensure that such contacts are in writing. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.7)]

    7.2 Subcontracts. Provider shall require all Subcontracts and downstream Subcontracts that relate to the provision of Covered Services be in writing and include all applicable provisions of the Contract and this Medi-Cal Program Addendum including:

        7.2.1 The 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.

        7.2.2 As applicable, Section 2, *Compliance with Laws*; Section 3, *Provider Data*; Section 4, *Encounter Data*; Section 7, *Additional Subcontractor Requirements*; Section 8, *Records Retention*; Section 9, *Access to Books and Records*; Section 10,

Records Related to Recovery for Litigation; Section 11, *Transfer*; Section 12, *Unsatisfactory Performance*; Section 13, *Hold Harmless*; Section 14, *Prohibition on Member Claims and Member Billing*; Section 15, *Prospective Requirements*; Section 16, *Network Provider Training*; Section 17, *Language Assistance and Interpreter Services*; Section 18, *Fraud, Waste, and Abuse Reporting*; Section 19, *Provider Identified Overpayments*; Section 20, *Health Care Provider's Bill of Rights*; Section 21, *Provider Grievances*; Section 22, *Effective Dates*; Section 23, *Assignment and Sub-delegation*; Section 24, *Quality Improvement & Utilization Management*; Section 25, *Emergency Services and Post-Stabilization Delegation*; Section 28, *Amendment and Termination*; Section 29, *Delegated Activities*; Section 30, *Utilization Data*; Section 59, *DHCS Beneficiary*; and any other section of this Attachment E that is applicable to the obligations Subcontractor has undertaken.

7.2.3 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.

7.2.4 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 of 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.

[DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.12)]

8. Records Retention. Provider and Subcontractors shall maintain and retain all books and records of all items and services provided to Members, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the DHCS Contract, 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 and pursuant to HSC § 1381(b). 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 agency immediate and direct access and inspection of all such records at the time of any onsite audit or review.

   This provision shall survive the expiration or termination of this Contract.

   [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.4.D, 3.1.5(A.9) and (B.14); HSC § 1381; 28 CCR 1300.81]

9. Access to Books and Records. Provider agrees, and shall ensure its Subcontractors agree in Subcontracts, to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining directly or indirectly to the goods and services furnished under the terms of the Contract available for the purpose of an audit, inspection, evaluation, examination or copying at any time (i) in accordance with inspections and audits as directed by CalOptima, Regulators, the Department of Justice ("**DOJ**"), Office of Attorney General Division of Medi-Cal Fraud and Elder Abuse ("**DMFEA**"), DHCS's External Quality Review Organization contractor, and any other State or federal entity and their duly authorized designees statutorily entitled to have oversight responsibilities over CalOptima and/or Provider and its Subcontractors;

(ii) at all reasonable times at Provider's and Subcontractor's respective places of business or at such other mutually agreeable location in the State; and (iii) in a form maintained in accordance with the general standards applicable to such book or record keeping. Provider and Subcontractors shall provide access to all security areas and facilities and cooperate and assist State representatives in the performance of their duties. If DHCS, CMS, DMFEA, or DOJ or any other authorized State or federal agency, determines there is a credible allegation of fraud against Provider, CalOptima reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; immediately suspend payments to Provider; seek recovery of payments made to Provider or any Subcontractor; impose other sanctions provided under the DHCS Contract, and conduct additional monitoring.

Provider and Subcontractors shall cooperate in the audit process by signing any consent forms or documents required by but not limited to: DHCS, DMHC, the DOJ, Attorney General, Federal Bureau of Investigation, 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 and Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 1.3.4(D), § 3.1.5 (A.8) and (B.13); Exhibit E, § 1.1.22(B); APL 19-001, Attachment A; APL 17-001]

10. Records Related to Recovery for Litigation. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, DHCS, CMS, DMFEA, and any authorized State or federal agency in the form and manner specified by such entity, any information 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: (i) identify such privileged documents with sufficient particularity to reasonably identify the documents while retaining the privilege; and (ii) state the privilege being claimed that supports withholding production of the document. Provider agrees to promptly provide CalOptima with copies of any documents provided to any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time is of the essence in responding to such requests. 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. Provider further agrees to timely gather, preserve, and provide to DHCS any records in Provider's or its Subcontractor's possession. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.10) and (B.15); Exhibit E, § 1.1.27]

11. Transfer. Provider agrees and will require its Subcontractors to assist CalOptima in the transfer of Member care if in the event of: (i) termination of the DHCS Contract for any reason in accordance with the terms of the DHCS Contract; (ii) termination of this Contract for any reason; or (iii) a Subcontract terminates for any reason. Such assistance will include making available to CalOptima and DHCS copies of each Member's medical records and files, and any other pertinent information necessary to provide affected Members with case management and continuity of care. Such records will be made available at no cost to CalOptima, DHCS, or Members. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.11) and (B.16); Exhibit E, § 1.1.17(B)]

12. Unsatisfactory Performance. Provider agrees that the Contract or Provider's participation in the Medi-Cal program will be terminated, or subject to other remedies, if DHCS or CalOptima determine that Provider has not performed satisfactorily. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.12)]

13. Hold Harmless. Provider and its Subcontractors shall accept CalOptima's payment as described in this Contract as payment in full for all Covered Services and Administrative Services. Provider and its Subcontractors agree to hold harmless both the State and Members in the event that CalOptima cannot or will not pay for obligations undertaken by Provider pursuant to this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.13) and (B.18)]

14. Prohibition on Member Claims and Member Billing**.** Provider and its Subcontractors will not bill or otherwise collect reimbursement from a Member for any services provided under this Contract. Provider and its Subcontractors will ensure that Members are not balance billed for any service provided out of network. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.14); 3.3.6; 5.2.7]

15. Prospective Requirements. CalOptima will inform Provider of prospective requirements added by State or federal law, or DHCS to the DHCS Contract that would impact Provider's obligations before the requirement becomes effective. Provider agrees to comply with the new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by CalOptima or DHCS. Provider will ensure Subcontractors are (i) informed of prospective requirements that would impact their obligations before the requirements become effective and (ii) agree to comply with new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by CalOptima or DHCS. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.15), (B.22), and (B.23)]

16. Network Provider Training. Provider shall participate in training required by CalOptima in order for CalOptima to comply with the DHCS Contract. Such provider training may include, utilization management training, quality of care for children (early periodic screening, diagnosis and testing) training, Member's rights, and advanced directives. Training will also include training on cultural competency and linguistic programs as outlined in this section. Provider shall ensure that all Subcontractors receive all applicable training. [DHCS Contract, Exhibit A, Attachment III, §§ 2.3(F), 3.2.5, 5.1.1, 6.1.3(C)]

    16.1 Diversity, Health Equity, Cultural Competency, and Sensitivity Training. Provider shall ensure that annual diversity, Health Equity, cultural competency/humility, and sensitivity training is provided for employees and staff at key points of contact, pursuant to the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.16) and (B.24); 5.2.11(C)]

    16.2 Cultural/Linguistic Training Programs. Provider shall participate in and comply with any applicable performance standards, policies, procedures, and programs established from time to time by CalOptima and federal and State agencies and provided or made available to Provider with respect to cultural and linguistic services, including attending training programs and collecting and furnishing cultural and linguistic data to CalOptima and federal and State agencies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.11]

17. Language Assistance and Interpreter Services. Provider and its Subcontractors will comply with language assistance standards developed pursuant to HSC § 1367.04 and the DHCS Contract. Provider agrees to provide or arrange for the provision of interpreter services for Members. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.17) and (B.25); 5.1.3(F)]

18. Fraud, Waste, and Abuse Reporting. Provider shall report suspected fraud, waste, or abuse to CalOptima in accordance with the Contract. Provider agrees to provide CalOptima with all information reasonably requested by CalOptima, DHCS, or other State and federal agencies with jurisdiction in order for CalOptima to comply with fraud, waste, or abuse investigations and

reporting requirements. In the course of a fraud, waste, or abuse investigation, CalOptima may share with Provider information that DHCS has disclosed to CalOptima ("**FWA Confidential Data**"). Provider acknowledges and agrees to maintain FWA Confidential Data confidentially. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.2(D), 3.1.5(A.18) and (B.26),]

19. Provider Identified Overpayments. In addition to Overpayment requirements under the Contract, Provider shall report in writing to CalOptima when it has received an Overpayment, identify the reason for the Overpayment, and promptly return the overpayment to CalOptima as outlined within sixty (60) days of the date Provider identified the Overpayment. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.6, 3.1.5(A.19) and (B.27)]

20. Health Care Providers' Bill of Rights. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights, as set forth in HSC § 1375.7, in the administration of this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.20)]

21. Provider Grievances. Provider has the right to submit a dispute or grievance through CalOptima's formal process to resolve provider disputes and grievances pursuant to HSC §1367(h)(1). CalOptima's process to resolve Provider disputes or grievances are set forth in this Contract and the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.20), 3.2.2(B)]

22. Effective Dates. This Contract and its amendments will become effective only as set forth in the DHCS Contract, which requires filing and approval by DHCS of template contracts and amendments, and Subcontractor and Downstream Subcontractor agreements and amendments. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.2, 3.1.5(B.4)]

23. Assignment and Sub-delegation. Provider agrees that any assignment or delegation of an obligation or responsibility under this Contract by Provider to a Subcontractor shall be void unless prior written approval is obtained from CalOptima and DHCS. Provider further agrees that assignment or delegation by a Subcontractor is void unless prior written approval is obtained from DHCS. CalOptima or DHCS may withhold consent at their sole and absolute discretion. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.5) and (B.6); APL 19-001, Attachment A, Requirement 14]

24. Quality Improvement & Utilization Management. Provider agrees to cooperate and participate in CalOptima's QMI program including participating in QI Program, UM Program, QIHETP, and population needs assessments. [DHCS Contract, Exhibit A, Attachment III, §§ 2.2.4, 3.1.5(B.19)]

25. Emergency Services and Post-Stabilization Delegation. Responsibility for coverage and payment of Emergency Services and post-stabilization care services have not been delegated to Provider under the Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.9)].

26. Telehealth. When providing any Covered Services through telehealth and/or subsequently billing for telehealth Covered Services, Provider shall ensure that it complies with all applicable statutory and regulatory requirements, including HSC § 1374.13; W&I Code §§ 14132.72, 14132.100, and 14132.725; Business & Professions Code § 2290.5, and DHCS APL 23-007 (and any successor guidance) (collectively "**Telehealth Requirements**"). These Telehealth Requirements include (i) obtaining and documenting Member consent to use telehealth; (ii) ensuring the services can be appropriately delivered via telehealth; (iii) offering telehealth services via in-person, face-to-face interactions, as well, or arranging for referrals and facilitating in-person care so that a Member does not have to independently contact a different provider; (iv) establishing all new patients through telehealth using an approved methodology; (v) complying with all privacy and confidentiality laws

in rendering services; and (vi) satisfying the required documentation and coding requirements, as further outlined in CalOptima Policies. Claims for Covered Services provided through telehealth may not be reimbursable under the Contract if Provider did not comply with these Telehealth Requirements.

27. Electronic Prescriptions. Provider and any Subcontractors who may issue prescriptions under Business & Professions Code § 4040(a) shall have the capacity to prescribe electronically and shall issue electronic prescriptions in accordance with Business & Professions Code § 688.

28. Amendment and Termination. Provider agrees to notify DHCS if this Contract or an agreement with a Subcontractor is amended or terminated for any reason. For purposes of this section, notice is considered given when the notice is properly addressed and deposited in the United States Postal Service as first-class registered mail, postage prepaid. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.17); APL 19-001, Attachment A, Requirement 13]

29. Delegated Activities. If Provider is specifically delegated by CalOptima, delegated activities and reporting requirements will be further set forth in a separate attachment or addendum to this Contract. Such delegation may include, claims processing, utilization management, quality improvement, Health Equity activities, credentialing activities, and any other obligation that CalOptima is permitted to delegated to Provider, to the extent agreed upon between CalOptima and Provider. Provider agrees to perform and will require its Subcontractors to perform the obligations and functions of CalOptima undertaken pursuant to the Contract, including but not limited to reporting responsibilities, in compliance with CalOptima's obligations under the DHCS Contract in accordance with 42 CFR § 438.230(c)(1)(ii). Provider agrees to the revocation of the delegated activities and/or obligations, and/or any other specific remedies in instances where DHCS or CalOptima determine that Provider has not performed satisfactorily. If CalOptima delegates quality improvement activities, the Parties agree that the Contract will include provisions that address, at a minimum: (i) quality improvement responsibilities, and specific delegated functions and activities of CalOptima and Provider; (ii) CalOptima's oversight, monitoring, and evaluation processes and Provider's agreement to such processes; (iii) CalOptima's reporting requirements and approval processes, including, Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly; and (iv) CalOptima's actions/remedies if Provider's obligations are not met. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.1, 3.1.5(B.1), (B.8), (B.20), and (B.28); APL 19-001, Attachment A, Requirement 22]

30. Utilization Data. 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 solely for the purpose of Member care coordination. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.21); APL 19-001, Attachment A, Requirement 23]

31. Medical Decisions. Provider will ensure that medical decisions or any course of treatment in the provision of Covered Services by Provider, Subcontractors, or Downstream Subcontractors are not unduly influenced by fiscal and administrative management. [DHCS Contract, Exhibit A, Attachment III, § 1.1.5]

32. Capacity, Licensure, and Enrollment. Provider and its Subcontractors shall furnish to Medi-Cal Members those Medically Necessary Covered Services that Provider and Subcontractor is authorized to provide under this Contract, consistent with the scope of Provider's and/or Subcontractor's license, certification, and/or accreditation, and in accordance with professionally

recognized standards. Provider and its Subcontractors agree to comply with required provider screening, enrollment, and credentialing and recredentialing requirements. Provider warrants that it has and shall maintain through the Term adequate staff to comply with its obligations under the Contract and will require. [DHCS Contract, Exhibit A, Attachment III, § 1.3.3]

33. Medi-Cal Enrollment. If Provider is 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 22 CCR § 51000.35.

34. Prohibition Against Payment to Excluded Providers. Provider agrees that CalOptima is prohibited from contracting with individuals excluded from participation in State or federal programs and agrees that CalOptima shall not pay Provider if Provider is excluded from State or federal programs, as outlined in Section 2.26 of the Contract. Provider further agrees to not contract with or make payments to Subcontractors excluded from State or federal programs. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.4, 3.3.18]

35. Ownership Disclosure Statement. Prior to commencing services under this Contract, Provider shall provide CalOptima with the disclosures required by 42 CFR §§ 438.608(c)(2), 438.602(c), and 455.105, including the names of the officers and owners of Provider holding more than five percent (5%) of the stock issued by Provider, and major creditors holding more than five percent (5%) of the debt of Provider by completing the form in Attachment E, and Provider shall notify CalOptima whenever changes occur to the information provided therein. Provider shall promptly notify CalOptima of any change in the required disclosures. [DHCS Contract, Exhibit A, Attachment III, § 1.3.5; Exhibit E, § 1.1.11(A.5)]

    35.1 If a Subcontractor is not eligible to enroll in Medi-Cal, 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 22 CCR § 51000.35 for the Subcontractor.

36. Performance Improvement Projects. Provider and Subcontractors shall comply with all applicable performance standards and participate in performance improvement projects ("**PIP**s"), including any collaborative PIP workgroups, as may be directed by CMS, DHCS, or CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 2.2.9(A)-(B)]

37. No Punitive Action. CalOptima will not take punitive action against Provider if Provider requests an expedited resolution of or supports a provider or Member appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member (i) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, including any information the Member needs in order to decide among all relevant treatment options; (ii) for the risks, benefits, and consequences of treatment or non-treatment; (iii) for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment; and (iv) to express preferences about future treatment decisions. [DHCS Contract, Exhibit A, Attachment III, §§ 3.2.7, 4.6.5(A)]

38. Claims Processing. CalOptima will process claims in accordance with the DHCS Contract, HSC §§ 1371 through 1371.36 and their implementing regulations, and as outlined in the CalOptima Policies. If Provider is responsible for claims payments, Provider will pay claims consistent with this provision. [DHCS Contract, Exhibit A, Attachment III, § 3.3.5]

39. Cost Avoidance/Other Health Coverage. Provider acknowledges that Medi-Cal is a payor of last resort except for services in which Medi-Cal is required to be the primary payer. Accordingly, CalOptima shall not pay claims for services provided to a Member who has third-party coverage without proof that Provider has first exhausted all other payment sources. Provider shall not refuse to provide Covered Services to Members when OHC is indicated in the Member's Medi-Cal eligibility record. Provider shall review the Member's eligibility record for third party coverage, and if the Member has third-party coverage, Provider must notify the Member to seek the service from the third-party coverage. [DHCS Contract, Exhibit E, § 1.1.25(G)]

40. Public Record. Notwithstanding any other term of the Contract, this Contract and all information received in accordance with the DHCS Contract will be public record on file with DHCS, except as specifically provided by Laws. DHCS ensures the confidentiality of information and contractual provisions filed with DHCS to the extent the information and provisions are specifically exempted by Laws. [DHCS Contract, Exhibit A, Attachment III, § 3.1.11]

41. Provider Preventable Condition. CalOptima will not pay Provider for a provider preventable condition as described in 42 C.F.R. § 438.3(g). As a condition of payment, provider shall comply with reporting requirements on provider preventable conditions in the form and frequency required by DHCS in APL 17-009 or any superseding APL. [DHCS Contract, Exhibit A, Attachment III, § 3.3.17]

42. Member Rights. Provider and Subcontractors will not retaliate or take any adverse action against a Member for exercising the Member's rights under the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(A.1.r)]

43. Medical Records. All medical records shall be maintained in accordance with CalOptima Policies. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Subcontractor site. [DHCS Contract, Exhibit A, Attachment III, § 5.2.14]

44. Timely Access/Standards of Accessibility. Provider and Subcontractors will comply with applicable standards of accessibility and timely access requirements as outlined in the Contract and in CalOptima Policies. Provider and Subcontractors will comply with CalOptima's procedures for monitoring Provider's and Subcontractor's compliance with this section. [DHCS Contract, Exhibit A, Attachment III, § 5.2.5]

45. Minor Consent Services. Provider and its Subcontractors are prohibited from disclosing, and agree not to disclose, any information related to minor consent services without the express consent of the minor Member. Provider and its Subcontractors will comply with CalOptima's requirements for services to minor Members as outlined in the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.8(D)]

46. Emergency Preparedness Requirements. Provider agrees to cooperate with and comply with CalOptima's Emergency requirements, policies and procedures, and training to ensure continuity of care for Members during an Emergency. For purposes of this section, "**Emergency**" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by a public health crisis, natural and man-made hazards, or disasters. Provider will (i) annually submit to CalOptima evidence of adherence to CMS Emergency Preparedness Final Rule 81 Fed. Reg. 63859 and 84 Fed. Reg. 51732; (ii) advise CalOptima of Provider's Emergency plan; and (iii) notify CalOptima within twenty-four (24) hours of an Emergency if

Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency. [DHCS Contract, Exhibit A, Attachment III, §§ 6.1, 6.1.3(C)]

47. State's Right to Monitor. Provider and Subcontractors shall comply with all monitoring provisions of this Contract, the DHCS Contract, and any monitoring requests by CalOptima and Regulators. 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 Laws. Such monitoring, inspection, or evaluation activities will include inspection and auditing of Provider, Subcontractor, and Provider's and Subcontractors' facilities, management systems and procedures, and books and records, at any time, pursuant to 42 CFR § 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the Subcontractor(s). [DHCS Contract, Exhibit D(f) § 8; Exhibit E, § 1.1.22(B)]

48. Laboratory Testing. Provider agrees that if any performance under this Contract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC § 263a and the regulations thereto. [DHCS Contract, Exhibit D(f), § 18]

49. Third Party Tort Liability. Provider and Subcontractors 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, worker's compensation, class action claims 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 that may result in casualty insurance payments, tort liability, Workers' Compensation awards, class action claims, or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Welfare and Institutions Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9. [DHCS Contract, Exhibit E, §§ 1.1.25 and 1.1.26]

50. 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 seventy-five (75) days prior to the proposed effective date. [Exhibit A, Attachment III, § 5.2.9]

51. Confidentiality of Medi-Cal Members.

    51.1 Provider and its Subcontractors shall have policies and procedures in place to guard against unlawful disclosure of protected health information, personally identifying information, and any other Member confidential information in accordance with 45 CFR Parts 160 and 164, Civil Code §§ 1798 *et seq*. Provider and its Subcontractors shall obtain prior written authorization from the Member in order to disclose such information unless exempted by 22 CCR § 51009. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(B)]

    51.2 In accordance with 42 CFR § 431.300 *et seq*., as well as W&I Code § 14100.2 and regulations adopted thereunder, Provider and its employees, agents, and Subcontractors

shall protect from unauthorized disclosure the names and other identifying information, records, data, and data elements 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, and/or agents as a result of services performed under this Contract, except for statistical information not identifying any such persons. Provider and its employees, agents, and Subcontractors shall not use or 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.

51.2.1 Provider and its employees, agents, and Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider may release medical records in accordance with Laws pertaining to the release of this type of information. Provider is not required to report requests for medical records made in accordance with Laws.

51.2.2 With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider will, at the termination or expiration 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.

51.2.3 For purposes of this Section 51.2, identity shall include the name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

[DHCS Contract, Exhibit D(f) § 14; Exhibit E, § 1.1.23]

52. Debarment Certification. By signing this Contract, Provider agrees to comply with applicable federal suspension and debarment regulations, including 2 CFR 180 and 2 CFR 376.

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

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

52.1.2 Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for: (i) 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; (ii) a violation of federal or State antitrust statutes; or (iii) commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

52.1.3 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 Section 52.1.2, above;

52.1.4 Have not within a three (3)-year period preceding the Effective Date had one or more public transactions (federal, state, or local) terminated for cause or default;

52.1.5 Have not, within a three (3)-year period preceding this Contract, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376;

52.1.6 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 Part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

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

52.2 If the Provider is unable to certify to any of the statements in this Section 52, Provider shall submit an explanation to CalOptima prior to the Effective Date and then immediately upon any change in the certifications above during the Term.

52.3 The terms and definitions in this Section 52 not otherwise defined in the Contract have the meanings set out in 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

52.4 If the Provider knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause.

[DHCS Contract, Exhibit (D)(f) § 20]

53. DHCS Directions. If required by DHCS, Provider and its Subcontractors shall cease specified services for Members, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS. [DHCS Contract, Exhibit (D)(f) § 34]

54. Lobbying Restrictions and Disclosure Certification.

54.1 This Section 54 is applicable to federally funded contracts in excess of one hundred thousand dollars ($100,000) per 31 USC § 1352. If this Section 54 is applicable to the Contract, Provider shall comply with the requirements in this Section 54, as well as complete the disclosure forms in Attachment E prior to the Effective Date.

54.2 Certification and Disclosure Requirements.

54.2.1 If this Contract is subject to 31 USC § 1352 and exceeds one hundred thousand dollars ($100,000) at any tier, Provider shall file the certification and disclosure forms in Attachment E prior to the Effective Date.

54.2.2 Provider shall file a disclosure (in the form set forth in Attachment E, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if Provider has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or

any extension or amendment of that contract or grant that would be prohibited under Section 54.3 if paid for with appropriated funds.

54.2.3 Provider 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 Provider under Section 54.2.2. An event that materially affects the accuracy of the information reported includes:

54.2.3.1 A cumulative increase of twenty-five thousand dollars ($25,000) or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

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

54.2.3.3 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.

54.2.4 Each Subcontractor who requests or receives from Provider or Subcontractor a contract, subcontract, grant, or subgrant exceeding one hundred thousand dollars ($100,000) at any tier under this Contract shall file a certification, and a disclosure form, if required, to the next tier above that Subcontractor.

54.2.5 All disclosure forms (but not certifications) completed under this Section 54.2 and Attachment E shall be forwarded from tier to tier until received by CalOptima. CalOptima shall forward all disclosure forms to DHCS program contract manager.

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

[DHCS Contract, Exhibit (D)(f) § 37.b]

55. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt by Laws. If applicable, Provider agrees to comply with all standards, orders, or requirements issued under the Clean Air Act (42 USC §§ 7401 *et seq.*), as amended, and the Clean Water Act (33 USC §§ 1251 et seq.), as amended. [DHCS Contract, Exhibit (D)(f) § 12]

56. Smoke-Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994, 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 eighteen (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 one thousand dollars ($1,000) for each violation and/or the imposition of an administrative compliance order on the responsible party. Provider shall comply with the applicable requirements of the Pro-Children Act. Provider further agrees that it will insert this certification into any Subcontracts, if required by the Pro-Children Act. [DHCS Contract, Exhibit (D)(f) § 21]

57. Domestic Partners. Pursuant to HSC § 1261, if Provider is licensed pursuant to HSC § 1250, Provider agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child. [HSC § 1261]

58. Conflict of Interest. Provider agrees to avoid conflicts of interest or the appearance of a conflict of interest and shall (i) comply with conflict of interest avoidance requirements of the DHCS Contract; (ii) comply with any conflict avoidance plan issued by CalOptima; and (iii) notify CalOptima within ten (10) working days of becoming aware of any potential, suspected, or actual conflict of interest. [DHCS Contract, Exhibit H]

59. DHCS Beneficiary. Provider expressly agrees and acknowledges that (i) DHCS is a direct beneficiary of the Contract and any Subcontractor or Downstream Subcontractor agreement with respect to the obligations and functions undertaken under the Contract; and (ii) DHCS may directly enforce any and all provisions of the Subcontractor agreement or Downstream Subcontractor agreement. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.29)]

60. Employment Non-Discrimination. During the performance of this Contract, neither Provider nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, medical condition, mental disability, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, military and veteran status. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and shall comply with the provisions of the Fair Employment and Housing Act (Government Code §§ 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 11000 *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code § 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 Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Provider shall include the non-discrimination and compliance provisions of this Section 60 in all Subcontracts. [DHCS Contract, Exhibit E. § 1.1.28]

    60.1 Provider and all Subcontractors shall comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations promulgated under the above-listed statutes. Provider and all Subcontractors shall comply with California nondiscrimination requirements,

including, without limitation, the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I Code § 14029.91, and State implementing regulations. [DHCS Contract, Exhibit E. §1.1.29]

61. Member Non-Discrimination. Neither Provider nor Subcontractors shall discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, including the statutes identified in Section 60 above. For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; (v) assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, to the Members to be served; (vi) treating a Member or potential Member differently from others in determining whether they satisfy any admission, Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service; (vii) utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination; (viii) failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and (ix) failing to ensure meaningful access to programs and activities for limited English proficiency Members and potential Members.

    61.1 Provider shall take affirmative action to ensure all Members are provided Covered Services without unlawful discrimination, except where needed to provide equal access to limited English proficiency Members or Members with disabilities, or where medically indicated. For the purposes of this Section 61, 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 Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

    61.2 Provider shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

    61.3 Provider shall require all Subcontractors to cooperate with CalOptima's Member Complaint Policy and time requirements to Appeal within designated time frames.

    [DHCS Contract, Exhibit E § 1.1.30]

62. Program Integrity and Compliance Program. Provider will comply with CalOptima's program integrity and compliance program. [DHCS Contract, Exhibit A, Attachment III, § 1.3]

63. Federally Qualified Health Centers ("**FQHC**"), Rural Health Centers ("**RHC**"), or Indian Health Services ("**IHS**") Facility.

63.1 If Provider is an FQHC or an RHC, Provider will cooperate with and provide to CalOptima any information necessary for CalOptima to meet its obligations to DHCS pertaining to FQHCs and RHCs, including (i) submitting documentation of services provided, reimbursement level, and payment amounts; (ii) certifying that this Contract is offered to Provider on the same terms and conditions as those offered to other network providers providing similar services and that reimbursement is not less than the level and amount of payment which the entity would make for the service if they were furnished by a provider that is not an FQHC; and (iii) allowing DHCS review and audit of CalOptima's records pertaining FQHC and RHC reimbursement.

63.2 If Provider is an FQHC or an RHC, Provider acknowledges and agrees that CalOptima is not required to pay Provider the Medi-Cal per-visit rate for the clinic. The Parties agree that any financial incentive arrangements that Provider and CalOptima enter into will comply with DHCS guidance including DHCS Contract, Attachment III, § 3.3.7(B.7) and applicable APLs.

63.3 To the extent Provider is an Indian Health Services facility that qualifies as an FQHC and RHC; Provider agrees and acknowledges that the terms of this section applicable to FQHCs and RHCs also apply to Provider.

[DHCS Contract, Exhibit A, Attachment III, § 3.3.7(B)]

64. Lead Screening. If Provider is a school-based mental health and substance use disorder provider, Provider shall ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with 17 CCR §§ 37000-37100 and applicable APLs. As applicable, Provider will follow the Childhood Lead Poising in Prevention Branch guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including making referrals to the local public health department. Provider shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's medical record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent or guardian shall be documented in the Member's medical record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's medical record. Documented attempts that demonstrate Provider's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement. [DHCS Contract, Exhibit A, Attachment III, §5.3.4(D)]

II. OneCare Program Addendum

1. Hold Harmless. Provider agrees to hold harmless Members in case CalOptima cannot or will not pay for services under the Contract. This provision shall not prohibit collection of any applicable SOC billed in accordance with the terms of Members' evidence of coverage. Provider further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of Members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or Provider and Members or persons acting on their behalf that relates to liability for payment for Covered Services.

2. Accountability. Any services or other activity under the Contract performed by Provider and any of its Subcontractors will be performed in accordance with CalOptima's contractual obligations to CMS and DHCS, including the requirements at 42 C.F.R. § 438.414 in relation to the grievance system.

3. Coordination of Benefits 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 Medicare and the OneCare Product. Provider will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

4. 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. CalOptima shall provide payment to Provider within forty-five (45) business days of CalOptima's receipt of a Clean Claim from Provider, or CalOptima will contest or deny Provider's claim within forty-five (45) business days following CalOptima's receipt thereof.

5. Claims Payment. CalOptima will not pay Provider for a provider preventable condition. As a condition of payment, Provider will comply with the applicable reporting requirements on provider preventable conditions as described at 42 CFR § 447.26(d) and as may be specified by CalOptima or DHCS. Provider shall comply with such reporting requirements to the extent that Provider directly furnishes services.

6. Cost-Sharing. Provider agrees that Members will not be held liable for Medicare Part A and B cost-sharing. Medicare Parts A and B services must be provided at zero cost-sharing to Members. Provider and any of its contracted providers must not impose cost-sharing requirements on Members that would exceed the amounts permitted under Medi-Cal, 42 U.S.C. § 1395w-22(a)(7), and 42 C.F.R. section 422.504(g)(1)(iii). Provider shall (i) accept reimbursement from CalOptima under the Contract as payment in full for services rendered to Members, or (ii) bill Member's Medi-Cal managed care health plan, as applicable, for any additional Medicare payments that may be reimbursed by Medi-Cal. Provider will also comply with requirements outlined in W&I Code § 14019.4 related to Medi-Cal services.

7. Federal Funds. Provider acknowledges that payments Provider receives from CalOptima are, in whole or part, from federal funds. Therefore, Provider and any of its Subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975, as implemented by 45 CFR Part 91; the ADA; Section 504 of the Rehabilitation Act of 1973, as implemented by 45 CFR Part 84, and any other regulations applicable to recipients of federal funds.

8. Compliance with Medicare Laws. Provider will comply with all applicable federal and State laws (including Medicare laws), regulations, and CMS instructions, including laws and regulations designed to prevent or ameliorate FWA, including applicable provisions of federal criminal law, the False Claims Act (31 USC § 3729 *et seq*.), and the anti-kickback statute (Section 1128(B)(b) of the Social Security Act), and HIPAA administrative simplification rules at 45 C.F.R. Parts 160,

162 and 164. Further, Provider agrees that any services provided by Provider will be consistent with and will comply with CalOptima's contract with CMS ("**CMS Contract**").

9. Language Assistance. Provider will provide services in a culturally competent manner and agrees to arrange for the provision of interpreter services for Members at all Provider sites.

10. Reporting. Provider agrees to provide relevant reports, data, and information necessary for CalOptima to meet its obligations under the OneCare Product and Laws, including 42 CFR §§ 422.516 and 422.310. In addition, Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 CFR § 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.

11. Offshore Activities. Unless CalOptima has provided prior written authorization, all services provided by Provider pursuant to the Contract must be performed within the United States, the District of Columbia, or the United States territories.

12. Excluded Individuals/Program Integrity. Provider acknowledges and agrees that it is not excluded and shall not employ or contract for the provision of services pursuant to the Contract with any individual or entity (hereafter, "**Person**") whom Provider knows is excluded from participation in the Medicare or Medicaid programs under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded Person currently is employed by or under contract with Provider. Provider shall ensure that the Persons it employs or contracts for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, as defined in 42 CFR § 422.2. Provider shall promptly after discovery disclose to CalOptima any exclusion, or other event that makes a Provider employee or downstream entity ineligible to perform work related to federal health care programs, in accordance with 42 CFR § 422.752(a)(8). Provider agrees to be bound by the provisions set forth at 2 CFR Part 376.

13. Emergency Medical Treatment and Labor Act. Provider must comply with the federal Emergency Medical Treatment and Labor Act ("**EMTALA**"), as applicable, and ensure that there are no conflicts with hospital actions required to comply with EMTALA.

14. Punitive Action. CalOptima will not take punitive action against Provider if Provider requests an expedited resolution or supports a Member's appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient for a Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information a Member needs in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for a Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

15. Indemnity. Provider is not required to indemnify CalOptima for any expenses and liabilities, including judgments, settlements, attorney's 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, other policies, guidelines, or actions.

16. Member Billing Prohibitions. Provider (i) shall not impose cost-sharing requirements on Members that would exceed the amounts permitted under the Medi-Cal Program, Social Security Act § 1852(a)(7), and 42 CFR § 422.504(g)(1)(iii); (ii) shall not bill any Member for Medicare cost-

sharing amounts, including deductibles, coinsurance, and copayments, as mandated under Social Security Act § 1902(n)(3)(B); (iii) agrees to accept reimbursements from CalOptima as payment in full for services rendered to Members, or to bill Medi-Cal or CalOptima, as applicable and in accordance with Laws, for any additional Medicare payments that may be reimbursed by Medi-Cal; and (iv) shall comply with W&I Code § 14019.4.

III. MSSP Program Addendum

Not applicable to this Contract

IV. PACE Program Addendum

Not applicable to this Contract

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 failure.

Infomedia Group, Inc. dba Carenet Healthcare Services	{{N_es_:signer1:fullname }}
Name of Contractor	Printed Name of Person Signing for Contractor {{_es_:signer1:signature}}
Contract / Grant Number {{_es_:signer1:date }}	Signature of Person Signing for Contractor {{_es_:signer1:title }}
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
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type: initial
{{[]}} contract {{[]}} grant {{[]}} cooperative agreement {{[]}} loan {{[]}} loan guarantee {{[]}} loan insurance	{{[]}} bid/offer/application {{[]}} initial award {{[]}} post-award	{{[]}} initial filing {{[]}} material change For Material Change Only: Year {{Yr_es_signer1}} quarter {{Qtr_es_signer1}} date of last report

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
{{RepEntNm_es_signer1 }} Prime Subawardee Tier, if known: {{Tier_es_signer1 }}	{{RepEntNmSub_es_signer1 }}
Congressional District, If known: {{CongDist_es_signer1 }}	Congressional District, If known: {{CongDistSub_es_signer1 }}
6. Federal Department/Agency: {{FedDeptAgen_es_signer1 }}	7. Federal Program Name/Description: {{FedProg_es_signer1 }} CDFA Number, if applicable: {{CDFA_es_signer1 }}
8. Federal Action Number, if known: {{FedDeptNo_es_signer1 }}	9. Award Amount, if known: {{AwardAmt_es_signer1 }}
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm_es_signer1 }} {{LobEntAd_es_signer1 }} (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm2_es_signer1}} SF-LLL-A, If necessary)
Amount of Payment (check all that apply): ${{Amt_es_signer1}} actual planned	13. Type of Payment (Check all that apply): {{[]}} a. retainer {{[]}} b. one-time fee {{[]}} c. commission {{[]}} d. contingent fee {{[]}} e deferred {{[]}} f. other, specify: {{Other_es_signer1}}
Form of Payment (check all that apply): a. {{[]}} cash b. {{[]}} in-kind, specify: Nature	
Value {{Value_es_:signer1 }}	

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:
{{SrvcPerf_es_:signer1:multiline(4) }}

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes {{[]}} No {{[]}}

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: {{_es_:signer1:signature:showif(lobby=Checked)}} Print Name: {{Name_es_:signer1:showif(lobby=Checked)}} Title: {{_es_:signer1:title:showif(lobby=Checked)}} Telephone No.: {{Mobile_es_:signer1:phone:showif(lobby=Checked)}} Date: : {{_es_:signer1:date:showif(lobby=Checked)}}

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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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.

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Authorize Property Management Contract Amendment Related to the Garden Grove Street Medicine Support Center

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Actions

Authorize the Chief Executive Officer to execute a contract amendment with RiverRock Real Estate Group, LP effective June 1, 2024, to add property management, maintenance, and security services for 7900 Garden Grove Boulevard ("Garden Grove") to the existing master contract agreement.

Background

In September 2023, CalOptima Health acquired the real property located at 7900 Garden Grove Boulevard, Garden Grove, California, to become the future location of the initial Street Medicine Support Center. At the September 7, 2023, meeting, the Board approved a contract amendment with RiverRock Real Estate Group, LP (RiverRock) to provide property management, security, and preconstruction support from the property acquisition through May 31, 2024. The intention was to commence renovation work before that time, at which point the developer would take on the responsibility for security.

Discussion

After initial assessment, staff determined that this project would require additional time to go through the planning and procurement process. During this time, the property will require ongoing security, property management, and maintenance services commensurate with other CalOptima Health real estate assets. RiverRock has provided a 24/7 on-site physical security presence and has taken measures to secure the asset and reduce risk of harm to the property or to individuals, in addition to stabilizing utilities and providing maintenance services.

While it would be possible for staff to issue a competitive solicitation for those services at Garden Grove, there would be minimal benefit in doing so for the few months until renovation commences. Moreover, RiverRock has satisfactorily fulfilled all aspects of the contract amendment by providing the ongoing property, security, utilities, and site maintenance services. Consequently, staff recommends authorizing an amendment to the RiverRock agreement to further extend the term for Garden Grove services to be coterminous with the master contract. That contract expires May 31, 2025. It has two additional consecutive one-year terms, exercisable at CalOptima Health's sole discretion. There are no other requested changes to the existing contract terms and conditions. Since the initial Garden Grove property management contract was approved by Board in September 2023, for transparency and consistency with the Board-approved Purchasing Policy, staff is seeking additional board authority to execute the contract amendment with RiverRock.

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Fiscal Impact
The estimated fiscal impact of the contract amendment is $2,500 per month or $30,000 annually. If the developer takes over security responsibilities for Garden Grove, the fiscal impact will be reduced by those months.

Unspent reserve funds approved by the Board at the September 9, 2023, meeting for the Street Medicine Support Center will fund one-month's expenses of $2,500 for June 1, 2024, through June 30, 2024. Staff has included the estimated cost for this property management service in the proposed Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation
The recommended actions will allow CalOptima Health to provide ongoing property management for the 7900 Garden Grove Boulevard, Garden Grove, California, asset acquired in September 2023.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Amendment No. 4 to Contract 22-10791 between CalOptima Health and RiverRock Real Estate Group, LP
2. Entities Covered by this Recommended Board Action

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

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AMENDMENT NO. 4 to CONTRACT 22-10791
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba ORANGE
PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA HEALTH ("CALOPTIMA")
and
RIVERROCK REAL ESTATE GROUP, LP
("CONTRACTOR")

AMENDMENT NO. 4 to CONTRACT 22-10791 ("Amendment") is entered into as of the last signature date shown below, with respect to the following facts:

A. CalOptima and CONTRACTOR entered into Contract 22-10791 ("CONTRACT") on May 16, 2022, under which CONTRACTOR provides property management services.

B. The Parties entered into Amendment No. 1 on March 2,2023. On September 14,2023, the parties entered into Amendment No. 2. On September 20,2023, the parties entered into Amendment No. 3. Collectively, the Original CONTRACT and Amendment(s) specified herein shall be referred to herein as the "CONTRACT".

C. Pursuant to Section 19 of the CONTRACT, the CONTRACT may be amended only in writing and executed by Parties.

D. The Parties now desire to amend Amendment No.2 to extend the term.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Amend Amendment No.2 to be coterminous with Section 17 of the Contract Agreement.

2. **Authority to Execute**. The persons executing this Amendment on behalf of the Parties warrant that they are duly authorized to execute this Amendment and that by executing this Amendment, the Parties are formally bound.

3. **Counterparts.** This Amendment may be executed in any number of counterparts, all of which taken together shall constitute one and the same instrument, and any of the Parties may execute the Amendment by signing any such counterpart.

4. **No Other Changes**. This Amendment 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 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, if any, the provisions of this Amendment shall govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meanings 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.

[*signature page follows*]

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment on the day and year shown below.

RiverRock Real Estate Group, LP

Signature:_____

Name:_____

Title:_____

Date:_____

Signature:_____

Name:_____

Title:_____

Date:_____

Orange County Health Authority dba CalOptima Health

Signature:_____

Name:_____

Title:_____

Date:_____

Signature:_____

Name:_____

Title:_____

Date:_____

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
RiverRock	505 City Parkway West, Suite 160	Orange	CA	92868

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Approve Contract for Federal Advocacy Services

Contact

Veronica Carpenter, Chief of Staff, (657) 900-1161

Recommended Action

Authorize the Chief Executive Officer to execute a contract with DC Health Care Advisors LLC, doing business as Chamber Hill Strategies, for federal advocacy services, effective July 1, 2024, through December 31, 2026.

Background

CalOptima Health retains representation in Washington, DC to assist with tracking, analysis, and advocacy regarding federal legislation, regulations, and appropriations. In addition, CalOptima Health's representatives develop and maintain relationships with members and staff of the United States Congress, as well as federal departments and regulatory agencies, including but not limited to the Centers for Medicare and Medicaid Services (CMS).

CalOptima Health currently contracts with Potomac Partners DC LLC (PPDC) for federal advocacy services. Given the expiration of PPDC's current contract on June 30, 2024, and in light of CalOptima Health's evolving strategic and public policy priorities since the approval of PPDC's current scope of work (SOW), the Board authorized on February 1, 2024, the release of a request for proposals (RFP) for federal advocacy services with a revised SOW.

Discussion

Consistent with CalOptima Health's procurement process prescribed in policy *GA.5002: Purchasing*, an RFP for federal advocacy services was issued on March 8, 2024. By the submission deadline of April 2, 2024, CalOptima Health received proposals from eight advocacy firms. A staff evaluation committee reviewed the submitted written proposals and recommended four firms for first-round virtual interviews. Following these interviews, staff then recommended three finalists for second-round virtual interviews.

The evaluation criteria for the written proposals and interviews included:

- Account team qualifications and experience;
- Experience with similar clients;
- Strategies to engage Orange County's delegation and key committees in Congress;
- Strategies to engage federal agencies, including CMS;
- Knowledge of federal health care trends; and
- Consideration of 2024 election outcomes and implications.

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Following the second-round interviews, staff recommended the top-scoring firm Chamber Hill Strategies to provide federal advocacy services for CalOptima Health. The final scoring of the three finalists was as follows:

Firm	Score
Chamber Hill Strategies	92.63
The Vogel Group	87.13
PPDC	77.25

Specifically, the evaluation team recommended Chamber Hill Strategies because of its strong and unique capabilities to meet the requirements of and expanded SOW. As an exclusively health care focused bipartisan advocacy firm, Chamber Hill Strategies has specific experience representing other Medicaid managed care organizations. Members of the Chamber Hill Strategies account team also have strong relationships with several leaders, members, and staff of California's, including Orange County's, delegation and key health care committees in Congress, as well as staff in the Executive Office of the President, U.S. Department of Health and Human Services (including CMS), and other federal agencies and commissions. In addition, Chamber Hill Strategies also proposed the most comprehensive proactive strategy for engaging in federal policy, funding, and advocacy opportunities in close coordination with CalOptima Health staff. Therefore, staff believes that Chamber Hill Strategies will provide added value to CalOptima Health's Government Affairs program and advance federal priorities that promote health equity in support of our members, providers, and stakeholders.

Staff recommends Board approval of the proposed contract with Chamber Hill Strategies for a two-and-a-half-year period from July 1, 2024, through December 31, 2026, which will align the contract schedule with the two-year Congressional sessions. The proposed contract also includes a single two-year extension option exercisable at CalOptima Health's sole discretion with Board approval. Chamber Hill Strategies' proposed contract is priced at $27,500 per month – a nearly equivalent rate to CalOptima Health's current contract for federal advocacy services – which includes direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, and materials. Not included in the contract price are any travel expense reimbursements in an amount up to $12,000 per year. If necessary, the contract also includes an optional provision to increase payment by up to $5,000 per month to Chamber Hill Strategies for creating and leading an advocacy coalition on behalf of CalOptima Health. Although not anticipated to be exercised at this time, CalOptima Health's increased payment would be subject to the advance approval of the Chief Executive Officer and only effective during the period in which such coalition-related activities are performed. Finally, if the Board exercises the single two-year extension option due to the performance of Chamber Hill Strategies, the base contract price would increase from $27,500 to $30,000 per month under the same terms.

As part of CalOptima Health's standard practice, staff will monitor Chamber Hill Strategies' performance to ensure that the deliverables and components outlined in the contract and SOW are achieved. Deliverables include, but are not limited to, written and verbal monthly reports, updates, and discussions with staff. Chamber Hill Strategies will also provide in-person updates at one or two Board meetings per year.

Fiscal Impact
Funding for the recommended action is a budgeted item under the proposed Fiscal Year 2024-25 Operating Budget. Management will include expenses for the Chamber Hill Strategies contract for the period of July 1, 2025, through December 31, 2026, in future operating budgets.

Rationale for Recommendation
Federal advocacy efforts continue to be a priority for CalOptima Health given the level of activity on health care issues in Washington, DC. CalOptima Health anticipates that several important issues will require focus, attention, involvement, and advocacy.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
1. Entities Covered by this Recommended Board Action
2. Proposed Chamber Hill Strategies Contract No. 24-11007

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

Attachment to the June 6, 2024 Board of Directors Meeting – Agenda Item 11

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
DC Health Care Advisors LLC d/b/a Chamber Hill Strategies	601 New Jersey Ave NW, Suite 620	Washington	DC	20001

CONTRACT NO. 24-11007 ("**Contract**")
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA HEALTH ("**CalOptima**")
And
DC HEALTH CARE ADVISORS LLC, dba
CHAMBER HILL STRATEGIES
("**CONTRACTOR**")

This Contract is made and entered into as of July 01, 2024 ("**Effective Date**"), by and between the Orange County Health Authority, a public agency dba CalOptima Health ("**CalOptima**") and DC Health Care Advisors LLC, dba Chamber Hill Strategies, hereinafter referred to as "**CONTRACTOR.**" CalOptima and CONTRACTOR may be referred to herein collectively as the "**Parties**" or each individually as a "**Party**."

RECITALS

A. CalOptima desires to retain a contractor to provide Federal Advocacy Services, as described in the Scope of Work in Exhibit A;

B. CONTRACTOR provides such services;

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

D. CONTRACTOR desires to perform these services for CalOptima; and

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

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. "**Contract Documents**" include the following documents in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and addenda; (ii) CalOptima's Request for Proposal 24-055 ("**RFP**"), inclusive of any CalOptima revisions and addenda prior to the Effective Date; and (iii) CONTRACTOR's proposal dated April 02, 2024 ("**Proposal**"). Any new terms and conditions attached to CONTRACTOR's best and final offer, Proposal, invoices, or request for payment shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All Contract Documents are incorporated into this Contract by this reference. Any changes to the Contract or the Contract Documents shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima in accordance with Section 10. of this Contract. In the event of any conflict of provisions among the Contract and/or Contract Documents, the provisions shall prevail in the above-referenced descending order of precedence.

2. Scope of Work.

2.1 CONTRACTOR shall perform the work in accordance with (i) this Contract, including the Scope of Work in Exhibit A, (ii) the Contract Documents, (iii) the applicable standards and requirements of the Centers for Medicare and Medicaid Services ("**CMS**"), the California Department of Health Care Services ("**DHCS**"), and the California Department of Managed Health Care ("**DMHC**"), and (iv) all applicable laws.

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3. Insurance.

3.1 At CONTRACTOR's sole expense and prior to undertaking performance of services under this Contract and at all times during performance hereunder, CONTRACTOR shall maintain insurance policies and amounts set forth in Exhibit A, which shall be full-coverage insurance not subject to self-insurance provisions, in accordance with applicable laws and industry standards. CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the Term.

3.2 Within five (5) days of the Effective Date and prior to commencing performance of any services or its receipt of any compensation under the Contract, CONTRACTOR shall furnish to CalOptima with additional insured endorsements broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR. CONTRACTOR's Certificates of Insurance shall additionally comply with the following:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR, including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies, as applicable, and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this Contract, the CONTRACTOR's insurance coverage shall be primary insurance with respect to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies, as applicable.

3.2.3 CONTRACTOR's insurance carrier agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this Section 3.2 and Exhibit A. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required in this Contract, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Require the insurance carrier to provide thirty (30) days' prior written notice of cancellation to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3 and Exhibit A, CalOptima may terminate this Contract upon written notice to CONTRACTOR. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth in this Contract.

3.6 "**Occurrence**" means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR shall defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "**Indemnified Parties**") against any and all claims, losses, demands, damages, costs, expenses, or liability arising out CONTRACTOR's, or its officers, employees, subcontractors, agents, or representatives', breach of this Contract, negligence, recklessness, or intentional conduct, except to the extent any such loss was caused by the gross negligence, recklessness, or intentional misconduct of CalOptima. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions at its sole expense, which shall include all costs and fees, including attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding. CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder

4.3 CONTRACTOR's indemnification and duty to defend obligations shall survive the expiration or earlier termination of this Contract until such time as any action against the Indemnified Parties for such a matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including those set forth under the California Government Claims Act (Cal. Gov. Code §900 *et seq*.).

4.4 In the event of any conflict between this Section 4 and the indemnification provisions set forth elsewhere in the Contract, including any business associate agreement ("**BAA**") between the Parties, the indemnification provision(s) in the BAA or elsewhere in the Contract shall be interpreted to relate only to matters within the scope of the BAA or those other Contract provisions.

4.5 The terms of this Section 4 shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which shall include for purposes of this Section 5 all subcontractors, agents, and employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor and nothing in this Contract shall be construed as creating a partnership, joint venture, or agency. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees, agents, and/or subcontractors in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, state and federal income tax withholding, other payroll taxes, unemployment compensation, workers' compensation, and similar matters. CONTRACTOR shall file all required returns related to such taxes, contributions, and payroll deductions.

6. Personnel.

6.1 CONTRACTOR Staffing. CONTRACTOR shall ensure that only fully qualified CONTRACTOR personnel are assigned to perform the services under the Contract, and such CONTRACTOR personnel shall perform services diligently and in a timely manner, according to the applicable professional and technical standards.

6.2 CONTRACTOR Personnel Restrictions. When on CalOptima's premises, CONTRACTOR personnel shall comply with CalOptima policies and procedures, including CalOptima's identification requirements (e.g., name badges).

6.3 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

6.4 Neither Party shall actively solicit employees of the other Party for employment that directly or indirectly provided services under the Contract during the Term and for a period of one (1) year after termination.

7. Compensation.

7.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full compensation for the faithful performance of this Contract, the rates, charges, and other payment terms identified in Exhibit B.

7.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

7.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance set forth in the Contract, including in Exhibit A. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES, OR COSTS WHATSOEVER INCURRED BY**

CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING BY CALOPTIMA UNDER THIS CONTRACT.

7.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in Exhibit B, without the express prior written authorization of CalOptima. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

7.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority and shall have no liability for or any obligation to refund any payments withheld.

8. Confidential Material.

8.1 During the Term, either Party may have access to confidential material or information ("**Confidential Information**") belonging to the other Party or the other Party's customers, vendors, or partners. Confidential Information includes the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and other proprietary information, or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. CalOptima's Confidential Information also includes all user information, patient information, and clinical data that comes into CalOptima's possession, custody or control. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

8.2 For the purposes of Section 8.1, Confidential Information does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other Party's Confidential Information or proprietary information; (iv) is lawfully received from a third party that is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure, pursuant to California Public Records Act, Government Code Section 6250 *et seq*., applicable provisions of California Welfare and Institutions Code, or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

8.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers, or agents, who are bound by confidentiality obligations no less stringent than those in this Section 8, on a "need to know" basis in connection with the services performed under this Contract. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; provided, however, that the receiving Party gives reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and assists the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or court does not relieve the receiving Party of its confidentiality obligations with respect to the other Party.

8.4 CONTRACTOR shall establish and maintain environmental, safety, and facility procedures, data security procedures and other safeguards against the unauthorized access, destruction, loss, or alteration of CalOptima's Confidential Information in the possession, custody, or control of CONTRACTOR. Those security procedures and other safeguards shall be no less rigorous than those maintained by CONTRACTOR for its own information of a similar nature.

8.5 Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party or destroy all documents, notes, and other tangible materials representing the disclosing Party's Confidential Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

8.6 If a breach of the obligations under this Section 8 occurs, the injured Party may be entitled to such injunctive relief and any and all other remedies available at law or in equity. This Section 8 in no way limits the liability or damages that may be assessed against a Party if another Party breaches any of the provisions of this Section 8.

8.7 This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit protected health information ("**PHI**"). As such, no BAA is required for this Contract; provided, however, that if CONTRACTOR or its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, PHI regarding CalOptima members during the Term, CONRACTOR and its employees, agents, and subcontractors shall immediately notify CalOptima, protect such PHI from any additional disclosure, not use or disclose that PHI in any way that would violate a federal or state privacy or security law, its implementing regulations, or any other state or federal law, and execute a BAA with CalOptima, as necessary and requested by CalOptima.

9. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 *et seq.*) (the "**PRA**"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless exempt from disclosure under the provisions of the PRA. CalOptima may be required to reveal certain information pursuant to the PRA believed to be proprietary or confidential by CONTRACTOR. If CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the PRA that are not so marked. If CalOptima receives a request under the PRA that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. Within five (5) days from receipt of CalOptima's notice, CONTRACTOR shall notify CalOptima if it intends to object to production of CONTRACTOR's information; otherwise CalOptima will respond to the PRA request according to the requirements of the PRA. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including attorneys' fees, and any costs awarded to the person or entity that sought CONTRACTOR's marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR-marked material (collectively referred to for purposes of this Section 9 as "**Public Records Act Claim(s)**"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

10. Modifications. CalOptima may modify the Contract upon written notice to CONTRACTOR at any time should such modification be required by CMS, DHCS, the DMHC, or applicable law or regulation ("**Regulatory Amendment**"). Any other modifications of the Contract that are not Regulatory

Amendments shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for CONTRACTOR's performance.

11. Assignments.

11.1 CONTRACTOR may not assign, transfer, or delegate any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole discretion. If CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, or delegation may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, or delegation made without CalOptima's express written consent shall be void.

11.2 For purposes of this Section 11, an assignment is: (1) the change of more than fifty percent (50%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than fifty percent (50%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12. Subcontracts. CONTRACTOR may not subcontract or delegate its obligations or the performance of services under this Contract without CalOptima's prior written consent, which CalOptima may exercise in its sole discretion. CalOptima-approved subcontractors are listed in Addendum 1 to Exhibit A.

13. Term. This Contract shall commence on the Effective Date and shall continue in full force and effect through December 31, 2026 ("**Initial Term**"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to One additional consecutive Two-year term ("**Extended Term**"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. The Initial Term together with any Extended Term constitute the "**Term**" of this Contract.

14. Termination.

14.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days' prior written notice. Upon termination, CalOptima shall pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

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

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

14.2.2 In the event of termination under Section 14.2.1, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall

not be entitled to payment for any other items, including lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

14.3 Termination for Default. CalOptima may immediately terminate this Contract upon notice to CONTRACTOR for (i) CONTRACTOR's bankruptcy, (ii) if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR; or (iii) if CONTRACTOR makes an assignment, as defined in Section 11, for the benefit of creditors ("**Termination for Default**").

14.4 Termination for Breach. Either Party may at its option, terminate this Contract by notice to the other Party if the other Party breaches one of its obligations under this Contract and fails to cure that breach or default within thirty (30) days after receiving notice identifying that breach, provided that the non-breaching party may terminate the Contract immediately upon written notice if the non-breaching Party reasonably determines that cure of the default within thirty (30) days is impossible. The rights described in this Section 14.4 to terminate this Contract shall be in addition to any other remedy available to the non-breaching Party, whether under this Contract or in law or equity, on account of that breach.

14.5 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3 (Insurance) or Section 8 (Confidential Material).

14.6 Effect of Termination. Upon expiration or receipt of a termination notice under this Section 14:

14.6.1 CONTRACTOR shall promptly discontinue all services (unless CalOptima's notice directs otherwise) and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs, and any other products, data and such other materials, equipment, and information, including Confidential Information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure.

14.6.2 CalOptima may take over the services and may award another party a contract to complete the services under this Contract.

14.6.3 In the event of termination under Sections 14..3, 14.4, or 14.5, either Party shall be liable for any and all reasonable costs incurred by the non-breaching Party as a result of such a termination.

15. Dispute Resolution

15.1 Meet and Confer. If either Party has a dispute arising under or related to this Contract, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 15.2.

15.2 Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq.*) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS;

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

15.3 Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 15.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the meet-and-confer processes.

15.4 Waiver. By agreeing to binding arbitration as set forth in Section 15.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

16. General Provisions.

16.1 Non-Exclusive Relationship. This is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

16.2 Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima vendor policies relating to services under the Contract that are in effect when this Contract is signed or that come into effect during the Term and are available to CONTRACTOR on CalOptima's website.

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

16.4 Time is of the Essence. Time is of the essence in performance of this Contract.

16.5 Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. If any Party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

16.6 Force Majeure. When satisfactory evidence of a cause beyond a Party's control is presented to the other Party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the Party not performing, a Party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause,

including any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local governments, or a material act or omission by the other Party. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of Ten (10) days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

16.7 Notices. All notices required or permitted under this Contract shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any notice not related to termination of this Contract may be submitted electronically to the address set forth below. Any Party whose address changes shall notify the other Party in writing.

To CONTRACTOR:	**To CalOptima Health:**
Chamber Hill Strategies	CalOptima Health
601 New Jersey Ave, NW, Suite 620	505 City Parkway West
Washinton, DC 20001	Orange, CA 92868
Attention: Shawn Friesen	Attention: Kim Marquez
Email: sfriesen@chamberhill.com	Email: kmarquez@caloptima.org

16.8 Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima.

16.9 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the Parties agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability related to this Contract. [County of Orange Ordinance No 3896, codified in Orange County Municipal Code Section 4-11-7(a)]

16.10 Entire Agreement. This Contract, including all exhibits, addenda, and Contract Documents, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations, and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

16.11 Waiver. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in a writing that is signed and dated by the Parties. A waiver by either of the Parties of a breach of any of the covenants, conditions, or agreements to be performed by the other Party shall not be construed to be a waiver of any succeeding breach of the Contract or of any other covenant or condition of the Contract. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

16.12 Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Sections 4 (Indemnification), 5 (Independent Contractor), 8 (Confidential Material), 9 (California Public Records Act), 14.6 (Effect of Termination), 15 (Dispute Resolution), 16.3 (Names and Marks), 16.5 (Choice of Law), 16.9 (No Liability of County of Orange), this Section 16.12, 16.14 (Interpretation), 16.15 (Third-Party Beneficiaries), 16.16 (Successors and Assigns) and any other Contract provisions that by their nature are intended to survive termination or expiration of this Contract.

16.13 Severability. If any section, subsection or provision of this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall remain in effect.

16.14 Interpretation. The terms of this Contract are the result of negotiation between the Parties. Accordingly, any rule of construction of contracts (including California Civil Code Section 1654) that ambiguities are to be construed against the drafting party shall not be employed in the interpretation of this Contract.

16.15 Third Party Beneficiaries. There are no intended third-party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

16.16 Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties. Nothing in this Contract is intended to confer upon any party other than the Parties or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

16.17 Without Limitation. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

16.18 Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

16.19 Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

16.20 Recitals and Exhibits. The recitals, exhibits, and addenda attached to this Contract are made a part of the Contract by this reference.

[Signatures follow on next page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 24-11007 on the day and year last shown below.

Chamber Hill Strategies	CalOptima Health
By:	By:
Print Name: Jennifer Bell	Print Name:
Title: Founding Partner	Title:
Date: 05-22-2024	Date:

By:	By:
Print Name:	Print Name:
Title:	Title:
Date:	Date:

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EXHIBIT A
Scope of Work

1. **Description of Work**

1.1. **Purpose**

Contract shall represent CalOptima's interests, as specified below, in Washington, DC, and have the responsibility of monitoring and influencing legislative and regulatory policies, building and maintaining positive and mutually beneficial relationships with officials, and providing CalOptima with necessary advocacy services.

1.2. **Reporting Relationship**

The Chief Executive Officer; Chief Administrative Officer; Chief of Staff; Senior Director, Federal & Local Government Affairs; and Director, Public Policy; and/or their designees will be the primary contacts and will direct the work of the CONTRACTOR.

1.3. **Objectives/Deliverables**

CONTRACTOR agrees to provide to CalOptima, as requested by CalOptima, the following services:

1.3.1. Register and serve as a legislative advocate for CalOptima pursuant to the rules, procedures, and reporting requirements of the Clerk of the United States House of Representatives, the Secretary of the United States Senate, and any other necessary entities for which registration and reporting may be necessary.

1.3.2. Regularly consult with CalOptima's primary contacts and other contracted advocacy firms regarding CalOptima's government affairs program.

1.3.3. Develop a robust, proactive advocacy strategy with CalOptima's Government Affairs Department, Executive Office, and Board, including by providing ongoing legislative/political analysis and strategic and tactical recommendations regarding CalOptima's advocacy priorities and activities.

1.3.4. Maintain regular contact with leadership and staff of the federal government of the United States of America, including but not limited to the following entities:

- United States Senate:
  - Committee on Finance (including the relevant subcommittees thereof);
  - Committee on Health, Education, Labor and Pensions (including the relevant subcommittees thereof);
- United States House of Representatives:
  - Committee on Ways and Means (including the relevant subcommittees thereof);
  - Committee on Energy and Commerce (including the relevant subcommittees thereof);
- Executive Office of the President of the United States (EOP);
- United States Department of Health and Human Services (HHS);
- United States Centers for Medicare and Medicaid Services (CMS); and
- Any other federal departments, agencies, boards, and commissions, when directed by CalOptima.

1.3.5. Prioritize the development of relationships with Members of Congress who represent any portion of Orange County, as well as any staff thereof, to improve their awareness and positive perception of CalOptima, secure their alignment with and advocacy for CalOptima's positions, and improve opportunities for current and future collaboration.

1.3.6. As directed by CalOptima, brief Orange County's Congressional delegation with CalOptima updates, publications and other informational items. These may include the annual Report to the Community, Fast Facts, and other materials.

1.3.7. Arrange meetings and briefings for CalOptima Board and staff with federal officials and staff. Contractor shall be proactive in scheduling strategic, targeted meetings and briefings, especially but not limited to times when CalOptima Board and staff are scheduled to be in Washington, DC.

Meetings and briefings may include formal briefings, as well as informal social meetings, as appropriate.

1.3.8. Notify CalOptima of anticipated, introduced or amended federal legislation, as well as proposed and final administrative, budgetary, and regulatory actions which could impact CalOptima. These activities include but are not limited to the following:
- Providing the bill number and brief summary of introduced or amended federal legislation;
- Providing copies of legislation, committee analyses, and any other relevant analyses;
- Providing information relative to Congressional hearings;
- Providing a brief summary of proposed and final administrative, budgetary, and regulatory actions; and
- Providing recommendations regarding CalOptima's response, engagement, and advocacy.

1.3.9. Identify new programs and funding opportunities that relate to CalOptima.

1.3.10. Advocate for CalOptima's programs, positions on legislation introduced in the United States Congress, and positions on administrative, budgetary, and regulatory proposals introduced by federal agencies and the EOP. Advocacy activities include but are not limited to the following:
- Developing and implementing an advocacy strategy;
- Coordinating and engaging in virtual and in-person meetings;
- Drafting and submitting written letters of support and opposition;
- Drafting bill amendments to proposed legislation, as well as circulating and securing support for such amendments from Members of Congress and their staff;
- Identifying witnesses, preparing written testimony, and delivering verbal testimony as directed before committees of the United States Congress; and
- Optional: If necessary, although not anticipated, creating and leading an advocacy coalition on behalf of CalOptima, pursuant to the additional payment terms outlined in Exhibit B and subject to the advance approval of the Chief Executive Officer and added via signed amendment by both parties.

1.3.11. Proactively identify and engage in additional opportunities for CalOptima to influence federal legislative, regulatory, budgetary, and administrative proposals and policymaking processes for the benefit of CalOptima.

1.3.12. Maintain relationships with, and engage in partnership opportunities with, CalOptima's trade associations and other health care and non-health care associations and organizations to advance CalOptima's shared advocacy priorities.

1.3.13. Provide monthly, written reports which shall include federal legislative, regulatory, budgetary, and administrative updates, as well as a description of the nature and extent of services or actions taken on behalf of CalOptima. The services and actions shall include a summary of the Contractor's meetings along with the issues discussed with Members of Congress, Congressional staff, and appropriate federal departments, agencies, boards, commissions, and any staff thereof. The reports shall be delivered on a schedule as directed by CalOptima staff and may be included in the publicly available CalOptima Board agendas and/or otherwise provided to Board members. The frequency of written reports may be modified at any time.

1.3.14. Provide in-person and/or over-the-phone briefings, as directed by CalOptima staff, to the CalOptima Board and executive leadership. Contractor shall provide an in-person briefing at no less than one and no more than two public meetings of the CalOptima Board per calendar year.

1.3.15. Provide to CalOptima staff the copies of all written correspondence, testimony, and position papers given on behalf of CalOptima, as well as access to federal appropriations documents and any other relevant materials, as they become available.

1.3.16. CalOptima staff may prepare a formal annual review of Contractor's work product at the end of each calendar and/or fiscal year.

1.4. **Performance of Duties**
CONTRACTOR agents shall faithfully, industriously, and to the best of their ability, experience, and talents, perform all of the duties that may reasonably be assigned to him or her hereunder and devote such time to the performance of such duties as may be necessary, therefore.

2. Standard of Performance; Warranties.

2.1. CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

2.2. If CONTRACTOR may subcontract for services under this Contract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work and will comply with all applicable provisions of this Contract.

2.3. CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR. CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. If CONTRACTOR fails to adjust, repair, correct, or perform other work made necessary by such defects, CalOptima may make such adjustments, repairs, and/or corrections and charge CONTRACTOR the costs incurred.

2.4. CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

2.5. CONTRACTOR's obligations under this Section 2 are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both Parties.

2.6. Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

3. Record Ownership and Retention.

3.1. The originals of all letters, documents, reports, and any other products and data prepared or generated for the purposes of this Contract shall be delivered to and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

3.2. CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

4. Required Insurance

4.1. Commercial General Liability, including contractual liability and coverage for independent contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

4.1.1. Per occurrence: $1,000,000

4.1.2. Personal Advertising Injury: $1,000,000

4.1.3. Products Completed Operations: $2,000,000

4.1.4. General Aggregate: $2,000,000

4.2. If Contractor or subcontractors are on CalOptima's premises or transporting CalOptima members or employees, Commercial Automobile Liability covering any auto, whether owned, lease, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

4.3. Worker's Compensation and Employer's Liability Policy written in accordance with applicable laws and providing coverage for all of CONTRACTOR's employees:

4.3.1. The policy must provide statutory coverage for Worker's Compensation.

4.3.2. The policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

4.4. Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with $1,000,000 per occurrence and $2,000,000 general aggregate.

4.5. Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and them of client property with $1,000,000 limits per occurrence.

4.6. Cyber Liability insurance with the minimum limits of insurance listed below covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

4.6.1. One Million ($1,000,00.00) each occurrence/claim and One Million ($1,000,00.00) aggregate.

4.7. "**Occurrence**" means any event or related exposure to conditions that result in bodily injury or property damage.

EXHIBIT A
Addendum 1

The following is a list of subcontractors approved to perform Services under this Contract:

Subcontractor Name	Functions
N/A	N/A

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EXHIBIT B
Payment

1. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

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

3. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 24-11007; detailed description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

4. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that for the Initial Term of the Contract, CalOptima's monthly payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed $27,500.00 Dollars per month, including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract. This rate is fixed for the duration of the Contract. If the contract is extended for the Extended Term, CalOptima and CONTRACTOR mutually agree that CalOptima's monthly payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed $30,000.00 Dollars per month.

5. If the contract is terminated at any point mid-month, the final month payment will be prorated on a daily basis, calculated at 1/30th of the monthly retainer.

6. Not included in the maximum cumulative payment obligation above in Section 4, CONTRACTOR shall also invoice CalOptima on a monthly basis for travel-related expenses. All expenses charged to CalOptima under this Contract shall be consistent with CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. Travel-related expenses shall not exceed $12,000.00 annually. CONTRACTOR shall be required to travel to CalOptima at least one time annually, and a maximum amount of two times annually. CalOptima shall not pay CONTRACTOR for time spent traveling.

7. Not included in the maximum cumulative payment obligation above in Section 4, if both parties agree to utilize the optional Coalition SOW listed in Exhibit A (1.3.10, bullet 6), CalOptima's monthly payment obligation hereunder for work performed and/or products received shall not exceed $5,000.00 Dollars per month while that piece of the SOW is active. If that SOW is initiated or terminated at any point mid-month, the first and last month payment will be prorated on a daily basis, calculated at 1/30th of the monthly retainer.

EXHIBIT B-1

[Not applicable to this Contract]

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EXHIBIT C
Regulatory Requirements

CalOptima is a public agency and is licensed by the DMHC. In addition, CalOptima arranges for the provision of Medi-Cal services to Medi-Cal beneficiaries under a contract with DHCS ("**DHCS Contract**") and Medicare Advantage ("**MA**") services to Medicare beneficiaries under a contract CMS ("**CMS Contract**"). This Exhibit C sets forth the statutory, regulatory, and contractual requirements that CalOptima must incorporate into the Contract as a public agency and DMHC-licensed health care service plan with MA and Medi-Cal products.

1. **Medi-Cal Requirements.**

1.1. Compliance with Medi-Cal Standards. CONTRACTOR agrees that the Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract, including 42 C.F.R. § 438.230; Health & Safety Code § 1340 *et seq.* (unless otherwise excluded under the DHCS Contract); 28 C.F.R. § 1300.43 *et seq.*; Welfare & Institutions Code § 14000 *et seq.*; and 22 C.C.R. §§ 53800 *et seq.*, 22 C.C.R. §§ 53900 *et seq.* CONTRACTOR and Subcontractors shall comply with all applicable requirements of the Medi-Cal program pertaining to its reporting requirements and other obligations under this Contract, including Medicaid and Medi-Cal laws and regulations, sub-regulatory guidance, DHCS all plan letters, and the DHCS Contract and comply with all monitoring of the DHCS Contract and any other monitoring requests by DHCS. CalOptima or DHCS may revoke any activity under this Contract, including terminating this Contract, if CONTRACTOR and/or its Subcontractors do not perform that activity in compliance with the requirements in this Exhibit C. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsections B.7-B.8, B.11, B.28; 42 C.F.R. § 438.230]

1.2. Disclosure of Officers, Owners, Stockholders and Creditors. Pursuant to Exhibit A, Attachment III, § 1.3.5 of the DHCS Contract and 42 C.F.R. Section 455.104, upon the Effective Date, on an annual basis, and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit D of this Contract and submitting the form to CalOptima:

1.2.1. All officers and owners who own greater than five percent (5%) of the CONTRACTOR;

1.2.2. All stockholders owning greater than five percent (5%) of any stock issued by CONTRACTOR; and

1.2.3. All creditors of CONTRACTOR's business if such interest is over five percent (5%).

1.3. Compliance with Employment and Labor Laws. Each Party shall, at its own expense, comply with all applicable laws in performing their respective obligations under the Contract, including, but not limited to, the National Labor Relations Act, the Americans With Disabilities Act, all applicable employment discrimination laws, overtime laws, tax laws, immigration laws, workers' compensation laws, occupational safety and health laws, and unemployment insurance laws and any regulations related thereto. CONTRACTOR acknowledges and agrees that:

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

subcontractors' obligation to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees. [DHCS Contract, Exhibit D(f), Provision 1.a.]

1.3.2. CONTRACTOR and its subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. [DHCS Contract, Exhibit D(f), Provision 1.b.]

1.3.3. CONTRACTOR and its subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State of California, advising the labor union or workers' representative of CONTRACTOR and its subcontractors' commitments under this Section 1.3 and shall post copies of the notice in conspicuous places available to employees and applicants for employment. [DHCS Contract, Exhibit D(f), Provision 1.c.]

1.3.4. CONTRACTOR and its subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212), and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and of the rules, regulations, and relevant orders of the Secretary of Labor. [DHCS Contract, Exhibit D(f), Provision 1.d.]

1.3.5. CONTRACTOR and its subcontractors will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246, Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders. [DHCS Contract, Exhibit D(f), Provision 1.e.]

1.3.6. If CONTRACTOR and its subcontractors' do not comply with the requirements of this Section 1.3 or with any federal rules, regulations, or orders referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law. [DHCS Contract, Exhibit D(f), Provision 1.f.]

1.3.7. CONTRACTOR and its subcontractors will include the provisions of this Section 1.3 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity", and as supplemented by regulation at 41 C.F.R. part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor", or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment

Assistance Act, so that such provisions will be binding upon each subcontractor. CONTRACTOR and its subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that if CONTRACTOR and its subcontractors become involved in, or are threatened with litigation by a subcontractor as a result of such direction by DHCS, CONTRACTOR and its subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation to protect the interests of the State of California and of the United States. [DHCS Contract, Exhibit D(f), Provision 1.g.]

1.4. Debarment and Suspension Certification.

1.4.1. By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable federal suspension and debarment regulations, including, as applicable, 7 C.F.R. 3017, 45 C.F.R. 76, 40 C.F.R. 32, or 34 C.F.R. 85. [DHCS Contract, Exhibit D(f), Provision 20.a.]

1.4.2. By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

1.4.2.1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any state or federal department or agency; [DHCS Contract, Exhibit D(f), Provision 20.b.(1)]

1.4.2.2. Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state anti-trust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; [DHCS Contract, Exhibit D(f), Provision 20.b.(2)]

1.4.2.3. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in Section 1.4.2.2 of this Exhibit C; [DHCS Contract, Exhibit D(f), Provision 20.b.(3)]

1.4.2.4. Have not within a three (3)-year period preceding the Effective Date of this Contract had one or more public transactions (federal, state or local) terminated for cause or default; [DHCS Contract, Exhibit D(f), Provisions 20.b.(4)(5)]

1.4.2.5. Have not and shall not knowingly enter into any lower-tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 C.F.R. 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State of California; and [DHCS Contract, Exhibit D(f), Provision 20.b.(6)]

1.4.2.6. Will include a clause entitled, "Debarment and Suspension Certification" that sets forth the provisions herein in all lower-tier covered transactions and in all solicitations for lower-tier covered transactions. [DHCS Contract, Exhibit D(f), Provision 20.b.(7)]

1.4.3. If the CONTRACTOR is unable to certify any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima. [DHCS Contract, Exhibit D(f), Provision 20.c.]

1.4.4. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549. [DHCS Contract, Exhibit D(f), Provision 20.d.]

1.4.5. If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the federal government, CONTRACTOR shall promptly notify CalOptima in writing, and CalOptima may terminate this Contract for cause. [DHCS Contract, Exhibit D(f), Provision 20.e.]

1.5. Lobbying Restrictions and Disclosure Certification.

1.5.1. *Certification and Disclosure Requirements.*

1.5.1.1. If Contract is subject to 31 U.S.C. § 1352 and exceeds $100,000 at any tier, CONTRACTOR and its subcontractors, as applicable, shall file a certification (in the form set forth in Exhibit E, consisting of one page, entitled "Certification Regarding Lobbying") that CONTRACTOR and its subcontractors, as applicable, have not made, and will not make, any payment prohibited by Section 1.5.2 below. [DHCS Contract, Exhibit D(f), Provision 37.a.(1); 31 U.S.C. § 1352]

1.5.1.2. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure (in the form set forth in Exhibit E, entitled "Certification Regarding Lobbying") if CONTRACTOR and its subcontractors, as applicable, have made or agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with the Contract or a subcontract thereunder that would be prohibited under Section 1.5.2 below if paid for with appropriated funds. [DHCS Contract, Exhibit D(f), Provision 37.a.(2)]

1.5.1.3. CONTRACTOR and its subcontractors, as applicable, shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by CONTRACTOR and its subcontractors, as applicable, under this Section 1.5.1. An event that materially affects the accuracy of the information reported includes: [DHCS Contract, Exhibit D(f), Provision 37.a.(3)]

1.5.1.3.1. A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; [DHCS Contract, Exhibit D(f), Provision 37.a.(3)(a)]

1.5.1.3.2. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or [DHCS Contract, Exhibit D(f), Provision 37.a.(3)(b)]

1.5.1.3.3. A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action. [DHCS Contract, Exhibit D(f), Provision 37.a.(3)(c)]

1.5.1.3.4. As applicable and required by this Section 1.5, CONTRACTOR's subcontractors shall file a certification and a disclosure form, if required, to the next tier above. [DHCS Contract, Exhibit D(f), Provision 37.a.(4)]

1.5.1.3.5. All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by CONTRACTOR. CONTRACTOR shall forward all disclosure forms to CalOptima. [DHCS Contract, Exhibit D(f), Provision 37.a.(5)]

1.5.2. *Prohibition.* 31 U.S.C. § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for

influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. [DHCS Contract, Exhibit D(f), Provision 37.b.]

1.6. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will timely gather, preserve, and provide, upon written request of CalOptima, the Secretary of Health and Human Services Office of Inspector General, the Comptroller General of the United States, the U.S. Department of Justice, DHCS, the DMHC, the Bureau of Medical Fraud, or any of their duly authorized representatives, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. CONTRACTOR and Subcontractors must maintain all books and records in accordance with good business practices and generally accepted accounting principles. This provision shall also apply to any agreement with a CONTRACTOR Subcontractor or an organization related to a CONTRACTOR Subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsections B.12-B.15]

1.7. Confidentiality of Member Information.

1.7.1. If CONTRACTOR and its employees, agents, or subcontractors access or receive, whether intentionally or unintentionally, personally identifying information during the Term, CONTRACTOR and its employees, agents, and subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the express terms of and CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information, except requests for medical records in accordance with applicable law, not emanating from the CalOptima member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the CalOptima member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima specifying that the information is releasable under Title 42 C.F.R. Section 431.300 *et seq.*, Section 14100.2, Welfare and Institutions Code, and regulations adopted there under. For purposes of this Section 1.7, identity shall include name, identifying number, symbol, or other identifying detail assigned to the individual, such as finger or voice print or a photograph. [DHCS Contract, Exhibit D(f), Provision 14; Exhibit E, § 1.1.23]

1.7.2. Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq.*, Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to CalOptima members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with

applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a CalOptima member under this Contract that is obtained by CONTRACTOR or its subcontractors, CONTRACTOR will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose. [DHCS Contract, Exhibit D(f), Provision 14; Exhibit E, § 1.1.23]

1.8. Member Hold Harmless. To the extent CONTRACTOR provides services or supplies to CalOptima members, CONTRACTOR hereby agrees that in no event, including nonpayment by CalOptima, the insolvency of CalOptima, or breach of the Contract, shall CONTRACTOR bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against CalOptima members, persons acting on their behalf, or DHCS. CONTRACTOR further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of CalOptima members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or CONTRACTOR and a CalOptima member or persons acting on their behalf that relates to liability for payment for services under the Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsections A.13 and B.18; CMS Medicare Managed Care Manual Chapter 11, Section 100.4]

1.9. Member Grievances. CONTRACTOR shall cooperate with CalOptima's member grievances and appeals procedures as necessary for CalOptima to carry out its legal obligations. [DHCS Contract, Exhibit A, Attachment III § 4.6; 28 C.C.R. §§ 1300.68, 1300.68.01; 22 C.C.R. § 53858; 43 C.F.R. § 438.402-424]

1.10. Air and Water Pollution Requirements. If this Contract or any subcontract thereunder is in excess of one hundred thousand dollars ($100,000), CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 *et seq.*), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 *et seq.*), as amended. [DHCS Contract, Exhibit D(f), Provision 12]

1.11. Effective Dates. This Contract and its amendments will become effective only as set forth in the DHCS Contract, which requires filing and approval by DHCS of template contracts and amendments. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.2, 3.1.5, subsection B.4]

1.12. Prospective Requirements. CalOptima will inform CONTRACTOR of prospective requirements added by the State, federal law, or DHCS to the DHCS Contract that would impact CONTRACTOR's obligations before the requirement becomes effective. CONTRACTOR agrees to comply with the new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by DHCS. CONTRACTOR will ensure Subcontractors are (i) informed of prospective requirements that would impact their obligations before the requirements become effective and (ii) agree to comply with new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by DHCS. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsections B.22 and B.23]

1.13. DHCS Beneficiary. CONTRACTOR expressly agrees and acknowledges that (i) DHCS is a direct beneficiary of the Contract and any Subcontractor agreement with respect to the obligations and functions undertaken under the Contract, and (ii) DHCS may directly enforce any and all provisions of the Contract or Subcontractor agreement. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.29]

1.14. Termination. CONTRACTOR shall notify DHCS if this Contract or an agreement with a Subcontractor is amended or terminated for any reason. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.17; APL 19-001, Attachment A, Requirement 13]

1.15. Cultural Competency. CONTRACTOR and Subcontractors must ensure that cultural competency, sensitivity, health equity, and diversity training is provided for CONTRACTOR's and Subcontractor's staff at key points of contact with CalOptima members, if applicable. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.24]

1.16. Interpreter Services. CONTRACTOR and Subcontractors, to the extent they communicate with CalOptima members, will provide interpreter services for members and comply with language assistance standards developed pursuant to Health and Safety Code § 1367.04 [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.25]

1.17. Fraud Reporting. CONTRACTOR and Subcontractors must notify CalOptima within ten (10) business days of any suspected fraud, waste, or abuse, and CalOptima may share such information with DHCS in accordance with Exhibit A, Attachment III, Section 1.3.2 (D), Fraud and Abuse Reporting, of the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.26]

1.18. Overpayment Reporting. CONTRACTOR and all Subcontractors must report directly to CalOptima, or through CONTRACTOR or Subcontractor, as applicable, when it has received an overpayment; return the overpayment to CalOptima within sixty (60) calendar days after the date the overpayment was identified; and notify CalOptima in writing of the reason for the overpayment. [42 C.F.R. § 438.608(d)(2); DHCS Contract, Exhibit A, Attachment III, § 3.1.5, subsection B.27]

2. **Medicare Requirements.**

2.1. CONTRACTOR expressly warrants that CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. CONTRACTOR further agrees and acknowledges that this provision will be included in all agreements with CONTRACTOR's subcontractors.

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

2.2.1. Abide by all federal and state laws regarding confidentiality and disclosure of medical records and other health and enrollment information. CONTRACTOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purposes for which the information will be used within CONTRACTOR's organization; and (b) to whom and for what purposes CONTRACTOR will disclose the information.

2.2.2. Ensure that the medical information is used and released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas.

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

2.3. CONTRACTOR shall cooperate with CalOptima as necessary for CalOptima to comply with the reporting requirements provided in Title 42 of the Code of Federal Regulations, including Sections 422.516 and 422.310.

2.4. CONTRACTOR shall comply with the reporting requirements provided in 42 C.F.R. § 422.516, as well as the encounter data submission requirements in 42 C.F.R. § 422.257.

2.5. For all contracts in the amount of $100,000 or more, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 C.F.R. 60-300.5(a) and 41 C.F.R. 60-741.5(a) as follows:

2.5.1. CONTRACTOR and its subcontractors shall abide by the requirements of 41 C.F.R. § 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans. [41 C.F.R. § 60-300.5(d)]

2.5.2. CONTRACTOR and its subcontractors shall abide by the requirements of 41 C.F.R. § 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of

disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities. [41 C.F.R. § 60-741.5(d)]

2.6. In addition to the termination provisions of Section 14 of the Contract, CalOptima may terminate the Contract if CMS, DHCS, or CalOptima determines that CONTRACTOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay CONTRACTOR its allowable costs incurred to the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima for matters pertaining to this Contract.

2.7. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of the CMS Contract, CONTRACTOR shall comply with all such applicable requirements in the CMS Contract, at the direction of CalOptima.

2.8. CONTRACTOR shall ensure that the persons it employs or contracts with for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, defined in 42 C.F.R. § 422.2. CONTRACTOR shall promptly disclose to CalOptima any exclusion or other event that makes a CONTRACTOR employee or subcontractor ineligible to perform work related to federal health care programs. CONTRACTOR agrees to be bound by the provisions set forth at 2 C.F.R. Part 376. [42 C.F.R. § 422.752(a)(8)]

3. **Offshore Performance.**

3.1. Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by CalOptima prior to the provision of those services.

3.2. CONTRACTOR shall complete, sign, and return Exhibit G, "Attestation Concerning the Use of Offshore Subcontractors" as of the Effective Date and shall submit an executed Offshore Subcontractor Attestation to CalOptima no less than annually thereafter. CONTRACTOR represents and warrants that it has disclosed in Exhibit G any and all such offshore subcontractors and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the Effective Date.

3.3. Any subcontract with an offshore entity under which the offshore entity will have access to any confidential CalOptima member or other protected health information must be approved in writing by CalOptima prior to execution of the subcontract. CONTRACTOR is required to submit future Offshore Contractor Attestations to CalOptima within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

3.4. Unless specifically stated otherwise in this Contract, the restrictions of this Section 3 do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

3.5. The provisions of this Section 3 apply to work performed by subcontractors at all tiers.

4. **Prohibited Interest.**

4.1. CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq.*) and California Government Code § 1090 *et seq.* (collectively, the "**Conflict of Interest Laws**").

4.2. CONTRACTOR covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during his or her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. [22 C.C.R. § 53600(d)]. CONTRACTOR further covenants that, for the Term, and consistent with the provisions of 22 C.C.R. § 53600(f), no state officer or state employee shall be employed

in a management or contractor position by CONTRACTOR within one (1) year after the state office or state employee has terminated state employment.

4.3. CONTRACTOR, and any person designated by CONTRACTOR to make or participate in making a governmental decision on behalf of CalOptima, is considered a "**Consultant**" pursuant to CalOptima's Conflict of Interest Code and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually. [2 C.C.R. Section 18734]

4.4. CONTRACTOR understands that if this Contract is made in violation of California Government Code § 1090 *et seq.*, the entire Contract is voidable, CONTRACTOR will not be entitled to any compensation for services performed pursuant to this Contract, and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that CONTRACTOR may be subject to criminal prosecution for a violation of California Government Code § 1090.

4.5. If CONTRACTOR becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 4, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

5. **State Auditor Audit Disclosure**. Pursuant to California Government Code § 8546.7, if this Contract is more than ten thousand dollars ($10,000), it is subject to examination and audit of the California State Auditor, at the request of CalOptima or as part of any audit of CalOptima for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract, CONTRACTOR agrees that during the Term and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period. [Gov't Code § 8546.7]

EXHIBIT D
Medi-Cal Disclosure Form

Contractor Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: DC Health Care Advisors, LLC d/b/a Chamber Hill Strategies

Business Entity Type: LLC
(Sole Proprietorship, Partnership, LLC, California Corporation, etc.)

Business Address: 601 New Jersey Avenue NW Suite 620

City: Washington State: DC Zip: 20001

Business Phone: 202-470-4944 Email: : jbell@chamberhill.com

President: Jennifer Bell Contact Person: Jennifer Bell

Person(s) Signing Contract & Title: : Jennifer Bell

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
Jennifer Bell	Founding Partner / 100%

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

Jeff Bell
Authorized Signature

05-22-2024
Date

Founding Partner
Name and Title

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EXHIBIT E

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

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

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

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

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

DC Health Care Advisors, LLC d/b/a Chamber Hill Strategies
Name of Contractor

Jennifer Bell
Printed Name of Person Signing for Contractor

24-11007
Contract/Grant Number

Signature of Person Signing for Contractor

05-22-2024
Date

Founding Partner
Title

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

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

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: ☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	2. Status of Federal Action: ☐a. bid/offer/application ☐b. initial award ☐c. post-award	3. Report Type: ☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____
4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*:	
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:	
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____	
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*):	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): *(attach Continuation Sheet(s) SF-LLLA, if necessary)*	
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned 12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value _____	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____	
14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: *(Attach Continuation Sheet(s) SF-LLL-A, If necessary)*		
15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No		
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:	
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL	

Rev. 07/2022

Contract No. XX-XXXXX

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

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

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.
2. Identify the status of the covered federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.
4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.
6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.
7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."
9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

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.

EXHIBIT F

[Not applicable to this Contract]

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EXHIBIT G

CalOptima
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Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and Contractor must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☒ OneCare Connect ☒ PACE ☒ OneCare ☐ Medi-Cal

Please check one of the following:

☒ **Our Organization does not offshore any protected health information.**
Please skip to Part V below

☐ **Our Organization does offshore protected health information.**
Please complete Offshore Subcontractor Attestation (Part I through Part V) below

Part I — Offshore Subcontractor Information

Attestation	**Response**
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima	☐ Yes ☒ No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)

Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

CalOptima
Better. Together

Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐ Yes ☐ No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐ Yes ☐ No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐ Yes ☐ No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐ Yes ☐ No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐ Yes ☐ No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐ Yes ☐ No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐ Yes ☐ No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person: Jennifer Bell	Title: Founding Partner
Email: jbell@chamberhill.com	Phone #: 202-470-4944
Signature: Jennifer Bell	Date: 05-22-2024

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

EXHIBIT H

[Not applicable to this Contract]

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

12. Approve Actions Related to the Utilization Management Clinical Decision Criteria Application

Contacts

Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013
Richard Pitts, M.D., Chief Medical Officer, (714) 246-8491

Recommended Actions

Authorize the Chief Executive Officer, or designee, to amend and extend the contract with MCG Health through June 30, 2029.

Background

MCG Health is the current application CalOptima Health uses to access national evidence-based clinical guidelines to make decisions on treatment authorizations. The contract between MCG Health and CalOptima Health has been in existence since 2008 and expires on June 30, 2024. The original contract began April 1, 2008, with an initial expiration date of March 31, 2017. On September 1, 2016, the Board approved an extension of the contract through March 31, 2021. On June 6, 2019, staff submitted a COBAR, which included several software license contracts to be extended including MCG Health, and the Board approved an extension to June 30, 2024. The MCG Health application is a leader and sole acceptable source for evidence-based criteria, is integrated into the Jiva Clinical Platform, and delivers improved clinical decision support as staff manage the health of members. Change Healthcare InterQual is the only other software product vendor like MCG Health; however, the InterQual system does not interface with Jiva and is unable to meet CalOptima Health requirements.

Discussion

MCG Health streamlines care coordination through use of clinical criteria when making treatment authorization decisions for members. CalOptima Health uses the MCG Health application to make informed decisions for inpatient admissions, outpatient procedures, skilled nursing, ambulatory, behavioral health, and home health. The amendment also includes an application module designed to integrate with the clinical platform Jiva for automating authorizations between providers and the application portal. This will also support prior authorization regulatory requirements between provider electronic health record systems and CalOptima Health.

Pursuant to Section II.B.7.b. of CalOptima Health Policy GA.5002: Purchasing, this is a non-competitive, non-emergency procurement that will be completed on a sole source basis. The contracted services are necessary to conform with the existing clinical platform, Jiva and are only available from a single source, MCG Health. The MCG Health contract extension is aligned with the Jiva clinical platform contract dates. Extending the contract with MCG Health will also position CalOptima Health to meet the Centers for Medicare and Medicaid (CMS) Interoperability Prior Authorization Final Rule (CMS-57-F) requirements due January 1, 2027.

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Fiscal Impact

The average annual cost for the MCG Health contract is approximately $2.0 million. Funding for the period of July 1, 2024, through June 30, 2025, is included in the proposed Fiscal Year 2024-25 Operating Budget. Staff will include operating expenses for subsequent contract years in future operating budgets.

Rationale for Recommendation

The approval to extend the contract with MCG Health ensures continued use of clinical based criteria for treatment authorizations, streamlines same day treatment authorizations with automation, and aligns with the clinical operations core system, Jiva.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MCG Health	701 Fifth Avenue, Suite 4900	Seattle	WA	98104

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

13. Authorize the Chief Executive Officer to Execute an Amendment to the Contract with Kennaday Leavitt PC

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570

Recommended Action(s)

1. Authorize the Chief Executive Officer to execute an amendment to the contract with Kennaday Leavitt PC, to serve as general counsel, to update payment terms and renew the terms of the contract for three (3) years effective November 1, 2024, with two (2) additional one-year extension options, each exercisable at CalOptima Health's sole discretion.

Background

On September 2, 2021, the CalOptima Health Board of Directors (Board) authorized the release of a Request for Proposals (RFP) for an outside law firm to serve as the agency's general counsel to augment, and integrate with, the legal services provided by the agency's employed and contracted lawyers. Based on the outcome of that RFP, on November 4, 2021, the Board authorized the Chief Executive Officer (CEO) to execute a contract with Kennaday Leavitt PC (Kennaday Leavitt). The term of the contract was November 4, 2021, through October 31, 2022, with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

On May 5, 2022, the Board authorized the CEO to amend the contract with Kennaday Leavitt with additional scope of work that reflected the transition from a mixed internal and external legal services model to a full external legal services model. The Board also authorized revisions to the payment terms from a mixed retainer and hourly rate model to a blended hourly rate model and increased the travel allowance for increased onsite presence. CalOptima Health's contract with Kennaday Leavitt expires October 31, 2024. CalOptima and Kennaday Leavitt executed Amendment No. 1 on May 11, 2022, Amendment No. 2 on October 11, 2022, and Amendment No. 3 on November 01, 2023.

On May 2, 2024, the Board authorized the CEO to negotiate an amendment to the contract with Kennaday Leavitt, to update rates and extend the term from November 1, 2024, through October 31, 2027, with the option for two additional one-year extensions. CalOptima and Kennaday Leavitt executed Amendment No. 4 on May 29, 2024.

Discussion

CalOptima Health uses a full external legal services model and does not employ legal staff. Kennaday Leavitt provides legal services for all aspects of CalOptima Health's operations including, but not limited to, contracts and other legal documents drafting, review, and negotiations; legal and regulatory analyses; representation for regulatory and legal hearings and disputes; litigation; and review of all Board materials. Given the level of integration into daily operations and the satisfactory level of performance, and most importantly, the active legal issues, it is not a practical or effective use of resources for CalOptima Health to seek a change in legal counsel.

Back to Agenda

CalOptima Health also reviewed utilization patterns including the areas that require more legal support, and the level of legal support needed. Staff also reviewed rates for other legal firms, including CalOptima Health's other external legal firms. The current payment terms with Kennaday Leavitt include a blended hourly rate of $150 for paralegal services and a blended hourly rate of $475 for attorney services. Given the areas of need and the associated expertise required, staff proposes to amend hourly rates as follows:

- No change to paralegal services: $150
- Associates and Senior Associates: $475
- Partner: $575
- Senior Partner: $675

In addition, staff propose a 3.5% annual rate increase. Assessment of rates in the market shows that these are favorable rates for CalOptima Health.

Management requests the Board authorize the CEO to negotiate and execute an amendment to the contract with Kennaday Leavitt to update rates and extend the term from November 1, 2024, through October 31, 2027, with the option for two additional one-year extensions.

Fiscal Impact

The proposed Fiscal Year 2024-25 Operating Budget includes sufficient funding to support the contract for outside legal counsel services through June 30, 2025. Management will include operating expenses for subsequent contract years in future operating budgets.

Rationale for Recommendation

The requested amendments to the Kennaday Leavitt contract will ensure continuous and consistent legal services.

Attachments

1. Entities Covered by this Recommended Action
2. Amendment 1 to Contract No. 22-10289 between CalOptima and Kennaday Leavitt PC
3. Amendment 2 to Contract No. 22-10289 between CalOptima and Kennaday Leavitt PC
4. Amendment 3 to Contract No. 22-10289 between CalOptima and Kennaday Leavitt PC
5. Amendment 4 to Contract No. 22-10289 between CalOptima and Kennaday Leavitt PC
6. Amendment 5 to Contract No. 22-10289 between CalOptima and Kennaday Leavitt PC

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kennaday Leavitt PC	400 Capitol Mall, #2840	Sacramento	CA	95814

AMENDMENT NO. 1 TO CONTRACT NO. 22-10289
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
AND
KENNADAY LEAVITT PC
(CONTRACTOR)

AMENDMENT NO. 1 to this CONTRACT is entered into as of the last date executed below and effective as of 05/05/2022 ("**Amendment Effective Date**") with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter, individually referred to as "**Party**" or collectively as the "**Parties**") entered into Contract 22-10289 on 11/04/2021 for Outside General Counsel Services.

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing and executed by both Parties.

C. The Parties now desire to amend the SOW and Payment Exhibits of the original Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Exhibit A, SCOPE OF WORK of the original Contract is hereby deleted and replaced with the Exhibit A, entitled SCOPE OF WORK which is attached hereto as Attachment A to this Amendment No. 1.

2. Exhibit B, PAYMENT of the original Contract is hereby deleted and replaced with the Exhibit B, PAYMENT attached hereto as Attachment B to this Amendment No. 1.

   2.1. For May 2022, CalOptima shall pay CONTRACTOR a prorated retainer of Eleven Thousand Two Hundred Dollars ($11,200) for the first 5 days of May, calculated at 5 days divided 31, or 16%, of the original Seventy Thousand Dollar ($70,000) monthly retainer fee. The remaining 26 of 31 days will be billed in accordance with the fees outlined in Attachment B to this Amendment No. 1.

3. **No Other Changes.** This Amendment No 1 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. 1 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

4. **Authority to Execute.** The persons executing this Amendment on behalf of the Parties warrant that they are duly authorized to execute this Amendment and that by executing this Amendment, the Parties are formally bound.

5. **Counterparts.** This Amendment may be executed in any number of counterparts, all of which taken together shall constitute one and the same instrument, and any of the Parties hereto may execute the Amendment by signing any such counterpart.

[Signature Page Follows]

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 1 to Contract 22-10289 on the day and year last signed below.

KENNADAY LEAVITT PC

Signature: _____

Name: Kelli M. Kennaday

Title: Partner

Date: May 11, 2022

Signature: _____

Name: James F. Novello

Title: Partner

Date: May 11, 2022

CALOPTIMA

Signature: DocuSigned by: Nancy Huang D22E3B87032946F...

Name: Nancy Huang

Title: CFO, CalOptima

Date: 05/11/2022

Signature: DocuSigned by: Michael Hunn EDDDDCC19C894FB...

Name: Michael Hunn

Title: CEO

Date: 05/11/2022

Exhibit A

SCOPE OF WORK

I. Introduction

CalOptima is Orange County's ("County") public managed care health plan for County residents who are eligible for Medi-Cal benefits. As a county organized health care system, or "COHS," it is the sole health plan that eligible County residents may access to receive Medi-Cal program benefits. CalOptima currently arranges for the delivery of Medi-Cal health care services to over 800,000 beneficiaries, and it is anticipated that that number may grow significantly in the coming years. CalOptima also has a Medicare-Medi-Cal product, and a Program of All-Inclusive Care for the Elderly (PACE) program, that both continue to grow in membership.

Managed care is a complex, expensive and challenging business. Managed care plans offering predominantly Medi-Cal programs, as well as dual-eligible and PACE programs, are even more complicated to operate because of substantial regulation by both the state and federal government. Managed Medi-Cal plans that are public agencies are also accountable to the public and must comply with the numerous laws regulating public entities in California ("Public Laws"). Public Medi-Cal plans like CalOptima therefore need legal advice and services relating to a wide array of complex and specialized subject matter areas to meet the demands of an ever-changing healthcare and economic environment and operate in an effective and compliant manner.

As part of its strategic planning efforts, the CalOptima Board of Directors ("Board") is considering how best to organize and marshal its legal resources to meet this substantial and increasing demand for legal services. To that end, the Board is retaining an outside law firm to serve as the agency's general counsel ("CONTRACTOR").

II. General Requirements.

A. The CONTRACTOR must have substantial experience in representing California managed care organizations ("MCO") that serve predominantly Medi-Cal populations. It must also be able to demonstrate experience representing MCOs serving dual-eligible and PACE program populations.

B. The CONTRACTOR must have an experienced senior lawyer who will serve as the principal and consistent point of contact with CalOptima personnel ("Principal Lawyer"). While it is anticipated that other CONTRACTOR lawyers may work on CalOptima matters from time to time, the Principal Lawyer will be the professional who regularly interacts with the Board, and management personnel.

C. While it is anticipated that the CONTRACTOR may have multiple offices, the CONTRACTOR must maintain its principal offices in California. The Principal Lawyer must be able to travel to the locations as requested by CalOptima.

III. Strategic Duties.

A. The CONTRACTOR will regularly provide the Board and management with reports on legal trends, issues, and best practices in California and across the healthcare industry, particularly in the public sector domain, that may materially affect CalOptima's business and mission, both currently and in the future.

B. The CONTRACTOR will regularly meet and confer with the Board and management to support CalOptima's strategic planning efforts as an integral member of CalOptima's senior management staff.

IV. Governance Duties.

A. The CONTRACTOR will report to the Board and to the Chief Executive Officer (CEO) and shall attend all regular and special meetings of the Board, as well as other Board committee meetings by request.

B. The CONTRACTOR will ensure compliance with all Public Laws related to CalOptima's governance.

C. The CONTRACTOR will provide the Board and the CEO with written summaries of all material legal issues concerning the agency on a regular basis, for monthly board meetings at a minimum.

V. Health Care and Privacy Oversight Duties.

A. The CONTRACTOR will work with CalOptima's compliance personnel to establish and periodically update CalOptima's health care compliance programs and policies.

B. The CONTRACTOR will regularly attend CalOptima compliance committee meetings.

C. The CONTRACTOR will engage, assist and manage outside compliance counsel and other consultants and support personnel as may be needed from time to time, in connection with investigations, audits, responses to regulatory authorities, and other compliance matters that are not routine.

D. The CONTRACTOR will report to the Board and management regarding any material compliance issues.

VI. Regulatory Duties.

A. The CONTRACTOR will ensure compliance with all regulatory requirements of the California Department of Health Care Services, the California Department of Managed Health Care, the federal Center for Medicare & Medicaid Services, and any other governmental entities with jurisdiction over the agency and its products and programs, including application and maintenance of required licenses or authorities to operate the plan and any product or program offerings

B. The CONTRACTOR will report to the Board and management regarding any material regulatory issues.

Managed Care Operations Duties.

A. The CONTRACTOR will ensure that all legal issues related to CalOptima's managed care operations ("Operations Issues") are handled and resolved in a timely and appropriate manner. Operations Issues may involve a broad range of subject matter areas, including without limitation general business operations, payor and provider contracting, credentialing and administration, utilization review and quality assurance, member grievance resolution, provider dispute resolution, vendor contracting, procurement, real estate, intellectual property and technology, Public Laws, risk management and insurance, labor and employment, and general litigation.

B. The CONTRACTOR will manage outside counsel and other consultants and support personnel as may be needed from time to time, to provide legal services in connection with Operations Issues.

C. The CONTRACTOR will report to the Board and management regarding any material Operations Issues affecting the agency.

VII. Management Duties.

A. The CONTRACTOR will be responsible for managing the overall legal affairs of the agency.

B. The CONTRACTOR will regularly advise the Board about the status of any material legal issues affecting the agency and will be expected to keep the Board apprised of any legal issues that could adversely or positively affect CalOptima activities.

C. The CONTRACTOR will act as an integral part of the CalOptima senior management staff and shall provide advice, guidance, and assistance to management to support CalOptima's mission, vision and business goals.

VIII. Legal Defense Duties

A. The CONTRACTOR will lead defense of CalOptima in matters of litigation before state and federal courts and defense of CalOptima in administrative proceedings brought by any state or federal agency.

B. The CONTRACTOR will engage, assist and manage outside counsel and other consultants and support personnel as may be needed from time to time, in connection with legal defense.

IX. Out of Scope Items

A. Prior to incurring and fees for the services listed in Section IX, A, i-iii, CONTRACTOR and CalOptima shall agree in writing to agree to these services and potential fees.

i. It may become necessary to for CONTRACTOR to hire experts, consultants or investigators to aid in CalOptima's legal matter. Such persons may be employed by CONTRACTOR on CalOptima behalf. CalOptima agrees to pay for these items in addition to the other CONTRACTOR fees for legal services. All of the costs shall be billed to CalOptima and CalOptima shall be responsible to pay all said costs.

Exhibit B

PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

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

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 22-10289; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Rates:

a. CalOptima agrees to pay contractor the following rates:

1. Attorney rates shall be paid at a blended rate for all attorneys working on Cal Optima matters at $475.00 per hours

2. Paralegal rates shall be paid for all paralegals working on Cal Optima matters at $150.00 per hour.

3. CONTRACTOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

E. CONTRACTOR shall also invoice CalOptima on a monthly basis for travel-related expenses. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. Travel related expenses shall not exceed Five Thousand Dollars ($5,000.00) per month. CalOptima shall not pay CONTRACTOR for time spent traveling.

F. CONTRACTOR shall also invoice CalOptima on a monthly basis for certain in-house services as outlined in the Engagement Letter. All expenses charged to CalOptima under this Contract shall be consistent with the Engagement Letter. Receipts or reasonable evidence thereof are required. In-House related expenses shall not exceed Five Hundred Dollars ($500.00) per month.

AMENDMENT NO. 2 TO CONTRACT NO. 22-10289
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
AND
KENNADAY LEAVITT PC
(CONTRACTOR)

AMENDMENT NO. 2 to this CONTRACT is entered into as of the last date executed below ("**Amendment Effective Date**") with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter, individually referred to as "**Party**" or collectively as the "**Parties**") entered into Contract 22-10289 on November 04, 2021, for Outside General Counsel Services, and Amendment No. 1 on May 11, 2022.

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing and executed by both Parties.

C. The Parties now desire to extend the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. The first of two options outlined in Section 15 of the Contract is hereby exercised and the contract is extended through October 31, 2023.

2. **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 Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

3. **Authority to Execute.** The persons executing this Amendment on behalf of the Parties warrant that they are duly authorized to execute this Amendment and that by executing this Amendment, the Parties are formally bound.

4. **Counterparts.** This Amendment may be executed in any number of counterparts, all of which taken together shall constitute one and the same instrument, and any of the Parties hereto may execute the Amendment by signing any such counterpart.

[Signature Page Follows]

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 2 to Contract 22-10289 on the day and year last signed below.

KENNADAY LEAVITT PC

Signature: _____

Name: Kelli M. Kennaday

Title: Partner

Date: October 10, 2022

Signature: _____

Name: James F. Novello

Title: Partner

Date: October 10, 2022

CALOPTIMA

Signature: DocuSigned by: Nancy Huang D22E3B87032946F...

Name: Nancy Huang

Title: CFO, CalOptima

Date: 10/11/2022

Signature: DocuSigned by: M. Hunn EDDDDCC19C894FB...

Name: Michael Hunn

Title: CEO

Date: 10/11/2022

AMENDMENT NO. 3 TO CONTRACT NO. 22-10289
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
AND
KENNADAY LEAVITT PC
(CONTRACTOR)

AMENDMENT NO. 3 to this CONTRACT is entered into as November 01, 2023 ("**Amendment Effective Date**") with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter, individually referred to as "**Party**" or collectively as the "**Parties**") entered into Contract 22-10289 on November 04, 2021, for Outside General Counsel Services, Amendment No. 1 on May 11, 2022, and Amendment No. 2 on October 11, 2022.

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing and executed by both Parties.

C. The Parties now desire to extend the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. The second of two options outlined in Section 15 of the Contract is hereby exercised and the contract is extended through October 31, 2024.

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 Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

3. **Authority to Execute.** The persons executing this Amendment on behalf of the Parties warrant that they are duly authorized to execute this Amendment and that by executing this Amendment, the Parties are formally bound.

4. **Counterparts.** This Amendment may be executed in any number of counterparts, all of which taken together shall constitute one and the same instrument, and any of the Parties hereto may execute the Amendment by signing any such counterpart.

[Signature Page Follows]

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 3 to Contract 22-10289 as of November 01, 2023.

KENNADAY LEAVITT PC

Signature: _____

Name: Kelli M. Kennaday

Title: Partner

Date: November 1, 2023

Signature: _____

Name: James F. Novello

Title: Partner

Date: November 1, 2023

CALOPTIMA

Signature: DocuSigned by: Nancy Huang D22E3B87032946F...

Name: Nancy Huang

Title: CFO, CalOptima

Date: 11/03/2023

Signature: DocuSigned by: MHunn EDDDDCC19C894FB...

Name: Michael Hunn

Title: CEO

Date: 11/03/2023

AMENDMENT NO. 4 TO CONTRACT NO. 22-10289
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA HEALTH
AND
KENNADAY LEAVITT PC
(CONTRACTOR)

AMENDMENT NO. 4 to this CONTRACT is entered into as the date last signed below ("**Amendment Effective Date**") with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter, individually referred to as "**Party**" or collectively as the "**Parties**") entered into Contract 22-10289 on November 04, 2021, for Outside General Counsel Services, Amendment No. 1 on May 11, 2022, Amendment No. 2 on October 11, 2022, and Amendment No. 3 on November 01, 2023.

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing and executed by both Parties.

C. The Parties now desire to enter into a new Business Associate Agreement (BAA).

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. The BAA effective 11/04/2021 is hereby deleted and replaced with the BAA signed on the same date as this Amendment No. 4.

2. **No Other Changes.** This Amendment No 4 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 4 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

3. **Authority to Execute.** The persons executing this Amendment on behalf of the Parties warrant that they are duly authorized to execute this Amendment and that by executing this Amendment, the Parties are formally bound.

4. **Counterparts.** This Amendment may be executed in any number of counterparts, all of which taken together shall constitute one and the same instrument, and any of the Parties hereto may execute the Amendment by signing any such counterpart.

[Signature Page Follows]

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 4 to Contract 22-10289 as of the date last signed below.

KENNADAY LEAVITT PC

Signature: _____

Name: James F. Novello

Title: Shareholder

Date: March 20, 2024

Signature: _____

Name: _____

Title: _____

Date: _____

CALOPTIMA HEALTH

Signature: DocuSigned by: Nancy Huang D22E3B87032946F...

Name: Nancy Huang

Title: CFO, CalOptima

Date: 05/29/2024

Signature: DocuSigned by: EDDDDCC19C894EB...

Name: Michael Hunn

Title: CEO

Date: 05/29/2024

Business Associate Agreement

This Business Associate Agreement is entered into by and between the Orange County Health Authority, a California local public agency, doing business as CalOptima ("**CalOptima**"), and Kennaday Leavitt PC ("**Business Associate**"), effective as of the date last signed below ("**Effective Date**"). CalOptima and Business Associate are each a party to this Agreement and are collectively referred to as the "Parties." Any extensions or renegotiations of this Agreement shall be reviewed by both parties and pursuant to CalOptima Policy HH.3022: Business Associate Agreements.

RECITALS

WHEREAS, the Parties have executed an agreement(s) whereby Business Associate provides services to CalOptima, and Business Associate creates, receives, maintains, uses, transmits protected health information ("**PHI**") in order to provide those services ("**Services Agreement(s)**");

WHEREAS, as a covered entity, CalOptima is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act ("**HIPAA**") of 1996, Public Law 104-191, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations ("**C.F.R.**") Parts 160 and Subparts A and E of 45 C.F.R. Part 164 ("**Privacy Regulations**") and the Security Standards for Electronic Protected Health Information ("**Security Regulations**") at 45 C.F.R. Parts 160 and Subparts A and C of 45 C.F.R. Part 164, as amended by the Health Information Technology for Economic and Clinical Health Act ("**HITECH Act**") of 2009, Public Law 111-5, and regulations promulgated thereunder including the Breach Notification Regulations at Subpart D of 45 C.F.R. Part 164, and is subject to certain state privacy laws;

WHEREAS, as a business associate, Business Associate is subject to certain provisions of HIPAA, and regulations promulgated thereunder, as required by the HITECH Act and regulations promulgated thereunder;

WHEREAS, CalOptima and Business Associate are required to enter into a contract in order to mandate certain protections for the privacy and security of PHI;

WHEREAS, CalOptima's regulator(s) have adopted certain administrative, technical and physical safeguards deemed necessary and appropriate by it/them to safeguard regulators' PHI and have required that CalOptima incorporate such requirements in its business associate agreements with subcontractors that require access to the regulators' PHI;

NOW, THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the Parties agree as follows:

1. **Definitions**. The terms in this section and otherwise defined in this Business Associate Agreement shall have the definitions set forth below for purposes of this Business Associate Agreement. Terms used, but not otherwise defined, in this Business Associate Agreement shall have the same meaning as those terms in HIPAA, the HITECH Act, the IPA (as defined below), and/or regulations promulgated thereunder.

    1.1. **Agreement** as used in this document means both this Business Associate Agreement and the Services Agreement to which this Business Associate Agreement applies, as specified in such Services Agreement.

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1.2. **Breach** means, unless expressly excluded under 45 C.F.R. § 164.402, the acquisition, access, Use, or disclosure of PHI in a manner not permitted under Subpart E of 45 C.F.R. Part 164 which compromises the security or privacy of the PHI and as more particularly defined under 45 C.F.R. § 164.402.

1.3. **Business associate** has the meaning given such term in 45 C.F.R. § 160.103.

1.4. **Confidential Information** refers to information not otherwise defined as PHI in Section 1.15 below, but to which state and/or federal privacy and/or security protections apply.

1.5. **Data Aggregation** has the meaning given such term in 45 C.F.R. § 164.501.

1.6. **Designated Record Set** has the meaning given such term in 45 C.F.R. § 164.501.

1.7. **Disclose** and **Disclosure** mean the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

1.8. **Electronic Health Record** has the meaning given such term in 42 U.S.C. § 17921.

1.9. **Electronic Media** means:

1.9.1. Electronic storage material on which data is or may be recorded electronically including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

1.9.2. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via Electronic Media, because the information being exchanged did not exist in electronic form before the transmission.

1.10. **Electronic protected health information** ("**ePHI**") means Individually Identifiable Health Information, including PHI, that is transmitted by or maintained in Electronic Media.

1.11. **Health Care Operations** has the meaning given such term in 45 C.F.R. § 164.501.

1.12. **Individual** means the person who is the subject of PHI and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.13. **Individually Identifiable Health Information** means health information, including demographic information collected from an Individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present, or future payment for the provision of health care to an Individual, that identifies the Individual or where there is a reasonable

basis to believe the information can be used to identify the Individual, as set forth under 45 C.F.R. § 160.103.

1.14. **Information System** means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

1.15. **Protected health information** ("**PHI**"), as used in this Agreement and unless otherwise stated, refers to and includes both PHI as defined at 45 C.F.R. § 160.103 and personal information ("**PI**") as defined in the Information Practices Act at California Civil Code § 1798.3(a) ("**IPA**"). PHI includes information in any form, including paper, oral, and electronic.

1.16. **Required by Law** means a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law. Required by Law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

1.17. **Secretary** means the Secretary of the U.S. Department of Health and Human Services or the Secretary's designee.

1.18. **Security Incident** means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System.

1.19. **Services** has the same meaning as in the Services Agreement(s).

1.20. **Unsecured Protected Health Information** ("**Unsecured PHI**") means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in the guidance issued under 42 U.S.C. § 17932(h)(2).

1.21. **Use** and **Uses** mean, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within the entity that maintains such information.

2. CalOptima intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute PHI and/or Confidential Information protected by federal and/or state laws.

3. Business Associate is the business associate of CalOptima acting on CalOptima's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of CalOptima, and may create, receive, maintain, transmit, aggregate, Use or Disclose PHI in order to fulfill Business Associate's obligations under this Agreement.

4. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in

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this Agreement, Business Associate may Use or Disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of CalOptima, provided that such Use or Disclosure would not violate HIPAA, including the Privacy Regulations, or other applicable laws if done by CalOptima.

4.1. **Specific Use and Disclosure Provisions**. Except as otherwise indicated in this Agreement, Business Associate may Use and Disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may Disclose PHI for this purpose if the Disclosure is Required by Law, or the Business Associate obtains reasonable assurances, in writing, from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

4.2. **Data Aggregation**. If authorized as part of the Services provided to CalOptima under the Services Agreement, Business Associate may Use PHI to provide Data Aggregation services relating to the Health Care Operations of CalOptima

5. **Prohibited Uses and Disclosures of PHI**

5.1. **Restrictions on Certain Disclosures to Health Plans**. Business Associate shall not Disclose PHI about an Individual to a health plan for payment or Health Care Operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the Individual requests such restriction in accordance with HIPAA and the HITECH Act, including 45 C.F.R. § 164.522(a). The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103.

5. 2. **Prohibition on Sale of PHI; No Remuneration**. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written authorization of CalOptima and CalOptima's regulator(s), as applicable, and then, only as permitted by HIPAA and the HITECH Act. The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103.

6. **Compliance with Other Applicable Law**

6.1. To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, "**more protective**") privacy and/or security protections to PHI or other Confidential Information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

6.1.1. To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the Individuals whose information is concerned; and

6.1.2. To treat any violation of such additional and/or more protective standards as a Breach or Security Incident, as appropriate, pursuant to Section 17 of this

Agreement.

6.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or Confidential Information, as defined in Section 1.4 of this Agreement, include, but are not limited to the IPA, California Civil Code §§ 1798-1798.78, California Confidentiality of Medical Information Act ("**CMIA**"), Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, Welfare and Institutions Code § 5328, and California Health and Safety Code § 11845.5.

6.3 If Business Associate is a Qualified Service Organization ("QSO") as defined in 42 C.F.R. § 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 C.F.R. § 2.11.

7. **Additional Responsibilities of Business Associate**

7.1. **Nondisclosure**. Business Associate shall not Use or Disclose PHI or other Confidential Information other than as permitted or required by this Agreement or as Required by Law.

7.2. **Safeguards and Security**

7.2.1. Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with Subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent Use or Disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of Subpart C of 45 C.F.R. Part 164, in compliance with 45 C.F.R. § 164.316. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities.

7.2.2. Business Associate shall, at a minimum, utilize a National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security framework when selecting and implementing its security controls, and shall maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time.

7.2.3. Business Associate shall employ FIPS 140-3 compliant encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other Confidential Information, including, but not limited to, encryption of all workstations, laptops, and removable media devices containing PHI and data transmissions of PHI.

7.2.4. Business Associate shall apply security patches and upgrades, and keep virus

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software up-to-date, on all systems on which PHI and other Confidential Information may be used.

7.2.5. Business Associate shall ensure that all members of its workforce with access to PHI and/or other Confidential Information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

7.2.6. Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 C.F.R. Part 164, Subpart C.

7.3. **Minimum Necessary**. With respect to any permitted Use, Disclosure, or request of PHI under this Agreement, Business Associate shall make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of such Use, Disclosure, or request respectively, as specified in 45 C.F.R. § 164.502(b).

7.4. **Business Associate's Agent**. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "**Agents**") that Use or Disclose PHI and/or Confidential Information on behalf of Business Associate agree through a written agreement to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such PHI and/or Confidential Information.

8. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or disclosure of PHI and other Confidential Information in violation of the requirements of this Agreement.

9. **Access to PHI**. Except as otherwise provided in Section 9.1 below, Business Associate shall, to the extent CalOptima determines that any PHI constitutes a Designated Record Set, make the PHI specified by CalOptima available to the Individual(s) identified by CalOptima as being entitled to access and copy that PHI. Business Associate shall provide such access for inspection of that PHI within fifteen (15) calendar days after receipt of request from CalOptima. Business Associate shall also provide copies of that PHI ten (10) calendar days after receipt of request from CalOptima. If Business Associate maintains an Electronic Health Record with PHI and an Individual requests a copy of such information in electronic format, Business Associate shall make such information available in that format as required under the HITECH Act and 45 C.F.R. § 164.524.

9.1. **Business Associate of CalOptima PACE**. This Section applies when Business Associate is a business associate of CalOptima in CalOptima's capacity as a health care provider through CalOptima Program of All-Inclusive Care for the Elderly ("**CalOptima PACE**"). Business Associate shall, to the extent CalOptima determines that any PHI constitutes a Designated Record Set or patient records (as defined in California Health and Safety Code § 123105), make the PHI specified by CalOptima available to the Individual(s) identified by CalOptima as being entitled to access and copy that PHI. To enable compliance with California Health & Safety Code § 123110 and 45 C.F.R. § 164.524, Business Associate shall provide such access for inspection of that PHI within three (3) working days after receipt of request from CalOptima. Business Associate shall also provide copies of that PHI ten (10) calendar days after receipt of request from CalOptima.

10. **Amendment of PHI**. Business Associate shall, to the extent CalOptima determines that any PHI constitutes a Designated Record Set, make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526, as requested by CalOptima in the time and manner designated by CalOptima.

11. **Accounting of Disclosures**. Business Associate shall document and make available to CalOptima or (at the direction of CalOptima) to an Individual such disclosures of PHI and information related to such disclosures as necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI in accordance with HIPAA, the HITECH Act and implementing regulations, including 45 C.F.R. § 164.528. Unless directed by CalOptima to make available to an Individual, Business Associate shall provide to CalOptima, within thirty (30) calendar days after receipt of request from CalOptima, information collected in accordance with this Section 11 to permit CalOptima to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. Any accounting provided by Business Associate under this Section shall include:

    11.1. The date of the disclosure;

    11.2. The name, and address if known, of the entity or person who received the PHI;

    11.3. A brief description of the PHI disclosed; and

    11.4. A brief statement of the purpose of the disclosure.

    For each Disclosure that could require an accounting under this Section, Business Associate shall document the information enumerated above, and shall securely maintain the information for six (6) years from the date of the Disclosure.

12. **Compliance with HITECH Act**. Business Associate shall comply with the requirements of Title XIII, Subtitle D, of the HITECH Act, which are applicable to business associates, and shall comply with the regulations promulgated thereunder.

13. **Compliance with Obligations of CalOptima or DHCS**. To the extent Business Associate is to carry out an obligation of CalOptima or the California Department of Healthcare Services ("**DHCS**") under 45 C.F.R. Part 164, Subpart E, Business Associate shall comply with the requirements of such Subpart E that apply to CalOptima or DHCS, as applicable, in the performance of such obligation.

14. **Access to Practices, Books and Records**. Business Associate shall make its internal practices, books, and records relating to the Use and disclosure of PHI on behalf of CalOptima available to CalOptima upon reasonable request, and to the DHCS and the Secretary for purposes of determining CalOptima's compliance with 45 C.F.R. Part 164, Subpart E. Business Associate also agrees to make its internal practices, books and records relating to the Use and Disclosure of PHI on behalf of CalOptima available to DHCS, CalOptima, and the Secretary for purposes of determining Business Associate's compliance with applicable requirements of HIPAA, the HITECH Act, CMIA, and implementing regulations. Business Associate shall immediately notify CalOptima of any requests made by DHCS or the Secretary and provide CalOptima with copies of any documents produced in response to such request.

15. **Return or Destroy PHI on Termination; Survival**. At termination of this Agreement, if feasible, Business Associate shall return to CalOptima or, if agreed to by CalOptima, destroy all PHI and other Confidential Information received from, or created or received by Business Associate on behalf of, CalOptima that Business Associate or its Agents still maintains in any form, and shall retain no copies of such information. If CalOptima elects destruction of PHI and/or other Confidential Information, Business Associate shall ensure such information is destroyed in

accordance with the destruction methods specified in Sections 15.1 and 15.2 below and shall certify in writing to CalOptima that such information has been destroyed accordingly. If return or destruction is not feasible, Business Associate shall notify CalOptima of the conditions that make the return or destruction infeasible. Subject to the approval of CalOptima's regulator(s) if necessary, if such return or destruction is not feasible, CalOptima shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall also extend the protections of this Agreement to the information and limit further Uses and Disclosures to those purposes that make the return or destruction of the information infeasible.

15.1 **Data Destruction**. Data destruction methods for CalOptima PHI or Confidential Information must conform to the NIST Special Publication 800-88. Other methods require prior written permission of CalOptima and, if necessary, CalOptima's regulator(s).

15.2 **Destruction of Hard Copy Confidential Data**. CalOptima PHI or Confidential Information in hard copy form must be disposed of through confidential means, such as cross cut shredding and pulverizing.

16. **Special Provision for SSA Data**. If Business Associate receives data from or on behalf of CalOptima that was verified by or provided by the Social Security Administration ("**SSA Data**") and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by CalOptima, a list of all employees and Agents and employees who have access to such SSA Data, including employees and Agents of its Agents, to CalOptima.

17. **Breaches and Security Incidents**. Business Associate shall implement reasonable systems for the discovery and prompt reporting of any Breach or Security Incident, and take the following steps:

17.1. **Notice to CalOptima**

17.1.1. **Immediate Notice**. Business Associate shall notify CalOptima immediately upon the discovery of a suspected Breach or Security Incident that involves SSA Data. This notification will be provided by email upon discovery of the Breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to CalOptima.

17.1.2. **24-Hour Notice**. Business Associate shall notify CalOptima within 24 hours by email (or by telephone if Business Associate is unable to email CalOptima) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

17.1.2.1. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

17.1.2.2. Any suspected Security Incident which risks unauthorized access to PHI and/or other Confidential Information;

17.1.2.3. Any intrusion or unauthorized access, Use or Disclosure of PHI in violation of this Agreement; or

17.1.2.4. Potential loss of confidential data affecting this Agreement.

17.1.3. Notice shall be provided to the CalOptima Privacy Officer ("**CalOptima**

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Contact") using the CalOptima Contact Information at Section 17.7 below. Such notification by Business Associate shall comply with CalOptima's form and content requirements for reporting privacy incident and shall include all information known at the time the incident is reported.

17.2. **Required Actions**. Upon discovery of a Breach or suspected Security Incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

17.2.1. Prompt action to mitigate any risks or damages involved with the Security Incident or Breach;

17.2.2. Any action pertaining to such unauthorized disclosure required by applicable federal and state law; and

17.2.3. Any corrective actions required by CalOptima or CalOptima's regulator(s).

17.3. **Investigation**. Business Associate shall immediately investigate such Security Incident or confidential Breach. Business Associate shall comply with CalOptima's additional form and content requirements for reporting such privacy incident.

17.3.1. Incident details including the date of the incident and when it was discovered;

17.3.2. The identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the Breach;

17.3.3. The nature of the data elements involved and the extent of the data involved in the Breach;

17.3.4. A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data;

17.3.5. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized;

17.3.6. A description of the probable causes of the improper Use or Disclosure;

17.3.7. Any other available information that the Business Associate is required to include in notification to the Individual under 45 C.F.R. § 164.404(c);

17.3.8. Whether the PHI or confidential data that is the subject of the Security Incident, Breach, or unauthorized Use or Disclosure of PHI or confidential data included Unsecured PHI;

17.3.9. Whether a law enforcement official has requested a delay in notification of Individuals of the Security Incident, Breach, or unauthorized Use or Disclosure of PHI or Confidential Information because such notification would impede a criminal investigation or damage national security and whether such notice is in writing; and

17.3.10. Whether Section 13402 of the HITECH Act (codified at 42 U.S.C. § 17932),

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California Civil Code §§ 1798.29 or 1798.82, or any other federal or state laws requiring individual notifications of breaches are triggered.

17.4. **Complete Report**. Business Associate shall provide a complete written report of the investigation ("Final Report") to the CalOptima Contact within seven (7) working days of the discovery of the Security Incident or Breach. Business Associate shall comply with CalOptima's additional form and content requirements for reporting of such privacy incident.

17.4.1. The Final Report shall provide a comprehensive discussion of the matters identified in Section 17.3 above and the following:

17.4.1.1. An assessment of all known factors relevant to a determination of whether a Breach occurred under HIPAA and other applicable federal and state laws;

17.4.1.2. A full, detailed corrective action plan describing how Business Associate will prevent reoccurrence of the incident in the future, including its implementation date and information on mitigation measures taken to halt and/or contain the improper Use or Disclosure and to reduce the harmful effects of the Breach. All corrective actions are subject to the approval of CalOptima and CalOptima's regulator(s), as applicable; and

17.4.1.3. The potential impacts of the incident, such as potential misuse of data and identity theft.

17.4.2. If CalOptima or CalOptima's regulator(s) requests additional information, Business Associate shall make reasonable efforts to provide CalOptima with such information. A supplemental written report may be used to submit revised or additional information after the Final Report is submitted.

17.4.3. CalOptima and CalOptima's regulator(s), as applicable, will review and approve or disapprove Business Associate's determination of whether a Breach occurred, whether the Security Incident or Breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

17.4.4. **New Submission Timeframe**. If Business Associate does not complete a Final Report within the seven (7) working day timeframe specified in Section 17.4 above, Business Associate shall request approval from CalOptima within the seven (7) working day timeframe of a new submission timeframe for the Final Report. Business Associate acknowledges that a new submission timeframe requires the approval of CalOptima and, if necessary, CalOptima's regulator(s).

17.5. **Notification of Individuals**. If the cause of a Breach is attributable to Business Associate or its Agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate shall notify Individuals accordingly and pay all costs of such notifications, as well as costs associated with the Breach. The notifications shall comply with applicable federal and state law. All such

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notifications shall be coordinated with CalOptima. CalOptima and CalOptima regulator(s), as applicable, shall approve the time, manner and content of any such notifications. Business Associate acknowledges that such review and approval by CalOptima and CalOptima regulator(s), as applicable, must be obtained before the notifications are made.

17.6. **Responsibility for Reporting of Breaches to Entities Other than CalOptima**. If the cause of a Breach of PHI is attributable to Business Associate or its Agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate agrees that CalOptima shall make all required reporting of the Breach as required by applicable federal and state law, including any required notifications to media outlets, the Secretary, and other government agency/regulator.

17.7. **CalOptima Contact Information**. To direct communications to CalOptima Privacy Officer, the Business Associate shall initiate contact as indicated here. CalOptima reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

CalOptima Privacy Office

Privacy Officer
c/o: Office of Compliance
CalOptima
505 City Parkway West
Orange, CA 92868

Email: privacy@caloptima.org

Telephone: (714) 246-8400 (ask the operator to connect to Privacy Officer)

18. **Responsibilities of CalOptima**

18.1 CalOptima agrees to not request the Business Associate to Use or Disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

18.2 **Notification of SSA Data**. CalOptima shall notify Business Associate if Business Associate receives data that is SSA Data from or on behalf of CalOptima.

19. **Indemnification**. Business Associate will immediately indemnify and pay CalOptima for and hold it harmless from (i) any and all fees and expenses CalOptima incurs in investigating, responding to, and/or mitigating a Breach of PHI or Confidential Information caused by Business Associate or its Agents; (ii) any damages, attorneys' fees, costs, liabilities or other sums actually incurred by CalOptima due to a claim, lawsuit, or demand by a third party arising out of a Breach of PHI or Confidential Information caused by Business Associate or its Agents; and/or (iii) for fines, assessments and/or civil penalties assessed or imposed against CalOptima by any government agency/regulator based on a Breach of PHI or Confidential Information caused by Business Associate or its Agents. Such fees and expenses may include, without limitation, attorneys' fees and costs and costs for computer security consultants, credit reporting agency services, postal or other delivery charges, notifications of Breach to Individuals and regulators, and required reporting of Breach. Acceptance by CalOptima of any insurance certificates and endorsements required

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under the Service Agreement(s) does not relieve Business Associate from liability under this indemnification provision. This provision shall apply to any damages or claims for damages whether or not such insurance policies shall have been determined to apply.

20. **Audits, Inspection and Enforcement**

20.1. From time to time, CalOptima and/or CalOptima's regulator(s) may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the CalOptima Privacy Officer in writing. Whether or how CalOptima or CalOptima's regulator(s) exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2. If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify CalOptima unless it is legally prohibited from doing so.

21. **Term and Termination**

21.1 **Term**. This exhibit is effective as of the Effective Date and shall terminate when (i) the Services Agreement terminates, (ii) in accordance with this Section 21, or (iii) when all of the PHI provided by CalOptima to Business Associate, or created or received by Business Associate on behalf of CalOptima, is destroyed or returned to CalOptima, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in Section 15.

21.2. **Termination for Cause**. Upon CalOptima's knowledge of a violation of this Agreement by Business Associate, CalOptima may in its discretion:

21.2.1. Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by CalOptima; or

21.2.2. Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.3. **Judicial or Administrative Proceedings**. CalOptima may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. **Miscellaneous Provisions**

22.1. **Disclaimer**. CalOptima makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other Confidential Information.

22.2. **Amendment**

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22.2.1. Any provision of this Agreement which is in conflict with current or future applicable federal or state laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2. Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3. **Assistance in Litigation or Administrative Proceedings**. Business Associate shall make itself and its employees and Agents available to CalOptima or CalOptima's regulator(s) at no cost to CalOptima or CalOptima's regulator(s), as applicable, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CalOptima or CalOptima's regulator(s), their respective directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4. **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5. **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6. **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

22.7. **Statutory or Regulatory Reference**. Any reference to statutory or regulatory language in this Agreement shall be to such language as in effect or as amended.

22.8. **Injunctive Relief**. Notwithstanding any rights or remedies provided in this Agreement, CalOptima retains all rights to seek injunctive relief to prevent or stop the unauthorized Use or Disclosure of PHI or Confidential Information by Business Associate or any agent, subcontractor, employee or third party that received PHI or Confidential Information, and Business Associate agrees that CalOptima may seek injunctive relief under this section without any requirement to prove actual monetary damage or post a bond or other security.

22.9 **Monitoring.** As applicable, Business Associate shall comply with monitoring requirements of CalOptima's contracts with regulator(s) or any other monitoring requests by CalOptima's regulator(s).

EXECUTION

Subject to the execution of a Services Agreement or amendments thereto by Business Associate and CalOptima, this Business Associate Agreement shall become effective on the Effective Date.

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In witness thereof, the parties have executed this Business Associate Agreement:

Business Associate Kennaday Leavitt PC	CalOptima
James F. Novello Print Name	Nancy Huang Print Name
Signature	DocuSigned by: Nancy Huang D22E3B87032948F... Signature
Shareholder Title	CFO, CalOptima Title
May 23, 2024 Date	05/29/2024 Date
	Michael Hunn
Print Name	Print Name
Signature	DocuSigned by: EDDDDCC19C894FB... Signature
	CEO
Title	Title
	05/29/2024
Date	Date

Rev. 4/2024

AMENDMENT NO. 5 TO CONTRACT NO. 22-10289
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA HEALTH
AND
KENNADAY LEAVITT PC
(CONTRACTOR)

AMENDMENT NO. 5 to this CONTRACT is entered into as the date last signed below ("**Amendment Effective Date**") with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter, individually referred to as "**Party**" or collectively as the "**Parties**") entered into Contract 22-10289 on November 04, 2021, for Outside General Counsel Services, Amendment No. 1 on May 11, 2022, Amendment No. 2 on October 11, 2022, Amendment No. 3 on November 01, 2023, and Amendment No. 4 on May 29, 2024.

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing and executed by both Parties.

C. The Parties now desire to amend the contract to extend the contract, add in extension options, and modify the payment terms.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Extend the contract for 3 years through October 31, 2027. At the end of that term, CalOptima may, at its option, extend the contract for up to two additional one-years terms.

2. Exhibit B, PAYMENT which was amended as Attachment B to Amendment No. 1 is hereby deleted and replaced with Exhibit B, PAYMENT attached hereto as Attachment A to this Amendment No. 5.

3. **No Other Changes.** This Amendment No 5 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. 5 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

4. **Authority to Execute.** The persons executing this Amendment on behalf of the Parties warrant that they are duly authorized to execute this Amendment and that by executing this Amendment, the Parties are formally bound.

5. **Counterparts.** This Amendment may be executed in any number of counterparts, all of which taken together shall constitute one and the same instrument, and any of the Parties hereto may execute the Amendment by signing any such counterpart.

[Signature Page Follows]

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 5 to Contract 22-10289 as of the date last signed below.

KENNADAY LEAVITT PC	**CALOPTIMA HEALTH**
Signature:_____	Signature:_____
Name:_____	Name:_____
Title:_____	Title:_____
Date:_____	Date:_____
Signature:_____	Signature:_____
Name:_____	Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

Exhibit B

PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

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

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 22-10289; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Rates:
   1. Attorney rates shall be paid at the following rates for attorneys working on CalOptima matters:
      a. Senior Partner: $675 / hour
      b. Partner: $575 / hour
      c. Associate / Senior Associate: $475 / hour
      d. Firm-contracted attorneys will be billed at their appropriate level of expertise and experience, not to exceed the Senior Partner rate then in effect. CONTRACTOR shall obtain CalOptima approval prior to use of contracted attorneys.
   2. Paralegal rates shall be paid for all paralegals working on CalOptima matters at $150.00 per hour.
   3. Starting on November 01, 2025, and annually thereafter, Contractor may annually increase the rates in Section D by up to 3.5%.

E. CONTRACTOR shall also invoice CalOptima on a monthly basis for travel-related expenses. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima’s Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. Travel-related expenses shall not exceed Five Thousand Dollars ($5,000.00) per month. CalOptima shall not pay CONTRACTOR for time spent traveling.

F. CONTRACTOR shall also invoice CalOptima on a monthly basis for certain in-house services as outlined in the Engagement Letter. All expenses charged to CalOptima under this Contract shall be consistent with the Engagement Letter. Receipts or reasonable evidence thereof are required. In-House related expenses shall not exceed Five Hundred Dollars ($500.00) per month.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

14. Authorize a New Delegation Agreement for Claims Payment and Processing, Credentialing, and Utilization Management Delegated Responsibilities

Contacts

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

Recommended Actions

Authorize the Chief Executive Officer to:

1. Implement a new delegation agreement for delegated functions, including claims payment and processing, credentialing, and utilization management responsibilities;
2. Amend contracts with providers that have agreed to take responsibility for delegated functions to incorporate the new delegation agreement as an exhibit; and
3. Maintain and implement changes to the delegation agreement to comply with regulatory and contractual requirements and to align with CalOptima Health policies and procedures.

Background and Discussion

Staff requests the CalOptima Health Board of Directors (Board) approve a new delegation agreement exhibit for claims payment and processing, credentialing, and utilization management delegated responsibilities. The delegation agreement was revised to clarify delegation requirements and to align with regulatory requirements and industry standards. Effective July 1, 2024, the delegation agreement will be a distinct exhibit in contracts with providers that have agreed to take responsibility for delegated functions, including health networks, certain fee-for-service physicians, and certain ancillary providers.

The delegation agreement outlines activities delegated by CalOptima Health to applicable providers. The delegated activities under the agreement meet the requirements of delegation as determined by CalOptima Health's Delegation Oversight department for the delegated claims payment and processing, credentialing, and utilization management functions. In addition to identifying delegation requirements in the areas of claims payment and processing, credentialing, and utilization management, as noted above, the delegation agreement defines specific areas of responsibility and requirements that will not be delegated and continue to be managed by CalOptima Health, including oversight of all functions and responsibilities, in accordance with CalOptima Health's Delegation Oversight Policy & Procedure (GG.1619).

To achieve improved clarity regarding delegation requirements, staff requests the Board approve incorporating the delegation agreement as a defined exhibit to applicable provider contracts, upon meeting delegation requirements, along with all other embedded attachments. Staff further request Board approval to maintain the delegation agreement to comply with regulatory and contractual changes and to align with CalOptima Health policies and procedures.

Fiscal Impact

There is no additional fiscal impact related to the new Delegation Agreement exhibit. The proposed CalOptima Health Fiscal Year 2024-25 Operating Budget includes funding for forecasted medical expenses with contracted providers.

Rationale for Recommendation

Authorization of this action will streamline the health network contracts for both CalOptima Health and providers.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Delegation agreement
3. GG.1619: Delegation Oversight

Board Actions

N/A

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

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ATTACHMENT __
Delegation Attachment __

For purposes of this Attachment F, [insert Provider/Physician/Physician Group/Hospital naming convention] shall be referred to as "**Delegate**". Delegate agrees to perform the delegated services in accordance with the responsibilities outlined in this Attachment F for CalOptima and its Members assigned to Delegate.

This Attachment F shall supersede all prior delegation agreements between the Parties and remain in effect for the term of the Contract.

1. Definitions

a. "**Standards and Requirements**" means currently applicable NCQA accreditation standards; DHCS, DMHC, CMS requirements; state and federal statutes, regulations, and sub-regulatory requirements; and CalOptima Policies and contractual requirements, including the State Contract.

2. Delegate Obligations

a. **Standards and Requirements:** Delegate agrees (either itself or through a CalOptima-approved Subcontractor or downstream entity) to provide the delegated services set forth in Schedules A, B, C, and D, as applicable, ("**Delegated Services**") in accordance with the terms of this Attachment F and Standards and Requirements. Delegate shall comply with new or revised Standards and Requirements from and after the effective date of any new or revised standard or rule. Changes necessary to comply with new/revised Standards and Requirements are not a change to a material term of this Attachment F requiring approval by either party.

b. **Policies and Procedures:** Delegate shall comply with CalOptima's policies and procedures, including but not limited to CalOptima Policy GG.1619: Delegation Oversight. Delegate shall submit to CalOptima copies of Delegate's written policies and procedures for each delegated service as part of a readiness assessment and at least once each year during the term of the Contract. Delegate's policies and procedures are subject to annual review and/or review upon request by CalOptima.

c. **Subdelegation:** Delegate agrees not to subdelegate any Delegated Services without prior written notice to and approval by CalOptima. Delegate shall provide CalOptima a written and complete list of subdelegates, vendors, subcontractors, and offshore entities performing services for or on behalf of Delegate at least sixty (60) days before the date Delegated Services are to begin under this Attachment F. The parties shall update the list shall no later than sixty (60) days before any changes approved by CalOptima take effect, including new subdelegates or offshore entities or the movement of Delegated Services from one subdelegate or offshore entity location to another. CalOptima may audit Delegate's subdelegates with advance notice, and Delegate will ensure its contracts with Subcontractors and subdelegates provide such an audit right for CalOptima. All Delegate contracts with subdelegated entities shall require the subdelegated entity to perform all Delegated Service(s) in compliance with the Contract, including this Attachment F and all Standards and Requirements. Delegate is responsible for ensuring each subdelegate complies with the Standards and Requirements. Subdelegation shall not relieve Delegate of its obligations or liability under the Contract, including this Attachment F and its Schedules A, B, C, and D (as applicable). Delegate represents and warrants that it shall take all steps necessary to cause subdelegates to comply with this Attachment F, including all Schedules.

d. **Offshore Entities:** Delegate represents and warrants it does not and will not use any offshore entity to perform Delegated Services unless and until:

i. Delegate provides sixty (60) days' advance written notice to CalOptima before entering into any agreement to subcontract any Delegated Service to an offshore entity;

ii. CalOptima, in its sole discretion, agrees in writing to the subdelegation of Delegated Services to the offshore entity;

iii. Delegate and offshore entity consent to and cooperate with CalOptima's right to audit the offshore entity. Delegate shall also audit the offshore entity before the offshore entity's provision of Delegated Services and annually as long as Delegate subdelegates Delegated Services to the offshore entity; and

iv. CalOptima and Delegate file the proposed subdelegation of functions or services to the offshore entity with the appropriate regulatory authorities for approval and receive regulatory approval Delegate and the delegated offshore entity shall comply with any requirements that the applicable regulatory authority may issue at any time during the term of the Contract.

e. **Systems & System Conversions:** Delegate agrees to take all necessary steps to ensure the Delegate's systems perform in a manner that assures Delegate's compliance with all Standards and Requirements. Delegate shall provide CalOptima at least sixty (60) days' prior written notice of any systems conversions or modifications that directly impact its obligations under this Attachment F. All systems processing and/or storing of protected health information ("**PHI**") and/or personally identifiable information ("**PII**") must have at least one (1) system risk assessment/security review conducted annually that demonstrates to CalOptima that Delegate's administrative, physical, quality, and technical controls are functioning effectively in compliance with Standards and Requirements. Delegate agrees to cooperate with CalOptima and facilitate CalOptima's performance of any system risk assessment, security reviews, compliance, and/or system reviews, as required by law and its regulators.

3. **Delegate Representations and Warranties**

a. **Good Standing; Exclusion Lists:** Delegate represents and warrants to CalOptima that:

i. Delegate is, and will remain throughout the Term of the Contract, in good standing under Standards and Requirements governing its existence and operations, and it is in compliance with and shall continue to comply with all laws and regulations applicable to this Attachment F and the duties and obligations under this Attachment F, including, but not limited to, Standards and Requirements related to Delegated Services (whether or not Delegate is directly obligated under or regulated by such Standards and Requirements);

ii. Delegate is in compliance with any licensing requirements and agrees to maintain such compliance under Standards and Requirements for the express purpose of performing each delegated service; and

iii. Neither Delegate nor any of Delegate's Subcontractors, as applicable, that are or will be fully or partially responsible for Delegate's performance of its obligations under this Attachment F have (A) pled guilty or no contest to or been convicted of any felony involving dishonesty or breach of trust; (B) been excluded from participation in any federal or state-funded health program; or (C) been listed in the Department of Health and Human Services Office of Inspector ("**OIG**") exclusion list or the General Services Administrative ("**GSA**") exclusion list. If the Delegate or any of Subcontractors or downstream entities, as applicable, are listed in the OIG or GSA exclusion lists after the effective date of the Contract, CalOptima shall have the right, in its sole discretion and judgment, to disqualify the listed person(s) from providing any part of the Delegated Services, or exercise CalOptima's rights to terminate Delegated Services under this Attachment F or to take other remedial steps.

b. **Program Representations:** Delegate warrants that each Delegated Service shall meet or exceed: (a) all CalOptima standards, policies, and procedures outlined in this Attachment F and CalOptima Policies, including the provider manual(s); (b) all Standards and Requirements applicable to Delegated Service; and (c)NCQA standards. In the event CalOptima or an accrediting organization's standards or any laws and regulations are materially changed or revised, Delegate agrees to comply with or implement, as applicable, and to the satisfaction of CalOptima, any such change or revision within the earlier of sixty (60) calendar days of receiving notice of such change or within such time frame as may be required by the accrediting organization, applicable laws and regulations, or CalOptima. The parties agree any such change or revision shall not be considered a change to a material term of this Attachment F, consistent with Section 2(a).

c. **Incentives:** Delegate further represents and warrants that as of the Effective Date and throughout the term of the Contract compensation, incentives or remuneration to persons performing such functions under this Attachment F shall not be based, directly or indirectly, on the quantity, frequency or percentage of or in any way relating to denials of Covered Services.

d. **Compliance - Government Programs:** Delegate shall (and shall cause its Subcontractors and downstream entities, as applicable) to institute, operate, and maintain an effective compliance program to detect, correct, and prevent the incidence of non-compliance with applicable state and federal regulatory requirements and the incidence of fraud, waste, and abuse. Such compliance program shall be appropriate to Delegate's, and, as applicable, Subcontractors and downstream entity organization and operations and shall include: (a) written policies, procedures, and standards of conduct articulating the entity's commitment to comply with Standards and Requirements, as well as providing mechanisms for employee/Subcontractor use in adhering to expectations regarding the reporting of potential non-compliance or fraud, waste, and abuse issues (internally and to CalOptima, as applicable); (b) for all officers, directors, employees, Subcontractors, agents, and downstream entities of Delegate, as applicable, required participation in effective compliance and anti-fraud training and education (this required training includes general compliance and fraud, waste and abuse training completion and code of conduct dissemination, initially within ninety (90) days of hire/contracting and at least annually after that; Delegate and Subcontractors and downstream entities, as applicable, may use CalOptima's code of conduct and training or an equivalent approved by CalOptima); and (c) processes to oversee and ensure compliance with these requirements.

e. **Notice of Adverse Action:** Delegate agrees to notify CalOptima promptly of: (a) any litigation brought against Delegate related to any Delegated Service or similar services provided by Delegate to other persons; (b) any actions taken or investigations initiated by any government agency involving Delegate or any entity in which Delegate holds more than a five percent (5%) interest; or (c) any legal actions or investigations, or notice thereof, initiated against Delegate by governmental agencies or individuals regarding fraud, abuse, false claim, or kickbacks. Upon CalOptima's request, Delegate agrees to provide all known details of the nature, circumstances, and disposition of any suits, claims, actions, investigations, or listings to CalOptima.

f. **Standard Operating Hours:** Delegate attests to standard operating hours for all contracted lines of business and all Delegated Services in this Attachment F.

4. **Rights and Obligations of CalOptima**

a. **Oversight:** Delegate agrees to allow and cooperate with CalOptima to maintain oversight of the Delegated Services, including, but is not limited to:

i. **Annual Audits:** Delegate shall allow CalOptima to conduct annual audits and/or review of Delegated Services upon thirty (30) calendar days' prior written notice or upon shorter

notice in the event CalOptima determines a shorter period is necessary to ensure CalOptima or Delegate's compliance with Standards and Requirements. Cooperation with an annual audit shall include permitting CalOptima to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to delegated services performed by Delegate and any subdelegate, downstream or offshore entity, as applicable.

ii. **Corrective Action Plan:** If CalOptima has reason to believe Delegate failed to carry out a delegated service per the terms of this Attachment F or CalOptima's performance expectations, CalOptima will require the Delegate to submit, within a specified timeframe, a corrective action plan ("**CAP**") to address any compliance or other problems identified by CalOptima. Once the CAP is approved by CalOptima, Delegate will be required to implement, within ten (10) business days, or as designated by CalOptima, the approved CAP and permit increased audits of Delegate's performance to ensure compliance with such CAP. CalOptima may take further remediation actions as outlined in Section 14.

iii. **External Audits:** Delegate shall allow and cooperate with CalOptima or CalOptima's designated agent(s), federal, state, and local governmental authorities having jurisdiction, and any applicable accrediting organization to audit, interview staff, and access view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services during regular business hours upon at least ten (30) calendar days' prior written notice, or upon shorter notice if CalOptima determines a shorter period is necessary to ensure CalOptima's compliance with Standards and Requirements. Any such audit shall be permitted during the term of this Attachment F and for six (6) years thereafter (or longer if required by law), with Delegate and CalOptima responsible for their own expenses incurred related to such audit. This Section 4(a)(iii) shall survive the termination of the Contract, regardless of the cause of termination.

iv. **Onsite Monitoring:** Delegate shall permit and cooperate with CalOptima or CalOptima's designated agent(s), federal, state and local governmental authorities having jurisdiction, and any applicable accrediting organization to conduct routine and non-routine on-site visits and monitoring at any site at any time where the Delegate performs Delegated Services under the terms of this Attachment F with five (5) business days' advance notice for routine monitoring and one (1) day notice for non-routine monitoring (or upon shorter notice as required by Standards and Requirements). Cooperation with on-site monitoring shall include allowing CalOptima or CalOptima's designated agent(s), federal, state and local governmental authorities having jurisdiction, and any applicable accrediting organization, to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services.

v. **Accreditation Review:** Delegate shall permit and cooperate with NCQA to conduct on-site review of any documents related to services provided by Delegate under this Attachment F during a health plan accreditation survey of CalOptima by NCQA or other accrediting organization. Cooperation with such NCQA or other accrediting organizations, on-site review, and accreditation survey shall include permitting NCQA or other accrediting organizations to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services.

vi. **Authority over Delegated Services:** CalOptima retains discretionary authority over all Delegated Services, including final decision-making and the operation thereof.

5. Records and Confidential Information

a. **Records:** Delegate agrees to retain Delegated Services records for the longer of ten (10) years following the date of service or the period required by Standards and Requirements. Delegate agrees to provide CalOptima or CalOptima's designated agent(s), federal, state, and local governmental authorities having jurisdiction, and any applicable accrediting organization, access to all delegated services records during regular business hours. This record retention provision (Section 5) shall survive the termination of the Contract regardless of the cause giving rise to the termination.

6. **Reporting:** Delegate shall provide Delegated Service reports via electronic submission to CalOptima's delegation oversight representative, as follows:

a. As outlined in the Schedules A, B, C and D, as applicable.

b. All other reports as required by CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting and the Report Binder.

c. CalOptima shall provide Member experience data to Delegate on an on-going basis. Member experience data shall be provided at least annually and include complaints, results of Member satisfaction surveys (such as CAHPS), and results of focused studies.

d. Delegate shall provide clinical performance data monthly or upon request and shall include HEDIS measure rates, HEDIS member-detail care gap reports, and other clinical data. Data shall be provided on Delegate's assigned secure file transfer protocol site.

7. **Conflicting or Overlapping Standards and Requirements:** If one or more regulatory or accreditation bodies have Standards or Requirements that create conflict or overlap, Delegate shall comply with the most stringent applicable Standards and Requirements for each Delegated Service. If Delegate is unsure of which standards may apply in a given situation, Delegate should contact healthnetworkdepartment@caloptima.org.

8. Claims Delegation:

a. Timely Adjudication of Claims:

i. Except for OneCare Member claims, Delegate will process claims from and pay Providers in compliance with timeliness requirements outlined in Standards and Requirements, including, without limitation, California Health and Safety Code Section 1371, 28 CCR Sections 1300.71 and 1300.77.4.

ii. For Medi-Cal Members, Delegate shall also comply with DHCS standards.

iii. For OneCare members, Delegate shall comply with federal laws and regulations applicable to Medicare organizations.

iv. If Delegate delegates to a Subcontractor (*e.g.*, management company, claims administrator, subcontracted capitated provider) the obligation to process claims on Delegate's behalf, then Delegate shall: (A) notify CalOptima of such delegation in advance, and (B) require the Subcontractor to comply with the claims processing procedure requirements in this Attachment F and Standards and Requirements.

b. **Claims Forwarding**: If Delegate receives a claim for services provided to a Member and the claim is the financial responsibility of CalOptima or another health plan, Health Network, or Provider,

Delegate shall timely forward the claim to CalOptima or the applicable health plan, Health Network, or Provider within ten (10) working days pursuant to 28 CCR Section 1300.71(b)(3).

c. **Failure to Make Payment:** Notwithstanding anything in this Attachment F, if Delegate fails to pay a Provider for Covered Services under the delegate's financial responsibility within the time frames outlined in this Attachment F and Standards and Requirements, (allowing for permissible disputes and appeals) and CalOptima reasonably determines that such amount is due and payable by Delegate, CalOptima may, after providing no fewer than ten (10) business days' prior written notice to Delegate, pay the amount due and deduct and offset such payment from any amount then or thereafter payable by CalOptima to Delegate.

9. **Utilization Management Delegation:** Delegate will maintain a well-structured and documented utilization management ("**UM**") program and will make UM decisions in a fair, impartial, and consistent manner, consistent with all Standards and Requirements, including CalOptima's UM program, and this Contract.

   a. Timely Decisions Made by Appropriately Licensed Professionals: Delegate will process UM requests in accordance with Standards and Requirements timelines for pre-service, concurrent, urgent, and post-service requests. The UM decisions will be made by appropriately licensed professionals and based upon all relevant clinical information.

   b. **Member and Provider Notification:** Delegate will provide verbal, electronic and/or written UM denial notices to Members and treating Providers within Standards and Requirements timelines. Such notices will be written in using sixth (6^{th}) grade language, contain the specific protocol, benefit provision, and/or guideline that is the basis for denial, and include detailed instructions for appealing the UM decision. Further, Provider notices shall contain the name and direct telephone number, if available, or a general number and extension of the UM denial decision maker.

   c. UM System Controls: At all times, Delegate shall maintain detailed policies and procedures in its UM system controls that meet all Standards and Requirements. The UM system controls will define date(s) of receipt and notification, document the process for recording dates, specify authority to modify dates, define system tracking of modifications to dates, and describe how compliance with system policies and procedures are monitored and enforced.

10. **Credentialing Delegation:** Delegate will maintain a well-structured and documented credentialing program for evaluating and selecting licensed Providers to provide care to Members that comply with all Standards and Requirements and this Contract.

    a. **Credentialing Committee:** Delegate will operate a Credentialing Committee comprised of Participating Providers that makes recommendations regarding credentialing and re-credentialing Providers. Delegate will further ensure that credentialing files received from Providers that meet established credentialing or recredentialing criteria are reviewed and approved by Delegate's medical director, designated physician, or Credentialing Committee.

    b. **Timely Verification and Recredentialing:** Delegate will verify information using primary sources within one hundred (180) days of credentialing, or within a shorter timeframe if required by Standards and Requirements, to ensure Providers have the legal authority and relevant training and experience to provide quality care. Delegate will recredential Participating Providers within thirty-six (36) months of their prior credentialing/re-credentialing approval date.

    c. **Actions Against Providers:** Delegate will maintain policies and procedures for taking actions against Providers for violations of applicable standards and regulations that include the range of actions available to the Delegate and how Delegate makes appeal processes known to Providers.

    d. **Credentialing System Controls**: At all times, Delegate will maintain detailed policies and procedures in its credentialing system controls that meet all Standards and Requirements. The

system controls will define how primary source verification information is received, dated, and stored; document authority to modify information; define system tracking of modifications; and describe how compliance with system policies and procedures are monitored and enforced.

e. **Final Network Determination:** CalOptima retains the right to approve, suspend, and terminate individual Practitioners, Providers, and sites from the Delegate's network relative to CalOptima's Medi-Cal and/or OneCare program(s), even if CalOptima delegates credentialing and recredentialing decision-making to Delegate. CalOptima has the right to make the final determination of such participation in Delegate's network as it relates to CalOptima programs.

11. **Case Management Delegation:** Delegate will maintain a well-structured and documented case management program for members with multiple and/or complex health care conditions consistent with Standards and Requirements and this Contract.

    a. **Case Management Referral:** Delegate will have multiple referral avenues for Members and will accept referrals from sources including medical management, discharge planning, Member, Member's caregiver, and individual Practitioner. Delegate will begin the case management assessment process within thirty (30) days of referral to case management.

    b. **Case Management Process:** Delegate's case management process will address initial assessment of Member's health status, behavioral health status, daily living, and social determinants of health; evaluation of Member's needs, preferences, and limitations; and development of an individualized case management plan for each assigned Member, including ongoing communication strategies.

    c. **Case Management Systems:** Delegate will use a case management system that supports evidence-based, clinical guidelines to conduct assessment and management, automatic documentation of staff activity on case, and automated prompts for follow-up.

12. **Related Requirements**: Delegate will comply with all Standards and Requirements related to all Delegated Services, including, but not limited to:

    a. **New Provider Training**: Delegate will initiate training for all new Participating Providers no later than ten (10) business days from placing a Provider on active status in the network and shall complete the training within thirty (30) calendar days of placing a Provider on active status in the network. This training must include cultural and linguistic requirements, health inequities and identified cultural groups, and language and literacy needs.

13. **Regulatory Fines:** CalOptima and Delegate acknowledge that Delegated Services under this Attachment F are subject to regulation by governmental agencies with jurisdiction over the parties. If Delegate does not or is not able to fulfill any or all its obligations under this Attachment F, and if CalOptima is subject to any fines or fees from a governmental agency as a direct result thereof, Delegate agrees to pay to CalOptima the amount of such fines and any penalties incurred by CalOptima, including any applicable interest paid by CalOptima. CalOptima shall have sole discretion to pay such fees, fines, or penalties and/or to settle or compromise with such governmental agencies.

14. **Remediation for Delay or Failure to Implement CAP and/or Failures that May Cause Harm to Members:** If Delegate delays implementation of a CAP submitted and approved under Section 4(a)(ii), fails to complete a CAP within the timeframe specified in the CAP, or delegation failures that could jeopardize the health, safety, or welfare of Members, CalOptima may take any of the following remedial measures, in general order of escalation:

    a. Freeze Delegate Enrollment and/or Pause Auto-Assignment: CalOptima may freeze enrollment to the Delegate, through pausing auto-assignment of Members, or disallowing Member selection to the Delegate, or both.

b. **Withhold Quality, Shared Savings, or Incentive Payments:** CalOptima may withhold or delay any applicable quality or other incentive payments or shared savings payments until the CAP is fully implemented or Delegate's failure is fully cured, as determined by CalOptima in its sole discretion.

c. **Financial Penalties/Monetary Sanctions**: CalOptima may impose financial penalties/monetary sanctions if a Delegate fails to complete a CAP within the timeframe specified or demonstrates other failures impacting Member health, safety, or welfare:

   i. Per Member sanctions of $25,000 per Member:

      1. Delegate fails to provide medically necessary services that the Delegate is required to provide.
      2. Delegate inappropriately delays/denies Covered Services.
      3. Delegate fails to appropriately resolve a Member appeal consistent with Standards and Requirements.
      4. Delegate incorrectly charges premium or unnecessary out-of-pockets costs.
      5. Delegate inaccurately or untimely provides plan benefit information (*e.g.*, wrong denial notices).

   ii. Aggregate sanctions for failures that impact populations of Members

      1. One percent (1%) off the monthly capitation amount for a first violation.
      2. Two percent (2%) off the monthly capitation amount for a second violation.
      3. Three percent (3%) off the monthly capitation amount for each subsequent violation.

   iii. Per determination: If CalOptima does not have the Member-specific data or the per Member impact cannot be clearly analyzed, CalOptima may calculate the penalty under the per determination basis.

   iv. Delegate may appeal a financial penalty or monetary sanction through CalOptima's appeal process outlined in policy XXX.

d. **Use of a Monitor at Expense of Delegate:** In cases of continued non-compliance or failures that could jeopardize the health, safety, or welfare of Members, CalOptima may require the Delegate to engage and pay for an external auditor or other consultant acceptable to and approved by CalOptima, in order to correct the identified deficiency(ies) or areas of non-compliance, to CalOptima's satisfaction.

e. **Modification of Delegation:** If, for any reason, CalOptima or any state or federal governmental agency with jurisdiction is dissatisfied with the performance of the Delegated Services, CalOptima may, upon written notice to Delegate, modify Delegate's status (concerning all or a particular Delegated Service) from "fully delegated" to "delegated with corrective action." Such notice shall set forth the deficiencies perceived by CalOptima and/or any state or federal governmental agency in Delegate's performance of Delegated Services. If Delegate does not correct such deficiencies to the reasonable satisfaction of CalOptima and/or the governmental agency within ninety (90) days of such notice (or a shorter timeframe as determined by CalOptima in its reasonable discretion), CalOptima may, in its sole discretion, (a) extend the period given to Delegate to correct such deficiencies; (b) terminate all or any portion(s) of the delegation to Delegate; or (c) terminate this Attachment F.

f. **Termination of Delegation with Notice:** Notwithstanding Section 14(e), CalOptima may, upon sixty (60) days' prior written notice to Delegate, terminate all or any portion(s) of the delegation to Delegate if, after consulting with Delegate, CalOptima or any state or federal governmental agency determines that Delegate (i) no longer meets all criteria for performance of the Delegated Service(s), or (ii) is not performing, or is not reasonably likely to perform, the Delegated Service(s) in full compliance Standards and Requirements. If, within such sixty (60)-day notice period, Delegate cures such deficiencies to CalOptima's reasonable satisfaction, CalOptima may withdraw such termination.

g. **Immediate Termination of Delegation:** Notwithstanding Sections 14(e) and 14(f) of this Attachment F, CalOptima may, upon prior written notice, immediately terminate all or any portion(s) of the delegation to Delegate of the delegated service(s) if, after consulting with Delegate, CalOptima or any Government Official reasonably determines that the continued performance of the Delegated Service(s) by Group would jeopardize the health, safety, or welfare of members assigned to Delegate under this Attachment F. Such de-delegation shall terminate when Delegate demonstrates to the satisfaction of CalOptima that members' health, safety, or welfare is no longer in jeopardy.

h. **Material Breach**: Delegate agrees that Delegate's failure to agree to or begin reasonable implementation of a CAP designed to correct identified deficiencies in Delegated Services under this Attachment F shall be considered a material breach of the Contract. Additionally, Delegate agrees that Delegated Services failures that could jeopardize the health, safety, or welfare of Members shall be considered a material breach of the Contract. Any such material breach of this Attachment F shall permit CalOptima to implement or engage in any or all oversight or other CalOptima rights and obligations described in the Contract, including under Section 13.

15. **Termination of Delegation (De-Delegation):** In the event CalOptima terminates delegation, or assumes all or any portion(s) of the Delegated Service(s) under this Attachment F, the following provisions shall apply:

    a. **CalOptima's Assumption of Payment of Claims:** If Delegate's claims procedures fail to comply with the obligations outlined in Schedule A of this Attachment F, CalOptima may, as required or permitted by Standards and Requirements, assume responsibility for the processing of claims that are Delegate's financial responsibility under this Attachment F. Such assumption may be altered to the extent Delegate has established and fully implemented an approved CAP consistent with California Health and Safety Code Section 1375.4(b)(4) and 28 CCR § 1300.75.4.8.

    b. **Capitation reduction for de-delegation:** Upon termination or assumption by a CalOptima of all or any portion(s) of a Delegated Service pursuant to this Attachment F, CalOptima may, in its sole discretion, reduce the net monthly Capitation Payment otherwise payable to Delegate by the percentage set forth below. Such amounts are not intended to represent the portion of the Capitation Payment allocated to cover the cost of performance of the Delegated Service(s) by Delegate nor an estimate of the costs incurred by CalOptima as a result of the termination of the delegation; rather, the amounts set forth below are intended as a performance fee for Delegate's failure to meet the standards established for performance of the Delegated Service.

	Medi-Cal	**OneCare**
Utilization Management/ Case Management	3.0%	3.0%
Credentialing	1.0%	1.0%
Claims Processing		
- non-contracted only	1.0%	1.0%

- all claims	7.0%	7.0%
- non-contracted only payment withhold *	8.5%	8.5%
- all claims payment withhold	85.0%	85.0%

* = Subject to actual claims paid experience.

c. **Obligation to Cooperate:** Upon termination of the Contract for any reason, Delegate agrees to cooperate fully with CalOptima and comply with CalOptima procedures, if any, in the transfer of Delegate's obligations under this Attachment F to CalOptima or another CalOptima delegate. Delegate agrees to promptly provide CalOptima with any and all information and documentation necessary for such transfer. This shall include copies of all Delegated Services notes and accompanying records and information submitted by Providers as requested by CalOptima.

Policy:	GG.1619
Title:	**Delegation Oversight**
Department:	Office of Compliance
Section:	Delegation Oversight
CEO Approval:	*/s/ Michael Hunn 12/07/2023*
Effective Date:	04/01/1996
Revised Date:	11/01/2023
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process for oversight of a Delegated Entity, including but not limited to Health Networks, Pharmacy Benefit Manager (PBM), and Managed Behavioral Health Organizations (MBHO), to ensure compliance with statutory, regulatory, and contractual requirements, and CalOptima Health policies and procedures to ensure continuous improvement of Member care, management, and administrative processes.

II. POLICY

A. CalOptima Health shall provide oversight of the functions and responsibilities, processes, and performance of a Delegated Entity and its Delegated Services.

B. CalOptima Health's oversight activities include review of compliance with regulatory requirements, contractual requirements, accreditation standards, and CalOptima Health policies and procedures. CalOptima Health's Delegation Oversight Department identifies whether a Delegated Entity's performance is adequate or inadequate and collaborates with the functional (Utilization Management, Quality Improvement, Claims, etc.) business owners to monitor a Delegated Entity's performance to ensure that improvement occurs where performance is inadequate.

C. CalOptima Health shall continually assess a Delegated Entity's ability to perform delegated functions through initial reviews, ongoing monitoring, performance reviews, analysis of data, and utilization of benchmarks, if available. The Delegated Entity shall provide requested information in accordance with the timeframes for book or record keeping and as required in Section II.J. of this Policy.

D. At a minimum, audits of Delegated Entities will be conducted annually by desktop review, on-site review, and/or webinar. CalOptima Health shall ensure audits are conducted at reasonable times via a mutually agreed upon format (on-site versus webinar).

E. Successful completion of a Readiness Assessment and resolution of any corrective actions will be required prior to delegating any function to a Delegated Entity, except as provided in this Policy. This includes Delegation to a new Delegated Entity, a Delegated Entity that changes its Management Services Organization (MSO), or a request to change a capitated hospital partner.

F. If CalOptima Health or any authorized representative including, but not limited to, the State or Federal government, Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS), or the Department of Health and Human Services (DHHS) Inspector General, determines there is a reasonable possibility of Fraud or similar risk, the aforementioned agencies may inspect, evaluate, and audit the Delegated Entity at any time.

G. CalOptima Health shall revoke the delegation of activities or obligations or specify other remedies in instances where DHCS or CalOptima Health determine that the Delegated Entity has not performed satisfactorily.

H. To the extent that the Delegated Entity is responsible for the coordination of care for Members, CalOptima Health shall provide any utilization data required by the Delegated Entity for the purpose of Member care coordination.

I. CalOptima Health shall inform the Delegated Entity of prospective requirements to be met before the effective agreement date. The Delegated Entity shall comply with the new requirements within thirty (30) days of the effective date, unless otherwise instructed by CalOptima Health.

J. The Delegated Entities shall maintain contracts, books, documents, records, encounter data and financial statements for a minimum of ten (10) years from the final date of the contract period or from completion of any audit or investigation, whichever is later and shall be available for inspection, evaluation, monitoring, and auditing to:

    1. CalOptima Health or its Designee;

    2. Any authorized representative of the state or federal government, including the DHCS, CMS, the U.S. Health and Human Services Office of Inspector General, the Comptroller General, the U.S. Department of Justice, and the Department of Managed Health Care (DMHC); and

    3. Any quality improvement organization, accrediting organization (e.g., National Committee for Quality Assurance [NCQA]), their Designees, and other representatives of regulatory or accrediting organizations.

K. Upon request, CalOptima Health or its designated representatives shall have the right to inspect, review, and make copies of such records, at the Delegated Entity's expense, to facilitate CalOptima Health's obligation to conduct oversight activities.

L. CalOptima Health retains the right to publish data obtained from audits and performance reviews and may distribute such data to Members or the general public without further notice to, or consent from, a Delegated Entity.

M. CalOptima Health's Delegation Oversight Department shall maintain documentation of Delegated Entity oversight activities described herein.

N. Notwithstanding the processes described in this Policy, CalOptima Health's Delegation of activities and responsibilities to Delegated Entity is subject to CalOptima Health Board of Directors' approval of the underlying business relationship/contract.

III. PROCEDURE

A. CalOptima Health delegates activities to its Delegated Entities through the Contract for Healthcare Services and the Delegation Agreement, which incorporate DHCS and CMS contract requirements, regulations, and guidance, as well as NCQA standards and factors.

B. CalOptima Health shall provide oversight of all Delegated Entities, including proposed Delegated Entities. Such oversight shall be conducted using any or all, without limitation, the following actions:

1. Engagement Letter;

2. Readiness Assessment (desktop, webinar, and on-site reviews);

3. Annual audit (desktop, webinar, and on-site reviews);

4. Focused and ad hoc reviews, audits and monitoring;

5. Periodic reviews and audits; and

6. On-going monitoring.

C. The Delegated Entity shall:

1. Cooperate by furnishing information in response to performance reviews, the Corrective Action Plan (CAP) process, and validation reviews; and

2. Make staff available during the performance review to answer questions and provide the information necessary to complete the review.

D. CalOptima Health's Delegation Oversight Department shall develop audit (or other review) tools for oversight of the focus areas as described in Section III.C of this Policy, in consultation with subject matter experts including CalOptima Health operational departments, Regulatory Affairs & Compliance, and Legal Counsel, as necessary. Such audit tools are reviewed and updated by the Delegation Oversight Department in collaboration with the respective subject matter experts annually, or more often, based upon regulatory, contractual and accreditation changes.

E. Pre-Delegation and Annual Review Communication/Notices

1. CalOptima Health Delegation Oversight may, at its discretion, provide a Delegated Entity with advance notice of a performance review.

2. Each proposed Delegated Entity and each individual proposed Delegated Service shall be subject to a Readiness Assessment.

3. Prior to the date of the review, CalOptima Health Delegation Oversight may notify a Delegated Entity, in writing, of the following:

a. Date and time of the performance review;

b. Proposed agenda;

c. Areas to be reviewed;

d. Review team members;

e. Audit items and files selected to be reviewed; and

f. Documents that must be available on-site or submitted to CalOptima Health Delegation Oversight prior to the review.

4. If CalOptima Health Delegation Oversight furnishes a document requirement list to the Delegated Entity prior to the scheduled date of the review, the Delegated Entity shall perform the following:

   a. The Delegated Entity shall compile and furnish all documents identified on the document requirement list to CalOptima Health Delegation Oversight by the prescribed due date of the performance review. All documents must be organized to correspond and crosswalk to the categories.

      i. If the Delegated Entity produces the documents at the time of the review, the Delegated Entity shall ensure that all responsive documents are available at the commencement of the review and organized to correspond to the categories identified on the required document list.

   b. If the Delegated Entity is unable to furnish all required documents requested by CalOptima Health Delegation Oversight, CalOptima Health may impose Sanctions, including, but not limited to, payment for additional expenses incurred by CalOptima Health for independent audit vendors.

5. CalOptima Health shall take the following actions related to Readiness Assessment scores:

   a. A score of less than one hundred percent (100%) on any individual Readiness Assessment will result in a Corrective Action Plan (CAP) request for each non-passing proposed Delegated Service in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

   b. Final Scores on Readiness Assessment for each Delegated Service shall not be combined to determine whether all proposed Delegated Services are to commence. Each delegated functional area audited will be evaluated separately.

F. Readiness Assessment Process

1. Prior to granting Delegation to a proposed Delegated Entity, CalOptima Health shall conduct a Readiness Assessment to determine the Delegated Entity's ability to implement proposed delegated activities.

2. Preliminary notification of prospective Delegation:

   a. The CalOptima Health Contract Owner shall notify the Delegation Oversight Department of the prospective Delegation by completing the pre-Delegation application form, which can be requested by submitting an email to DelegationOversight@caloptima.org. The notification must include the following and be submitted at least ninety (90) calendar days prior to potential "go live" of the delegated function:

      i. Services and/or functions to be performed by the proposed Delegated Entity;

ii. Contact information (phone, facsimile, address and email address) for the proposed Delegated Entity;

iii. Mailing address of the proposed Delegated Entity, along with the addresses of all site locations;

iv. Lines of business proposed for Delegation;

v. Name and contact information of the CalOptima Health Contract Owner;

vi. Date of anticipated contract implementation; proposed service levels (performance standards) and reporting responsibilities of the proposed Delegated Entity; and

vii. Sub-delegate information, where applicable.

3. The CalOptima Health Delegation Oversight auditor shall conduct the Readiness Assessment and evaluation of the proposed Delegated Entity's ability to perform the Delegated Services.

4. Each proposed Delegated Entity and each individual proposed Delegated Service shall be subject to a Readiness Assessment.

   a. A score of less than one hundred percent (100%) on any individual Readiness Assessment will result in a Corrective Action Plan (CAP) request for each non-passing proposed Delegated Service in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

   b. Final Scores on Readiness Assessment for each Delegated Service shall not be combined to determine whether all proposed Delegated Services are to commence. Each delegated functional area audited will be evaluated separately.

5. The Delegation Oversight Department will schedule and conduct a Readiness Assessment for all proposed Delegated Services sixty (60) calendar days in advance of the effective date of Delegation based on business needs.

   a. New Delegated Entity: Desktop, on-site audit, and/or webinar

   b. Expansion of service: Desktop audit

6. It is the responsibility of the Delegation Oversight Department to facilitate audit material submissions in partnership with the auditor. All Delegation materials shall be submitted to the Delegation Oversight Department within thirty (30) calendar days from the engagement letter date.

7. The auditor shall complete the applicable audit tool, document any deficiencies and request CAP(s) for any area receiving a score of less than one hundred percent (100%).

8. The auditor shall notify the Contract Owner of all findings and CAPs.

9. The audit manager and/or auditor shall report to the Delegation Oversight Committee (DOC) the audit findings and CAPs, if any, and the successful and timely resolution of the CAP. Contingencies, if applicable, will be noted by the DOC. The audit manager and/or auditor may recommend the DOC request approval by the Compliance Committee of the proposed Delegation, if the proposed Delegated Entity:

a. Meets ninety- five percent (95% of the elements of the Readiness Assessment; or

b. Meets one hundred percent (100%) of essential elements and eighty percent (80%) or more of the non-essential elements and the proposed Delegated Entity developed a CAP and/or is set for implementation for the remaining non-essential elements.

c. Notwithstanding the above, recommendation for approval may not be made if there are any findings of significant deficiencies.

10. The DOC shall make a recommendation to the Compliance Committee to approve or deny Delegation based on the reports from the Readiness Assessment.

    a. If the proposed Delegated Entity's request is denied:

        i. The Delegation Oversight Department shall send a denial notice letter to the Delegated Entity. The denial notice letter shall include the deficiency acquired during the Readiness Assessment.

        ii. The proposed Delegated Entity may appeal the decision by submitting an appeal in accordance with CalOptima Health Policies MA.9006: Provider Complaint Process, and HH.1101: CalOptima Health Provider Complaint.

    b. If the proposed Delegated Entity's request is approved:

        i. The Delegation Oversight Department shall notify the proposed Delegated Entity of the DOC approval.

        ii. The Delegation Oversight Department shall coordinate implementation of any corrective actions and transitional activities with respective functional areas to ensure the appropriate level of expertise is exercised in determining compliance with program and implementation activities.

11. The DOC shall pend consideration of the proposed Delegated Entity if less than ninety- five percent (95%) of essential or eighty percent (80%) of non-essential elements are met. If there are contingencies, the auditor shall issue the CAP(s) and the Delegation Oversight designee will notify the proposed Delegated Entity via email.

12. After DOC consideration, the Delegation Oversight Department shall send the proposed Delegated Entity the results of the assessment, findings and any request for CAP(s) within thirty (30) calendar days after completing a review.

13. All CAPs must be satisfactorily resolved within the timeframe approved by the DOC in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

14. Once the CAP(s) have been remediated to the satisfaction of the auditor, the results will be presented to DOC by the audit manager for review and recommendation.

15. The Director of Delegation Oversight shall report the DOC's recommendations on Readiness Assessment results to the Compliance Committee for approval.

16. Following DOC approval, and any other required approvals, of the Delegation Agreement and prior to the Delegated Entity's commencement of Delegated Service, the Delegation Oversight Department shall:

a. Facilitate execution of the Delegation Agreement by the appropriate CalOptima Health Designee and the Delegated Entity; and

b. Upon completion of the above, the Delegated Entity is considered approved to "go live."

G. Request to change capitated hospital partner

1. If CalOptima Health allows for a change in delegated capitated partners, then both existing physician and hospital partners shall submit the request to the Health Network Relations Department.

2. The Health Network Relations Department shall forward all documents to the Delegation Oversight Department.

3. The Delegation Oversight Department shall review the request submitted by the Delegated Entity to determine if a Readiness Assessment is necessary. The Delegation Oversight Department may conduct a desk review, webinar, and/or an on-site assessment based on its review of the hospital partner's current financial statements, programs, plans or policies and procedures, and other documentation. CalOptima Health Delegation Oversight may forgo a desk review, webinar, and/or an on-site assessment if it determines that the requesting hospital partner has demonstrated its capacity to implement CalOptima Health's program standards based on review of the request submitted for the assessment or based on CalOptima Health's current business relationship with the hospital partner.

   a. If it is determined that a Readiness Assessment is not required, the Delegation Oversight Department shall present the request to change hospital partner to the DOC for a recommendation.

      i. Upon approval by the Compliance Committee of a recommendation by the DOC to deny a Delegated Entity's request to change hospital partner:

         a) The Delegation Oversight Department shall send a denial notice letter to the delegate.

         b) The Delegated Entity may appeal the decision by submitting an appeal in accordance with CalOptima Health Policies MA.9006: Provider Complaint Process and HH.1101: CalOptima Health Provider Complaint.

      ii. Upon approval by the Compliance Committee of a recommendation by the DOC to approve a Delegated Entity's request to change hospital partner, the Delegation Oversight Department shall notify the Delegated Entity of the DOC approval.

   b. If it is determined that a Readiness Assessment is required, the Delegation Oversight Department shall coordinate the assessment with internal staff, the Delegated Entity and the potential hospital partner in accordance with this Policy.

      i. The Delegation Oversight Department shall present the results of the Readiness Assessment to the DOC for a recommendation to approve or deny the request.

         a) Upon approval by the Compliance Committee of a recommendation by the DOC to deny the Delegated Entity's request to change hospital partner, the Delegation Oversight Department shall send a denial notice letter to the Delegated Entity. The Delegated Entity may appeal the decision by submitting an appeal in accordance

with CalOptima Health Policy MA.9006: Provider Complaint Process and HH.1101: CalOptima Health Provider Complaint.

b) Upon approval by the Compliance Committee of a recommendation by the DOC to approve of the Delegated Entity's request to change hospital partner, the Delegation Oversight Department shall notify the delegate of the DOC decision within thirty (30) calendar days after completing a review.

ii. The Delegation Oversight Department shall coordinate implementation of any corrective actions and transitional activities with respective functional areas to ensure the appropriate level of expertise is exercised in determining compliance with program and implementation activities.

H. Request to Change Management Services Organization (MSO)

1. A Delegated Entity may request to change its MSO by submitting a request to the Health Network Relations Department.

2. The Health Network Relations Department shall forward all documents to the Delegation Oversight Department.

3. The Delegation Oversight Department shall review the request submitted by the Delegated Entity to determine if a Readiness Assessment is necessary. The Delegation Oversight Department may conduct a desk review, webinar, and/or an on-site assessment based on its review of the MSO's current financial statements, programs, plans or policies and procedures and other documentation. CalOptima Health may forgo a desk review, webinar, and/or an on-site assessment if it determines that the requesting MSO has demonstrated its capacity to implement CalOptima Health's program standards based on review of the request submitted for the assessment or based on CalOptima Health's current business relationship with the MSO.

a. If it is determined that a Readiness Assessment is not required, the Delegation Oversight Department shall present the request to change MSO to the DOC for a recommendation.

i. Upon approval by the Compliance Committee of a recommendation by the DOC to deny the Delegated Entity's request to change MSO:

(a) The Delegation Oversight Department shall send a denial notice letter to the Delegated Entity.

(b) The Delegated Entity may appeal the decision by submitting an Appeal in accordance with CalOptima Health Policies MA.9006: Provider Complaint Process and HH.1101: CalOptima Health Provider Complaint.

ii. Upon approval by the Compliance Committee of a recommendation by the DOC to approve the Delegated Entity's request to change MSO, the Delegation Oversight Department shall notify the Delegated Entity of the DOC approval.

b. If it is determined that a Readiness Assessment is required, the Delegation Oversight Department shall coordinate the assessment with internal staff, the Delegated Entity and the MSO in accordance with this Policy.

i. The Delegation Oversight Department shall present the results of the assessment to the DOC for a recommendation to approve or deny the request.

c. Upon approval by the Compliance Committee of a recommendation by the DOC to deny the Delegated Entity's request to change MSO, the Delegation Oversight Department shall send a denial notice letter to the Delegated Entity. The Delegated Entity may appeal the decision by submitting an Appeal in accordance with CalOptima Health Policies MA.9006: Provider Complaint Process and HH.1101: Provider Complaint Process.

i. Upon approval by the Compliance Committee of the recommendation of the DOC to approve the Delegated Entity's or request to change MSO, the Audit & Oversight Department shall notify the delegate of the DOC decision within thirty (30) calendar days after completing a review.

ii. The Delegation Oversight Department shall coordinate implementation of any corrective actions and transitional activities with respective functional areas to ensure the appropriate level of expertise is exercised in determining compliance with program and implementation activities.

I. Annual Audit Process:

1. At least annually, the Delegation Oversight Department shall schedule an audit with the Delegated Entity. Oversight audits are required annually and shall be conducted as desktop, on-site, and/or webinar audits. The Delegation Oversight Department or the DOC may determine to conduct more frequent audits and/or targeted audits.

2. Using an audit tool developed, the audit will evaluate, at a minimum, the Delegated Entity's performance of delegated activities and responsibilities, as evidenced by the Delegation Agreement, and compliance with applicable legal requirements, and CalOptima Health policies and procedures.

3. The audit will include validation based on documentation (e.g., policies & procedures, training, reports, systems) and file review(s) based on percentages for elements assessed and passed.

4. If the Delegated Entity receives a score of less than ninety-five percent (95%) on any audit element of the Delegation standards, the Delegated Entity shall be required to develop a CAP.

   a. The auditor shall have ultimate responsibility for the CAP remediation and for monitoring and reporting the CAP to the DOC. The audit manager shall report the findings of the audit, the CAPs, if any, and the timeline for CAP remediation to the DOC.

5. Annual audit findings will be presented to the DOC, and the DOC shall determine the following based upon the Delegation Oversight Department's recommendations:

   a. Continued Delegation without interruption if nintey-five percent (95%) of the annual Audit elements are met;

   b. Continued Delegation without interruption under a CAP in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan, if scores are less than ninety-five percent (95%); or

   c. Any Sanction that shall be imposed, such as suspension, revocation or termination, suspension of enrollment or other action in accordance with CalOptima Health Policy HH.2002: Sanctions, if less than eighty percent (80%) of the annual Audit elements are met.

6. CalOptima Health shall provide a Delegated Entity with a written report within thirty (30) calendar days after completing a review.

7. The elements of the CAP must be resolved in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

    a. In the event the elements of the CAP are not successfully completed within ninety (90) calendar days, the Director of Delegation Oversight shall report to the DOC following the CAP period. DOC will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended or whether the Delegated Services should be revoked or terminated.

        i. The Delegation Oversight Department must demonstrate to the reasonable satisfaction of the DOC the reason for such an extension and provide a detailed, step action plan to ensure that the items for correction are being addressed in a timely manner.

8. In accordance with CalOptima Health Policy HH.2002: Sanctions, CalOptima Health may impose progressive disciplinary actions on Delegated Entity with consistent performance issues or findings regarding significant complaints. The Director of Delegation Oversight shall refer all incidents to the Compliance Committee for further action.

    a. If the Delegation Oversight Department recommends de-Delegation, the DOC will be notified and make the recommendation to Compliance Committee, and the Compliance Committee will make the final recommendation from the review.

    b. If the Compliance Committee recommends de-Delegation, the Contract Owner will be notified by the Delegation Oversight Department.

9. If, at any time during the term of the Delegation Agreement, a non-compliance of Delegation issue arises, it should be referred immediately to the Delegation Oversight Department, who will alert the DOC. The DOC shall determine whether ad hoc audits, reviews, and or other remediation are necessary to resolve any identified issues. Issues escalated will be reviewed by the Delegation Oversight Department, DOC, and Compliance Committee, as applicable.

J. Ongoing Monitoring Process

1. The Delegation Oversight Department, in conjunction with CalOptima Health Contract Owners, and functional business owners are responsible for reviewing and preparing monthly reports for each assigned Delegated Entity and each Delegated Service. These reports shall detail the on-going monitoring conducted by CalOptima Health related to the Delegated Entity and the Delegated Services in accordance with CalOptima Health Policies HH.2015: Health Networks Claims Processing, and GG.1605: Delegation & Oversight of Credentialing & Recredentialing.

2. CalOptima Health shall monitor a Delegated Entity through reports, communication materials, and continuous improvement activities submitted by the delegates on a periodic basis, including, but not limited to, those reports specified in the CalOptima Health, Health Network Service Agreement and CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting.

3. Delegated Entity Dashboard Reporting: On a monthly basis, data submitted by the Delegated Entities shall be used to monitor areas of timeliness and accuracy.

a. The DOC shall monitor the dashboards and may make recommendations for Corrective Action should metrics fall below the threshold.

b. If there is a consistent pattern of noncompliance by the Delegated Entity, the Delegation Oversight Department will conduct a focused review.

i. If the results of the focused review are unfavorable, the auditor and/or audit manager will escalate to the DOC for further actions.

4. The Delegation Oversight Department will conduct monitoring and oversight of the business areas as outlined in CalOptima Health Policy HH.4002: CalOptima Health Internal Oversight.

K. Corrective Action Plan

1. If any area of deficiency or non-compliance is identified through any internal or external sources, including but not limited to, Member or provider complaints, Readiness Assessment reviews, regulatory audits, regular reports, oversight reviews, and ongoing monitoring, the Delegation Oversight Department may require a Delegated Entity to respond to a CAP and submit a CAP response.

2. A Delegated Entity shall comply with CAP requirements as set forth in CalOptima Health Policy HH.2005: Corrective Action Plan.

3. In accordance with CalOptima Health Policy HH.2002: Sanctions, CalOptima Health may impose progressive disciplinary actions on Delegated Entity with consistent performance issues or findings regarding significant compliance issues.

L. Sub-Delegation Oversight Process

1. To ensure the Delegation Oversight Department has oversight of all sub-delegate arrangements and sub-delegate(s) are compliant with regulatory requirements, the Delegation Oversight Department shall monitor sub-Delegation through the Readiness Assessment and annual Audit of the Delegated Entities. The sub-Delegation attestation will be reviewed and signed during the Delegated Entity Readiness Assessment and annual Audit and more frequently, if required by CalOptima Health.

2. Each Delegated Entity shall attest if they use sub-delegates to perform Delegated Services.

a. Delegated Entities that sub-delegate Delegated Services shall provide a list of all sub-delegates and their functions.

b. Delegated Entities that have sub-delegates must provide evidence of a Business Associates Agreement (BAA) holding the sub-delegate to all contractual obligations as outlined in the BAA between the Delegated Entity and CalOptima Health.

c. Delegated Entities that have sub-delegates shall have contract provisions with the sub-delegate that require that sub-delegate to 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 DHCS, CMS, or the DHHS Inspector General, the Comptroller General, and DOJ, or their designees.

d. Delegated Entities that have sub-delegates shall retain all records and documents for a minimum of ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

M. Revocation of Delegation

1. Delegation may be revoked in instances where CalOptima Health or a regulatory agency determines that the Delegated Entity has not performed satisfactorily, including, but not limited to, failing to implement a CAP or quality improvement plan and or upon determination of Fraud.

2. CalOptima Health may also terminate the Delegation Agreement at any time for cause related to findings of significant deficiencies including a full investigation of Fraud. DHCS reserves the right to suspend or terminate the Delegated Entity from participation in the Medi-Cal program, seek recovery of payments made to the Delegated Entity, impose other sanctions provided under the State Plan, and direct CalOptima Health to terminate their Delegation Agreement with the Delegated Entity due to Fraud.

3. The DOC may recommend to the Compliance Committee to approve complete or partial de-Delegation of activities to a Delegated Entity.

4. Upon revocation or termination of Delegation, performed Delegated Services shall be conducted by CalOptima Health or will be delegated to another party.

5. If the Compliance Committee approves de-Delegation of activities from the Delegated Entity, CalOptima Health Delegation Oversight shall:

   a. Provide the Delegated Entity with a thirty (30) calendar day written notice of CalOptima Health's intent to de-delegate;

   b. Inform Members and providers of the de-Delegation, and provide instructions for continued services;

   c. Adjust the Delegated Entity's payments as appropriate to the Delegated Entity activity; and

   d. Prepare appropriate CalOptima Health departments to provide the de-delegated activities.

6. A Delegated Entity shall cooperate with CalOptima Health to ensure smooth transition and continuous care for Members during the de-Delegation transition period.

7. In the event CalOptima Health determines, in its sole discretion, that the circumstances warrant re-evaluation of a Delegated Entity's ability to perform delegated activities that were previously de-delegated, CalOptima Health shall conduct such re-evaluation no earlier than twelve (12) months after the effective date of the de-Delegation.

   a. CalOptima Health shall utilize the Readiness Assessment process as described in Section III.G of this Policy.

   b. CalOptima Health shall delegate activities to the Delegated Entity based on the Readiness Assessment results.

c. If the DOC approves Delegation of activities to the Delegated Entity, CalOptima Health shall re-delegate such activities, and adjust the Delegated Entity's payment accordingly.

d. If the DOC denies re-Delegation of activities to the Delegated Entity, it may recommend additional Sanctions on the Delegated Entity, up to and including termination of the CalOptima Health, Health Network Service Agreement.

8. CalOptima Health shall inform Providers of Providers' right to file Grievances in accordance with CalOptima Health Policy MA.9006: Provider Complaint Process and HH.1101: CalOptima Health Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
E. Health Network Service Agreement
F. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
G. CalOptima Health Policy HH.2002: Sanctions
H. CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting
I. CalOptima Health Policy HH.2005: Corrective Action Plan
J. CalOptima Health Policy HH.2015: Health Networks Claims Processing
K. CalOptima Health Policy HH.4002: CalOptima Health Internal Oversight
L. CalOptima Health Policy MA.9006: Provider Complaint Process
M. Delegation and Responsibility Agreement
N. Department of Health Care Services All-Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
O. Title 42, Code of Federal Regulations (C.F.R.), §438.230

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/03/2017	Department of Health Care Services (DHCS)	Approved as Submitted
02/28/2019	Department of Health Care Services (DHCS)	Approved as Submitted
01/19/2022	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/1996	GG.1619	Health Network Delegation Oversight	Medi-Cal
Effective	04/01/1999	HH.2004	Health Network Performance Review	Medi-Cal
Revised	05/01/1999	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	12/01/1999	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	10/01/2002	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	10/01/2002	HH.2004	Health Network Performance Review	Medi-Cal
Revised	10/01/2003	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	11/01/2004	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	11/01/2004	HH.2004	Health Network Performance Review	Medi-Cal
Effective	08/01/2005	MA.7014	Physician Medical Group Delegation Oversight	OneCare
Effective	08/01/2005	MA.9103	Physician Group Performance Review	OneCare
Revised	03/01/2007	MA.7014	Physician Medical Group Delegation Oversight	OneCare
Revised	04/01/2007	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	07/01/2007	HH.2004	Health Network Performance Review	Medi-Cal
Revised	01/01/2010	HH.2004	Health Network Performance Review	Medi-Cal
Effective	04/01/2010	MA.9111	Readiness Assessment	OneCare
Effective	08/01/2010	HH.2016	Readiness Assessment	Medi-Cal
Revised	09/01/2011	GG.1619	Health Network Delegation Oversight	Medi-Cal
Revised	02/01/2013	HH.2004	Performance Reviews	Medi-Cal OneCare
Revised	04/01/2014	HH.2004	Health Network Performance Review	Medi-Cal
Revised	10/01/2014	GG.1619	Delegation Oversight	Medi-Cal
Revised	09/01/2015	GG.1619	Delegation Oversight	Medi-Cal
Revised	09/01/2015	HH.2004	Health Network Performance Review	Medi-Cal
Revised	09/01/2015	HH.2016	Readiness Assessment	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2015	MA.7014	Physician Medical Group Delegation Oversight	OneCare OneCare Connect PACE
Revised	09/01/2015	MA.9103	Health Network Performance Review	OneCare OneCare Connect
Revised	09/01/2015	MA.9111	Readiness Assessment	OneCare OneCare Connect
Revised	07/01/2017	GG.1619	Delegation Oversight	Medi-Cal OneCare OneCare Connect
Retired	09/28/2017	HH.2004	Health Network Performance Review	Medi-Cal
Retired	09/28/2017	HH.2016	Readiness Assessment	Medi-Cal
Retired	09/28/2017	MA.7014	Physician Medical Group Delegation Oversight	OneCare OneCare Connect PACE
Retired	09/28/2017	MA.9103	Health Network Performance Review	OneCare OneCare Connect
Retired	09/28/2017	MA.9111	Readiness Assessment	OneCare OneCare Connect
Revised	12/07/2017	GG.1619	Delegation Oversight	Medi-Cal OneCare OneCare Connect
Revised	12/06/2018	GG.1619	Delegation Oversight	Medi-Cal OneCare OneCare Connect
Revised	12/05/2019	GG.1619	Delegation Oversight	Medi-Cal OneCare OneCare Connect
Revised	12/03/2020	GG.1619	Delegation Oversight	Medi-Cal OneCare OneCare Connect
Revised	12/20/2021	GG.1619	Delegation Oversight	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1619	Delegation Oversight	Medi-Cal OneCare
Revised	11/01/2023	GG.1619	Delegation Oversight	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Contract Owner	The one individual within CalOptima Health with ultimate responsibility for the relationship between CalOptima Health and the Delegated Entity. Contract Owner responsibilities include, but are not limited to, initial contact, procurement, negotiation of contract terms, compliance remediation, on-going entity relations, site closings, hours of operations, etc. The Contract Owner is the individual with responsibility for ensuring that the documentation regarding the relationship between CalOptima Health and the Delegated Entity is complete and accurate.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Delegated Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services
Delegated Services	Services delegated to a Delegated Entity through a Delegation Agreement, which may include, but are not limited to, administration and management services, marketing, utilization management, quality assurance, case management, claims processing, claims payment, credentialing, network management, provider claim appeals, customer service, enrollment, disenrollment, billing, sales and adjudicating organization determinations and appeals.
Delegation Agreement	Mutually agreed upon document, signed by both parties, which includes, without limit: 1. CalOptima Health responsibilities; 2. Duration of the agreement; 3. Termination of the agreement; 4. Delegated Entity responsibilities and Delegated Services; 5. Types and frequency of reporting to the Delegated Entity; 6. Process by which the CalOptima Health evaluates the Delegated Entity's performance (Performance Measurements); 7. Use of confidential CalOptima Health information including Member Protected Health Information (PHI) by the Delegated Entity; and 8. Remedies available to the CalOptima Health if the Delegated Entity does not fulfill its obligations.
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
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Health Network	For purposes of this policy, the contracted health networks of CalOptima Health, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Management Services Organization (MSO)	For purposes of this policy, an entity that provides management and administrative support services on behalf of a Delegated Entity.
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in a CalOptima Health program.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Readiness Assessment	An assessment conducted by a review team prior to the effective date of a Delegated Entity's or other contracted entity's contract with CalOptima Health of the Delegated Entity's or contracted entity's compliance with all or a specified number of operational functional areas as determined by CalOptima Health.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

15. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023

Contact

Donna Laverdiere, Executive Director, Strategic Development (714)-986-6981

Recommended Actions

Authorize the following activities to secure Medi-Cal funds through the Voluntary Rate Range Intergovernmental Transfer (IGT) for Calendar Year 2023 (IGT 13):

1. Submission of a proposal to the California Department of Health Care Services to participate in IGT 13;
2. Pursuit of funding partnerships with eligible participating entities; and
3. The Chief Executive Officer executing agreements with these entities and their designated providers, as necessary, to seek IGT 13 funds.

Background

The Voluntary Rate Range IGT program allows the Department of Health Care Services (DHCS) and CalOptima Health to secure additional Medi-Cal dollars for eligible Orange County entities. For each IGT transaction, DHCS identifies the estimated member months for rate categories (*e.g.*, adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. To receive funds, entities provide a dollar amount to DHCS, which is then used to obtain a federal match. DHCS distributes the funds and the match to the eligible entities through CalOptima Health. To date, CalOptima Health has participated in twelve Voluntary Rate Range IGT transactions.

CalOptima Health retains a 2% administrative fee of net proceeds to offset expenses for the administration of the Voluntary Rate Range IGT program.

Discussion

On May 29, 2024, CalOptima Health received notification from DHCS regarding the IGT 13 opportunity with up to $160.5 million in total funding availability for Orange County. CalOptima Health's proposal, along with the proposed funding entities' supporting documents, are due to DHCS no later than June 28, 2024.

CalOptima Health will contact the six CY 2022 program participants (University of California-Irvine, First 5 Orange County, the County of Orange, the City of Orange, the City of Newport Beach, and the City of Huntington Beach) to inform them of the CY 2023 Voluntary Rate Range IGT program timeline and funding availability. CalOptima Health will also reach out to additional potentially eligible funding partners to inform them of the program timeline and requirements.

Board approval is requested to authorize staff to submit the proposal letter to DHCS for participation in IGT 13 and to authorize the Chief Executive Officer to enter into agreements with each of the identified

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funding entities submitting a letter of interest, or their designated providers, for the purpose of securing available IGT funds. Staff will submit to the Board the final list of funding partners and allocations for ratification at the August 1, 2024, meeting of the Board.

Fiscal Impact

Staff anticipates IGT 13 will be net budget neutral to CalOptima Health. CalOptima Health will retain a 2% administrative fee of net proceeds or approximately $1.95 million to offset expenses for the administration of the program. The remaining net proceeds will be distributed to the participating IGT funding entities.

Rationale for Recommendation

Submission of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Calendar Year 2023. It will increase dollars to funding entities in Orange County to support Medi-Cal services to CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Department of Health Care Services Voluntary Rate Range IGT Program Notification Letter
2. CY 2023 DHCS Attachment B Voluntary Rate Range Program – DHCS Template
3. CY 2023 DHCS Attachment C – CalOptima Health Estimated Funding Allocation
4. CY 2023 Voluntary Rate Range Letter of Intent Template
5. Prior Year – CY 2022 Voluntary Rate Range Program Participating Entities

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Michelle Baass | Director

May 13, 2024

Peter Bastone
Chief Strategy Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Calendar Year (CY) 2023 (January 1, 2023 – December 31, 2023) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Peter Bastone:

The Calendar Year 2023 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of January 1, 2023, through December 31, 2023.

DHCS shall not direct the MCP's expenditure of payments received under the CY 2023 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

California Department of Health Care Services
Capitated Rates Development Division
1501 Capitol Avenue, P.O. Box 997413
Sacramento, CA, 95899-7413
MS 4413 | Phone (916) 345-7070 | Fax (916) 650-6860
https://www.dhcs.ca.gov/

DHCS shall continue to administer all aspects of the IGT related to the CY 2023 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR CALENDAR YEAR 2023:

MCPs should refer to the estimated CY 2023 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the CY 2023 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that the estimated contribution (Non-Federal Share) amounts are based on CY 2023 capitation rates delivered to plans in May 2024, and actual member months (as of March 2024). Actual amounts may change based on finalized rates and updated enrollment information.

If an MCP elects to participate in the CY 2023 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the CY 2023 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on **MCP letterhead**.
    2. The MCP's primary contact(s) information (name(s), title(s), e-mail address(s), mailing address(s), and phone number(s)).

3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for CY2023. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the CY 2023 Voluntary Rate Range Program Supplemental Attachment described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A (included below) must be filled out completely and printed on the participating governmental funding entity's letterhead. A separate letter of interest must be provided for each county or rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Calendar Year 2023 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by **Friday, June 28, 2024**.

- The proposals and letters of interest are due to DHCS ***by 5pm on* Friday, *June 28, 2024***. Please send a PDF copy of the required documents by e-mail to Vivian.Beeck@dhcs.ca.gov, Michael.Ha@dhcs.ca.gov, and Scott.Gale@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the CY 2023 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the CY 2023 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Vivian Beeck at (916) 345-8271 or by email at Vivian.Beeck@dhcs.ca.gov.

Sincerely,

DocuSigned by:
Michael Jordan
641B9785907E40F...

Michael Jordan
Staff Services Manager II
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Attachments

cc: Vivian Beeck
Staff Services Manager I
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Michael Ha
Health Program Specialist
Capitated Rates Development Division
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Scott Gale
Associate Governmental Program Analyst
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2023 (January 1, 2023 through December 31, 2023)

Provider's Legal Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than June 28, 2024.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2021-22 (July 1, 2021 - June 30, 2022).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -

* Include payments received and anticipated to be received, for dates of service from July 1, 2021 - June 30, 2022.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2021 - June 30, 2022 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***(Yes / No)***

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

(iv) Does the transferring entity have general taxing authority? ***(Yes / No)***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***(Yes / No)***

5. Comments / Notes

Attestation by duly authorized representative:
Please print the Name (first & last), and Title: _____

Signature & Date: _____

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Voluntary Rate Range Program
Attachment C
January 1, 2023 - December 31, 2023

HPC	Health Plan Name	County	Rate Categories (1)	SIS/ UIS	Total MMs CY 23 (2)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund	Governmental Funding Entity Portion	Non Federal Share %
506	CalOptima	Orange	Child	SIS	3,472,048	99.09	$ 106.27	$ 7.18	$ -	$ 7.18	$ 24,929,305	$ 10,525,551	42.22%
506	CalOptima	Orange	Child	UIS	148,873	32.09	$ 34.73	$ 2.64	$ -	$ 2.64	$ 393,025	$ 177,141	45.07%
506	CalOptima	Orange	Adult	SIS	1,423,569	212.50	$ 225.70	$ 13.20	$ -	$ 13.20	$ 18,791,110	$ 8,573,220	45.62%
506	CalOptima	Orange	Adult	UIS	267,683	178.51	$ 189.06	$ 10.55	$ -	$ 10.55	$ 2,824,056	$ 1,254,778	44.43%
506	CalOptima	Orange	ACA Optional Expansion	SIS	3,773,376	304.58	$ 322.43	$ 17.85	$ 4.46	$ 13.39	$ 50,525,505	$ 5,052,550	10.00%
506	CalOptima	Orange	ACA Optional Expansion	UIS	419,435	292.09	$ 308.77	$ 16.68	$ 4.17	$ 12.51	$ 5,247,132	$ 575,180	10.96%
506	CalOptima	Orange	SPD	SIS	442,469	949.31	$ 995.41	$ 46.10	$ -	$ 46.10	$ 20,397,821	$ 9,515,885	46.65%
506	CalOptima	Orange	SPD	UIS	86,182	755.35	$ 797.07	$ 41.72	$ -	$ 41.72	$ 3,595,513	$ 1,661,790	46.22%
506	CalOptima	Orange	SPD/Full-Dual	SIS	1,299,679	456.76	$ 472.77	$ 16.01	$ -	$ 16.01	$ 20,807,861	$ 9,720,739	46.72%
506	CalOptima	Orange	SPD/Full-Dual	UIS	6,355	119.05	$ 125.99	$ 6.94	$ -	$ 6.94	$ 44,104	$ 20,604	46.72%
506	CalOptima	Orange	LTC	SIS	2,597	949.31	$ 995.41	$ 46.10	$ -	$ 46.10	$ 119,722	$ 55,930	46.72%
506	CalOptima	Orange	LTC	UIS	1,559	755.35	$ 797.07	$ 41.72	$ -	$ 41.72	$ 65,041	$ 30,381	46.71%
506	CalOptima	Orange	LTC/Full-Dual	SIS	31,893	456.76	$ 472.77	$ 16.01	$ -	$ 16.01	$ 510,607	$ 238,539	46.72%
506	CalOptima	Orange	LTC/Full-Dual	UIS	124	119.05	$ 125.99	$ 6.94	$ -	$ 6.94	$ 861	$ 402	46.69%
506	CalOptima	Orange	Whole Child Model	SIS	133,436	1,761.91	$ 1,852.98	$ 91.07	$ -	$ 91.07	$ 12,152,017	$ 5,094,006	41.92%
506	CalOptima	Orange	Whole Child Model	UIS	4,171	552.77	$ 583.55	$ 30.78	$ -	$ 30.78	$ 128,383	$ 54,716	42.62%
506	**CalOptima**	**Orange**	**All COAs**		**11,513,449**	**287.15**	**$ 302.71**	**$ 15.56**	**$ 8.63**	**$ 13.94**	**$ 160,532,063**	**$ 52,551,412**	**32.74%**

Footnotes:
1 The supplemental payments (Maternity and BHT) are not included in the rate range calculation.
2 Mainstream Member Months are actuals for CY 23 MM effective as of March 2024.

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SHOULD BE DONE ON YOUR LETTER HEAD

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of _Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number _Insert Federal Tax I.D. Number, in working with Managed Care Plan's Name (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2023 through December 31, 2023. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

_Insert Participating Funding Entity Name is willing to contribute approximately $_____ for the Calendar Year 2023 (January 1, 2023 – December 31, 2023) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, title, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Signature

Attachment to the June 6, 2024 Board of Directors Meeting – Agenda Item 15

Attachment 5 – Prior Year CY 2022 Voluntary Rate Range Program Participating Entities

Legal Name	Address	City	State	Zip code
City of Huntington Beach	2000 Main Street	Huntington Beach	CA	92648
City of Newport Beach	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange	300 E. Chapman Avenue	Orange	CA	92866
Children and Families Commission of Orange County (First 5 Orange County)	1505 E 17th Street, Suite 230	Santa Ana	CA	92705
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
Regents of the University of California, Irvine Medical Center (UCI Health)	333 City Blvd. West, Suite 200	Orange	CA	92868

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

16. Approve Actions Related to the Workforce Development Initiative: Training and Development Innovation Fund

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions

1. Authorize the Chief Executive Officer, or designee, to issue a notice of funding opportunity (NOFO) for the Provider Workforce Training and Development Innovation Fund.
2. Authorize from the $50 million restricted Provider Workforce Development Fund an allocation of up to $5 million to fund the grant agreements.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

In June 2023, the CalOptima Health Board of Directors (Board) approved the $50 million Provider Workforce Development Fund. The goals of the investment focus on identifying and addressing shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population (including physicians), increasing the diversity of the health care workforce, and providing economic support to allow individuals to pursue a career in health care in service of CalOptima Health members in Orange County.

CalOptima Health performed stakeholder engagement, data analysis, and a review of research and best practices and proposed five initiatives in December 2023. These five initiatives were approved by the Board as outlined below.

	Proposed Initiative	Funding Type	Description
1	Grants to Educational Institutions to Increase Supply of Health Care Professionals (non-physician)	Competitive Grant	Grants for health professional program expansion and financial support for students.
2	Workforce Training & Development Innovation Fund	Competitive Grant	Grants for innovative cross-sector partnerships supporting workforce training, upskilling, and employment pathways.
3	Physician Recruitment Incentive Program	Incentive Program – Application Process	Incentive payments for recruitment of providers to existing practices to close network gaps - $125,000 for primary care and

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	Proposed Initiative	Funding Type	Description
			$150,000 for specialty care (including psychiatry).
4	Physician Loan Repayment Program	Loan Repayment Program – Application Process	Loan repayment awards of up to $5,000 per month for 36 months ($180,000 total), to eligible primary care specialties, including family medicine, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, and specific specialty gaps.
5	Orange County Health Care Workforce Development Collaborative	Stakeholder Collaborative	Collaborative to bring together educational institutions, provider organizations, and county workforce development organizations to design and develop joint programs to increase the health care workforce.

In December 2024, the Board approved up to $10 million for the first round of grants for educational investments to increase the pipeline of health professionals serving Medi-Cal members in Orange County. In March 2024, the Board increased the funding allowance for the first round of grants to up to $25 million due to the demand and interest in the grant program. In April 2024, the Board approved $24.6 million for the first round of grant awards to seven organizations.

This second NOFO corresponds to the second initiative, Workforce Training and Development Innovation Fund, as outlined above.

Discussion

CalOptima Health staff is seeking approval of up to $5 million for the second grant program for provider workforce training and development innovation. This grant round would seek applications from provider organizations and community organizations and would encourage innovative partnerships and approaches that address identified health care provider workforce shortages in Orange County. This grant round will prioritize, but not be limited to, applications addressing behavioral health provider shortages. This second round of grants will follow the same competitive review and selection process that CalOptima Health utilized during the first round of grants. CalOptima Health will award grants up to a maximum amount of $1 million per organization.

Eligible applicants for grant funding under this opportunity would be health systems, health care provider organizations, and community organizations. Potential activities that CalOptima Health would consider for funding under this opportunity include but are not limited to:

- Upskilling programs to increase capacity of advanced and highly-skilled health care workforce.
- Training, internship, and certification programs for current health care professionals to advance in their careers.
- Training and upskilling programs that include wraparound supports.
- Funding for residency programs that have a focus on the safety net.

- Retention incentives for high-need, shortage professions with high turnover rates, including salary increases, bonuses, and other financial retention strategies.

Pending Board approval, the NOFO will be released on July 12, 2024. The application deadline for grant applications will be August 19, 2024. Awardees under the second round of grants will be presented for Board approval at the November 7, 2024, Board meeting, with grant awards planned for November 2024, if approved by the Board.

Grants Management and Oversight
Staff will release the NOFO in accordance with the CalOptima Health Policy AA.1400: Grants Management. Staff will return to the Board to request review and approval of recommended grantees. Specific milestones, reporting requirements, and timelines will be developed as part of the grant award process.

Fiscal Impact
The recommended action has no additional fiscal impact. A previous Board action on June 1, 2023, created a restricted Provider Workforce Development Fund in an amount not to exceed $50 million over five years. An allocation of up to $5 million from this restricted fund will support the recommended action.

Rationale for Recommendation
Approval an allocation of up to $5 million from the $50 million total Provider Workforce Development Reserve Fund will enable CalOptima Health to make investments to grow the health care workforce in Orange County to better serve CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Notice of Funding Opportunity "Round 2: Workforce Training and Development Innovation Fund."
2. Previous Board Action April 4, 2024, "Approve Award Recommendations for Workforce Development Initiative Round 1 Grants." *
   *Which includes the following previous Board Actions:
   - March 7, 2024, "Approve Request to Modify Provider Workforce Development Initiative Allocations."
   - December 7, 2023, "Approve Actions Related to the Workforce Development Strategic Priority."
   - June 1, 2023, "Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund."

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 1, 2023	Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund	5 Years	$50 million
December 7, 2023	Approve Actions Related to the Workforce Development Strategic Priority	5 Years	$50 million
March 7, 2024	Approve Request to Modify Workforce Development Initiative Allocations	5 Years	$25 million
April 4, 2024	Approve Award Recommendations for Workforce Development Round One Grants	5 years	$25 million

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

Provider Workforce Development Notice of Funding Opportunity

Round 2: Provider Workforce Training and Development Innovation Fund

CalOptima Health solicits grant requests to increase the provider workforce with a focus on training, recruitment, and retention of safety net providers in Orange County.

Application Deadline — 08/19/2024 (5:00 p.m. PST)

Background

CalOptima Health's mission is to serve member health with excellence and dignity, respecting the value and needs of each person. Health care workforce shortages in Orange County and statewide are significant, and investment is needed to increase the number of health professionals in Orange County. To address these challenges, the CalOptima Health Board approved an investment of $50 million over five years to create the Provider Workforce Development Initiative to increase the supply of safety net providers serving CalOptima Health members in Orange County. Through the Provider Workforce Development Initiative, CalOptima Health is committed to increasing the number of providers serving Orange County's most vulnerable population.

CalOptima Health engaged in a robust stakeholder listening process to inform the design of the Provider Workforce Development Initiative strategy and plan. One of the key challenges highlighted through the stakeholder engagement process was the need for training, retention, and employment pathway programs to retain and develop the health care workforce. This funding opportunity will be **open for applications July 12, 2024 – August 19, 2024.**

Description of Grant Funding Opportunity

The second round of grant funding within the Provider Workforce Development Initiative will be available to support innovative programs and partnerships that are committed to training, retention, and development of health professionals in non-physician primary care, behavioral health, and allied health. This funding round will prioritize but not be limited to programs focused on increasing the behavioral health workforce serving CalOptima Health members.

Eligible programs to train, upskill, retain and develop the current health care workforce would include, but not be limited to:

- Upskilling programs to increase capacity of advanced and highly-skilled health care workforce.

- Training, internship, and certification programs for current health care professionals to advance in their careers.
- Training and upskilling programs that include wraparound supports.
- Funding for residency programs that have a focus on the safety net.
- Retention incentives for high-need, shortage professions with high turnover rates including salary increases, bonuses, and other financial retention strategies.

Eligible programs must be located in Orange County. Projects that include components that encourage health professionals to serve Medi-Cal members in Orange County will be prioritized.

Grant Amounts and Duration

This second round of funding will make available up to $5.0 million. Applicants may only submit ***one application per organization***. The requested grant amount should not exceed $1,000,000.00. For awarded grants, payment will be made as defined in the fully executed grant agreement.

Any CalOptima Health investments will avoid supplanting or replacing existing Federal, State, and/or CalOptima Health funding sources for workforce development initiatives.

Entities Eligible to Apply

- Eligible entities to receive this funding would be health systems, health care provider organizations, and community organizations.
- Grant funds may only be utilized for supporting health care professionals in Orange County.
- Applicants that previously received funding from CalOptima Health must be in good standing with the terms of that contract or grant agreement to be eligible for new funding.
- Applicants are strongly encouraged to apply for funds when they are ready to implement the activity proposed for funding.

Proposal Evaluation Criteria

	Criteria	Max Points	Description of basis for assigning points
	Eligibility	Pass/Fail	• Must be a provider organization or community-based organization. • Maximum of one application per organization. • Does not supplant other available Federal, State or CalOptima Health opportunities/sources.
1	CalOptima Health Core Mission and Value Alignment	10	• Project aligns with the CalOptima Health mission, vision, and values statements. • Proposed program demonstrates value to the CalOptima Health membership and the Medi-Cal program. • Proposed program fills an unmet need within the CalOptima Health investment and grantmaking portfolio.

2	Provider Workforce Development Initiative Goals	20	• Proposes investments targeted towards identified shortages in the health care workforce serving CalOptima Health members including primary care, behavioral health, and allied health. Priority will be given to projects that address behavioral health provider shortages. *Applications focused on behavioral health will receive a 1.5-point value weighting.* • Demonstrates how the project increases the number of health professionals in Orange County.
3	Proposed Program Design	20	• The proposed program is in alignment with the goals and objectives of the grant program as outlined in the Notice of Funding Opportunity. • The proposed program is clearly described and addresses identified workforce shortages that are supported by data/evidence. • The proposed program includes innovative approaches to training, retention, or upskilling components that aim to increase the number of health professions in identified shortage areas. • The proposed program clearly outlines any needed partnerships to support program success. • The program includes elements that encourage or incentivize participants to remain in Orange County and serve Medi-Cal members.
4	Equity	15	• Project aims to increase representation of underrepresented groups in health professions. • Project considers the diverse needs of the Medi-Cal population and the workforce investments needed to improve access to care for underserved groups.
5	Project Implementation Plan & Performance Measures	10	• Provides a clear and complete implementation plan with well-defined project milestones and timeframes. • Clearly states specific SMART objectives and defined measures of success for the project. • Clearly indicates that the program will be up and running within 6 months of grant award.
6	Budget & Financial Management	15	• Budget and financial plan are sound and aligned with the objectives and activities of the project. • Outlines direct and indirect costs, including partner budgets and expenditures. • Proposed budget prioritizes program activities that benefit participants and has a reasonable allocation for administrative expenses. • Project includes no more than 10% for indirect expenses.
7	Organization Experience and Program Capacity	10	• Applicant has demonstrated experience needed to perform the program.

			• Applicant is a stable organization and has demonstrated capacity to perform the functions of the program. • Identifies potential funding sources for sustainability of the project/program after the end of the grant agreement.
Total Earnable Points		**100**	*110 total points available with behavioral health weighting.*

Timeline

Activity	Date
NOFO Released and Portal Opens	7/12/2024 at 9 a.m.
Bidder's Conference *(virtual)*	7/15/2024 at 3 p.m.
Questions Posted from Bidder's Conference Session	7/22/2024
Application Deadline	**8/19/2024 at 5 p.m.**
Internal Review	8/20/2024-9/30/2024
CalOptima Health Board of Directors Meeting	**11/7/2024**
Announcement of Approved Grants	11/8/2024
Grant Agreements Processed	11/8/2024-12/9/2024
Grant Start Dates	12/16/2024

Documents and Portal Access

All documents related to this Notice of Funding Opportunity and application portal access will be made available at this site:
https://www.caloptima.org/en/About/CurrentInitiatives/WorkforceDev

Bidder's Conference Session

Join our Bidder's Conference Session for this funding opportunity by registering below:

Bidder's Conference Session
Date and Time: Monday, July 15, 2024, time to be announced.
Link: TBD

Questions about the funding opportunity or application? Contact Strategic Development at strategicdevelopment@caloptima.org

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
17. Approve Award Recommendations for Workforce Development Initiative Round One Grants

Contact
Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions
1. Approve the selection of seven recommended grantees with corresponding grant award allocations totaling $24,596,300 for educational investments to increase the pipeline of health care professionals in Orange County.
2. Approve the recommendation of a maximum grant award of $5 million per applicant organization.
3. Authorize the Chief Executive Officer, or designee, to enter into grant agreements with the recommended grantees.
4. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
In June of 2023, the CalOptima Health Board of Directors (Board) approved the $50 million Provider Workforce Development Fund. The goals of the investment focus on identifying and addressing shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population, including physicians, increasing the diversity of the health care workforce, and providing economic support to allow individuals to pursue a career in health care in service to CalOptima Health members in Orange County.

CalOptima Health performed stakeholder engagement, data analysis, and a review of research and best practices and proposed five initiatives in December 2023. These five initiatives were approved by the Board as outlined below.

	Proposed Initiative	Funding Type	Description
1	Grants to Educational Institutions to Increase Supply of Health Care Professionals (non-physician)	Competitive Grant	Grants for health professional program expansion and financial support for students.
2	Workforce Training & Development Innovation Fund	Competitive Grant	Grants for innovative cross-sector partnerships supporting workforce training, upskilling, and employment pathways. *Notice of funding opportunity currently in development.*

	Proposed Initiative	Funding Type	Description
3	Physician Recruitment Incentive Program	Incentive Program – Application process	Incentive payments for recruitment of providers to existing practices to close network gaps - $125,000 for primary care and $150,000 for specialty (includes psychiatry).
4	Physician Loan Repayment Program	Loan Repayment Program – Application process	Loan repayment awards of up to $5,000 per month for 36 months ($180,000 total), to eligible primary care specialties, including family medicine, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, and specific specialty gaps.
5	Orange County Health Care Workforce Development Collaborative	Stakeholder Collaborative	Collaborative to bring together educational institutions, provider organizations, and county workforce development organizations to design and develop joint programs to increase the health care workforce.

CalOptima Health requested an initial allocation of up to $10 million to fund the first grant initiative for educational investments to increase the supply of health care professionals serving CalOptima Health members in Orange County. The Board approved an initial allocation of up to $10 million for the first grant funding opportunity out of the total $50 million Provider Workforce Development Fund.

On March 7, 2024, due to the overwhelming response and interest in the first round of grant funding, the Board approved an increase in the initial allocation of $10 million to $25 million within the Workforce Development Initiative. This adjusted allocation will be used to award the first round of funding for educational investments.

Discussion

In December 2023, CalOptima Health released the first notice of funding opportunity (NOFO) for grants to increase health care workforce pipeline through educational investments. CalOptima Health hosted a bidder's conference to describe participation requirements and provided an opportunity for questions and answers. Interested grantees submitted grant applications from December 15, 2023, through January 31, 2024. CalOptima Health received a total of 30 applications with a total requested amount of $96.5 million. The grant applications received are summarized below.

Health Care Profession	Universities/Colleges		*Community-Based Organizations	
	# of Applications	Requested $ (in million)	# of Applications	Requested $ (in million)
Allied Health	4	$10.7	-	-
Behavioral	2	$2.0	8	$12.7
Nursing	5	$35.3	1	$4.6

Primary Care	1	$5.8	-	-
Multiple Professions	4	$18.8	5	$6.7
Total	**16**	**$72.6**	**14**	**$24.0**
*Must have partnerships with educational institutions.				

CalOptima Health convened a committee of six grant reviewers to evaluate each received application against the review criteria included in the NOFO. CalOptima Health review committee utilized a scoring rubric to evaluate the applications. The review committee is recommending the following applicants for grant awards based on their total score. In order to provide equal partnership opportunity across multiple entities, staff also recommends limiting each grant award to a maximum amount of $5 million for each applicant organization.

Organization	Proposal(s)	Requested Amount	Funding Amount
Coast Community College District	Expanding registered nurse pipeline at Golden West College by 40 students per year and develop a pathway to the radiologic technology certificate program at Orange Coast College for 30 students per year.	$2,040,000	$2,040,000
Santiago Canyon College	Increasing the behavioral technician program from 25-50 to 50-100 students annually; medical assistant program from 50 to 175 students annually; and develop a licensed vocational nursing curriculum/attain program accreditation to produce 60+ licensed graduates annually.	$1,200,000	$1,200,000
Sue & Bill Gross School of Nursing, University of California Irvine	Creating a program to provide a 1-year externship to 120 prelicensure nursing students and a 1-year residency for 8 family nurse practitioners and 4 psychiatric mental health nurse practitioners graduates to address Orange County's shortage of registered nurses and primary and behavioral healthcare providers.	$9,126,399	$5,000,000
Chapman University	Providing full tuition physician assistant scholarships (10 for first year and 10 for second year students), training, and local practice physician assistant education for academically qualified, low-income students.	$5,684,162	$5,000,000

CSU Fullerton Auxiliary Services Corporation	Increasing the Concurrent Enrollment Program admission number by 25-40 students annually to admit 200 associate degree nursing to bachelor of science in nursing (BSN) students and an expansion of the BSN program by eight students, from 80 to 88 admissions each year, following Board of Registered Nursing approval.	$9,999,732	$5,000,000
Orange County United Way	Expanding the UpSkill program, focusing on gaps within the healthcare workforce, and providing career coaching, connections to paid training and certification programs, and job placements in the healthcare industry to serve an additional 25 clients each year.	$1,356,300	$1,356,300
Concordia University, Irvine	Increasing the accelerated bachelor of science in nursing (ABSN) program and providing scholarships to 10 pre-nursing students per year and 20 ABSN students per year.	$5,629,907	$5,000,000
	Total:	**$35,036,500**	**$24,596,300**

Note: All funded projects are multi-year grant programs.

CalOptima Health will award and oversee these recommended grant awards in accordance with Policy AA.1400: Grants Management. Specific milestones and reporting requirements and timelines will be developed as part of the grant award process.

Fiscal Impact

The recommended action has no additional fiscal impact. Previous Board actions on December 7, 2023, and March 7, 2024, allocated $25.0 million, in aggregate, to fund the first round of grants to educational institutions to increase the supply of health care professionals. CalOptima Health reserves the right in the applicable grant agreements to recoup funds for lack of demonstrated effort or not meeting grant commitments.

Rationale for Recommendation

This action approves grant awards from the allocated $25 million for investments in increasing the pipeline of health care professionals in Orange County. These grant awards will help to increase the number of students seeking non-physician health professions in Orange County and will increase the supply of health professionals serving CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Workforce Development Round One Review Committee Scores
3. Previous Board Action March 7, 2024, "Approve Request to Modify Provider Workforce Development Initiative Allocations."
4. Previous Board Action December 7, 2023, "Approve Actions Related to the Workforce Development Strategic Priority."
5. Previous Board Action June 1, 2023, "Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund."
6. NOFO Round 1 Recommended Funding Decisions Presentation

/s/ Michael Hunn *03/29/2024*
Authorized Signature **Date**

Attachment to the April 4, 2024 Board of Directors Meeting – Agenda Item 17

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Chapman University	One University Drive	Orange	CA	92866
Coast Community College District	1370 Adams Avenue	Costa Mesa	CA	92626
Concordia University	1530 Concordia	Irvine	CA	92612
CSU Fullerton Auxiliary Services Corporation	1121 N State College Blvd	Fullerton	CA	92831
OC United Way	18012 Mitchell South	Irvine	CA	92614
Santiago Canyon College	8045 East Chapman Avenue	Orange	CA	92869
Sue & Bill Gross School of Nursing, University of California, Irvine	854 Health Sciences Quad, 2555	Irvine	CA	92617

Attachment to the April 4, 2024 Board of Directors Meeting – Agenda Item 17

SCORES OF ROUND ONE PROVIDER WORKFORCE DEVELOPMENT APPLICATIONS

#	Organization Name	Proposed Program Title	Score out of 100	Funding Recommendation
1	Coast Community College District	Orange County Dual Enrollment Nursing and Allied Health Pathways	87.33	Fund
2	Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Behavior Technicians	87.33	Fund
3	Sue & Bill Gross School of Nursing, University of California, Irvine	NURSE-OC: University of California, Irvine Nursing Workforce Pipeline through Externships and Residencies in Orange County (OC)	86.50	Fund
4	Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Licensed Vocation Nurse	84.83	Fund
5	Chapman University	Reflecting Orange County Communities: Building a Culture of Health through Physician Assistant Scholarships, Training, and Local Practice Physician Assistant Education for Academically Qualified Low Income Students	84.67	Fund
6	CSU Fullerton Auxiliary Services Corporation	Expanding Numbers of CSUF Baccalaureate-Prepared Registered Nurses in Orange County	84.50	Fund
7	Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Medical Assistant	84.17	Fund
8	CSU Fullerton Auxiliary Services Corporation	CalOptima Stipend Program for CSUF Accelerated Baccalaureate Nursing Students	83.17	Do Not Fund (Grantee exceeded maximum allowed grant award with highest scoring application)
9	Orange County United Way	UpSkill OC	83.00	Fund
10	Concordia University Irvine	Concordia Nursing Pipeline Program	81.83	Fund
11	CHOC	Health and Behavioral Health Field Practicum Expansion	80.17	Do Not Fund
12	Easterseals Southern California	Building Orange County's Mental Health Service Capacity	79.33	Do Not Fund
13	Big Brothers Big Sisters of Orange County and the Inland Empire	Mentoring Orange County's Next Healthcare Workers	78.83	Do Not Fund

14	Access California Services	AccessCal's Health Care Workforce Program	78.33	Do Not Fund
15	John Henry Foundation	Intern Psychologist Workforce Development Program	78.00	Do Not Fund
16	Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Lactation Education Pathway to International Board Certified Lactation Consultant (IBCLC)	77.83	Do Not Fund
17	UC Irvine Program in Public Health	Orange County Health Pathways Program	77.83	Do Not Fund
18	AltaMed Health Services Corporation	AltaMed Orange County Community Health Workforce Pipeline	76.83	Do Not Fund
19	North Orange County Regional Occupational Program - Adult Career Education	North Orange County ROP Healthcare Workforce Training Expansion Program	76.67	Do Not Fund
20	The Cambodian Family	Cambodian Mental Health Workforce Development Initiative	75.83	Do Not Fund
21	South Orange County Community College District dba Saddleback College	Orange County Surgical Technologist Career Pathway	75.00	Do Not Fund
22	UCI Susan Samueli Integrative Health Institute	Health and Wellness - Behavioral Health Track Coaching Certificate Program	74.67	Do Not Fund
23	Seneca Family of Agencies	Seneca Family of Agencies' OC Behavioral Health Clinical Internship Program	72.67	Do Not Fund
24	YMCA of Orange County	Developmental Disabilities Workforce Development Collaborative	72.67	Do Not Fund
25	Celebrating Life Community Health Center	Path to Medical Provider for Underserved Populations Academic Award Program	71.83	Do Not Fund
26	Orange County Asian and Pacific Islander Community Alliance, Inc.	Project VOICE-BH	71.33	Do Not Fund
27	Anaheim Union High School District	Connecting Students' Strengths, Interests, and Aspirations to Build a Better Healthcare Workforce through Daily Classroom Instruction	70.67	Do Not Fund
28	Camino Health Center	Camino Pathways	70.17	Do Not Fund
29	Orange County Department of Education	Orange County Health Careers Center	64.33	Do Not Fund

30	Sowing Seeds Health, Inc.	Clinical Rotation Position Expansion	63.50	Do Not Fund

CalOptima Health Board Action Agenda Referral

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

Report Item
11. Approve Request to Modify Provider Workforce Development Initiative Allocations

Contact
Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions
Authorize an increase to the Provider Workforce Development Initiative Allocation from $10 million to $25 million for educational investments to increase the supply of health care professionals from the $50 million restricted CalOptima Health Provider Workforce Development Fund, accounting for the high volume of funding applications received.

Background
In June of 2023, the CalOptima Health Board of Directors (Board) approved the $50 million Provider Workforce Development Fund. The goals of the investment focus on identifying and addressing shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population, including physicians, increasing the diversity of the health care workforce, and providing economic support to allow individuals to pursue a career in health care in service to CalOptima Health members in Orange County.

CalOptima Health performed stakeholder engagement, data analysis, and a review of research and best practices and proposed five initiatives in December 2023. These five initiatives were approved by the Board as outlined below.

	Proposed Initiative	Funding Type	Description
1	Grants to Educational Institutions to Increase Supply of Health Care Professionals (non-physician)	Competitive Grant	Grants for health professional program expansion and financial support for students.
2	Workforce Training & Development Innovation Fund	Competitive Grant	Grants for innovative cross-sector partnerships supporting workforce training, upskilling, and employment pathways. *Notice of funding opportunity currently in development.*
3	Physician Recruitment Incentive Program	Incentive Program – Application process	Incentive payments for recruitment of providers to existing practices to close network gaps - $125,000 for primary care and $150,000 for specialty (includes psychiatry).

	Proposed Initiative	Funding Type	Description
4	Physician Loan Repayment Program	Loan Repayment Program – Application process	Loan repayment awards of up to $5,000 per month for 36 months ($180,000 total), to eligible primary care specialties, including family medicine, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, and specific specialty gaps.
5	Orange County Health Care Workforce Development Collaborative	Stakeholder Collaborative	Collaborative to bring together educational institutions, provider organizations, and county workforce development organizations to design and develop joint programs to increase the health care workforce.

CalOptima Health requested an initial allocation of up to $10 million to fund the first grant initiative for educational investments to increase the supply of health care professionals serving CalOptima Health members in Orange County. The Board approved an initial allocation of up to $10 million for the first grant funding opportunity out of the total $50 million Provider Workforce Development Program.

Discussion

In December 2023, CalOptima Health released the first notice of funding opportunity for up to $10 million for investments related to increasing the supply of health professionals serving CalOptima Health members. CalOptima Health hosted a bidder's conference to describe participation requirements and provided an opportunity for questions and answers. Interested grant bidders submitted applications from December 15, 2023, through January 31, 2024.

CalOptima Health received an overwhelming response and interest in the first round of grant funding. In total, CalOptima Health received 30 applications with a total requested amount of $96.5 million. The wide range of applications spanned workforce shortage professions and proposed innovative and comprehensive solutions to addressing the affordability of education, supports for students completing their education, targeted recruitment efforts to increase participation by underrepresented groups, and investments in career opportunities for health professionals entering the workforce. This overwhelming response to the funding opportunity provides insight into the size and scope of the workforce development needs that exist in Orange County. The applications received are summarized below.

Workforce Shortage Area	Number of Applications	Total Grant Funds Requested
Nursing	6	$39,854,986
Varied Professions	9	$25,562,703
Behavioral Health	10	$14,729,363
Allied Health	4	$10,712,873
Primary Care	1	$5,684,162
Total	***30***	***$96,544,087***

Based on the applications listed above, CalOptima Health identified a greater need for grant investments in education to increase the pipeline of students seeking health professions in Orange County. For example, these applications identified the opportunity for nearly $40 million in investment in the nursing

professions alone.

CalOptima Health conducted a competitive scoring process for all grant applications received based on the published grant review criteria. Based on the overwhelming interest in the first grant initiative, CalOptima Health recommends an increased allocation for the first round of grants of $15 million in addition to the initial $10 million allocation requested, for a total allocation of $25 million. This increased investment will allow additional grant awards to be provided to the top scoring applicants. In addition, CalOptima Health may request grantees that requested more than $5 million for a single grant program to consider other funding sources to augment their proposed programs in order to spread the funds across more grantees and health professions.

Based on the increased allocation request of $15 million for a revised total of $25 million for the first round of grants, CalOptima Health will need to proportionately reduce investments in the remaining four initiatives for the Provider Workforce Development program approved by the Board in December 2023.

Staff will provide oversight of the grants pursuant to AA.1400p: Grants Management and will return to the Board to provide updates on the status of the initiative.

Fiscal Impact

The recommended action has no additional fiscal impact. A previous Board action on June 1, 2023, created a restricted CalOptima Health Provider Workforce Development Fund in an amount not to exceed $50 million over five years. If approved, this action will increase the allocation of funds for the first round of grants to educational institutions to increase supply of health care professionals from up to $10 million to up to $25 million. This increased allocation will reduce the total funds available for allocation to the remaining four initiatives to $25 million, in aggregate.

CalOptima Health reserves the right to recoup funds for lack of demonstrated effort or meeting grant commitments.

Rationale for Recommendation

Approval of the $15 million increased allocation for educational investments (from the $50 million total Workforce Development Fund) for a total of $25 million will enable CalOptima Health to make additional grant awards to help increase the supply of health care professionals serving CalOptima Health members in Orange County.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Previous Board Action December 7, 2023, “Approve Actions Related to the Workforce Development Strategic Priority.”
2. Previous Board Action June 1, 2023, “Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund.”

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 7, 2023	Approve Actions Related to the Workforce Development Strategic Priority	N/A	$10 million
June 1, 2023	Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund	5 Years	$50 million

_____ _____

Authorized Signature **Date**

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

22. Approve Actions Related to the Workforce Development Strategic Priority

Contacts

Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981
Yunkyung Kim, Chief Operating Officer, (714)-923-8834

Recommended Actions

1. Approve the proposed program pillars for Provider Workforce Development initiative as:
    a. Educational Investments to Increase Supply of Health Care Professionals.
    b. Workforce Training & Development Innovation Fund.
    c. Physician Recruitment Incentive Program.
    d. Physician Loan Repayment Program.
    e. Orange County Health Care Workforce Development Collaborative.
2. Authorize the Chief Executive Officer, or designee, to issue an initial notice of funding opportunity for Educational Investments to Increase Supply of Health Care Professionals.
3. Authorize from the $50 million restricted CalOptima Health Provider Workforce Development Fund an allocation of up to $10 million to fund the grant agreements.
4. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

In June of 2022, the CalOptima Health Board of Directors (Board) adopted the Strategic and Tactical Priorities for 2022-2025. The strategic priority areas and tactical priorities serve as the roadmap for strategic growth and funding allocations that support CalOptima Health's mission and vision. One strategic priority adopted by the Board was Future Growth, which includes the Member Access to Quality Care tactical priority. The $50 million Provider Workforce Development initiative, approved by the Board in June of 2023, supports the Member Access to Quality Care tactical priority among others.

Further, the goals of the initiative focus on identifying and addressing shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population, including physicians; increasing the diversity of the health care workforce; and providing economic support to allow individuals to pursue a career in health care in service to CalOptima Health members in Orange County.

Discussion

As part of Workforce Development Initiative development, CalOptima Health sought input from community stakeholders, including educational institutions, providers, and community organizations. CalOptima Health sought feedback on several existing meetings and forums including the Member and Provider Advisory Committee, the monthly Health Network Forum, and other provider meetings.

CalOptima Health also hosted three public listening sessions with broad stakeholder attendance. Each listening session focused on a key stakeholder group: educational institutions, provider organizations, and community organizations. Stakeholders shared information on the barriers they have observed that drive the shortages in health care providers and health professionals in Orange County. Approximately 110 attendees participated in the listening sessions. Based on all outreach, CalOptima Health developed four categories of feedback that informed the areas targeted within this initiative.

1. Overall Healthcare Workforce Shortages

Healthcare workforce shortages and gap areas identified by provider and community partners in these meetings as well as through CalOptima Health provider network data include:

- Primary care (including physicians, physician assistants, and nurse practitioners).
- Nurses.
- Behavioral health professionals.
- Specialty care professionals specifically in the specialty areas of anesthesiology, cardiology, dermatology, endocrinology, gastroenterology, neurology, plastics, psychiatry, pulmonology, rheumatology, urology, and pediatric specialties.
- Allied health professionals.

2. Educational Institutions

Educational institutions shared their perspectives on the challenges they face in increasing the pipeline of students seeking health professions. Stakeholders indicated that there is no shortage of students who are interested in entering health professions in Orange County. The barriers to an increased pipeline of students are related more to available slots in existing programs and affordability of higher education. Barriers to increasing the number of slots in existing programs include a shortage of clinical rotation placements and a shortage of clinical faculty.

3. Provider Organizations

Provider organizations shared their perspectives on the challenges they face with recruitment and retention as well as the key workforce shortages in their systems. They cited competition for talent as well as high cost of living, burnout, and physician retirements as key challenges. In addition, comparatively lower reimbursement for Medi-Cal services can result in access barriers for CalOptima Health members.

4. Community Organizations

Community organizations shared broad feedback on the challenges they observe in Orange County related to health care workforce needs and shortages as well as their perspectives on how to increase diversity in the workforce. In every community stakeholder forum, behavioral health shortages and wait times were cited as a critical shortage area. In addition, stakeholders indicated the opportunities that exist within the community health worker workforce, the need for expanded access to culturally competent care and support, shortages of care coordinators/navigators, and emerging challenges due to growth in the aging population. In terms of increasing diversity of the health care workforce, key barriers cited include affordability of educational opportunities, the need for enhanced wraparound supports, internships and mentorships, and the need to connect community members to assistance and resources available in the community.

Proposed Program Initiatives

Based on stakeholder engagement, data analysis, and a review of research and best practices, CalOptima Health proposes a set of five initiatives for Provider Workforce Development Reserve Fund investment that address several of the key barriers to health care workforce expansion and retention in Orange County. CalOptima Health staff request an initial allocation of up to $10 million from the Workforce Development Fund for the first competitive grant program, as outlined in the table below.

	Proposed Initiative	**Funding Type**	**Description**
1	Grants to Educational Institutions to Increase Supply of Health Care Professionals (non-physician)	Competitive Grant	Grants for health professional program expansion and financial support for students. *Notice of funding opportunity for Board approval.*
2	Workforce Training & Development Innovation Fund	Competitive Grant	Grants for innovative cross-sector partnerships supporting workforce training, upskilling, and employment pathways. *Notice of funding opportunity currently in development.*
3	Physician Recruitment Incentive Program	Incentive Program – Application process	Incentive payments for recruitment of providers to existing practices to close network gaps - $125,000 for primary care and $150,000 for specialty (includes psychiatry).
4	Physician Loan Repayment Program	Loan Repayment Program – Application process	Loan repayment awards of up to $5,000 per month for 36 months ($180,000 total), to eligible primary care specialties, including family medicine, internal medicine, obstetrics/gynecology, pediatrics, and psychiatry and specific specialty gaps.
5	Orange County Health Care Workforce Development Collaborative	Stakeholder Collaborative	Collaborative to bring together educational institutions, provider organizations, and county workforce development organizations to design and develop joint programs to increase the health care workforce.

Notice of Funding Opportunity for Educational Institutions to Increase Supply of Health Care Professionals

As noted above, there are two competitive grant opportunities proposed under the Workforce Development Initiative. CalOptima Health staff is seeking approval of up to $10 million for the first grant program under the outlined priority areas above for educational institutions to support investments in program expansion and student financial support.

Eligible applicants for grant funding under this opportunity would be educational institutions or partnerships among educational institutions and provider or community organizations. Potential activities that would be considered for funding under this opportunity include but are not limited to:

- Pipeline programs from high school into higher education with commitment to serve Orange County.
- Stipend programs with a commitment to serve Orange County.
- Funding to expand existing health care higher education programs to additional cohorts.
- Investments to expand clinical rotations to a greater number of students.
- Investments to develop and recruit faculty among health professions, including nurse educators, and others.

Potential types of programs that would be eligible for funding include, but are not limited to, nursing, allied health, and behavioral health. Future grant initiatives will be announced that focus on additional areas.

The notice of funding opportunity for this first round of competitive grants will be released on December 15, 2023. The application deadline for grant applications will be January 31, 2024. Awardees under the first round of grants will be presented for Board approval at the March 7, 2024 meeting of the Board, with grant awards planned for March 8, 2024 if approved.

Staff anticipates bringing an agenda item to the Board for review in April 2024 to approve the second round of competitive grants that will focus on the second identified priority initiative, Workforce Training & Development Innovation Fund.

Grants Management and Oversight
Staff will release each notice of funding opportunity in accordance with the CalOptima Health Policy AA.1400: Grants Management. Staff will return to the Board to request review and approval of recommended grantees. Specific milestones and reporting requirements and timelines will be developed as part of the grant award process.

Fiscal Impact

The recommended action has no additional fiscal impact. A previous Board action on June 1, 2023, created a restricted CalOptima Health Provider Workforce Development Fund in an amount not to exceed $50 million over five years. An allocation of up to $10 million from this restricted fund will support the recommended action.

Rationale for Recommendation

Approval of the proposed actions and the up to $10 million allocation from the $50 million total Workforce Development Fund will enable CalOptima Health to make investments to grow the health care workforce in Orange County to better serve CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Previous Board Action June 2, 2022, "Adopt Strategic and Tactical Priorities for 2022-2025"
2. Previous Board Action June 1, 2023, "Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund."
3. Notice of Funding Opportunity "Increasing the Health Care Workforce Pipeline Through Educational Investments."

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 2, 2022	Adopt Strategic and Tactical Priorities for 2022-2025		
June 1, 2023	Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund	5 Years	$50 million

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
18. Adopt Strategic and Tactical Priorities for 2022-2025

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Action(s)
1. Adopt Strategic and Tactical Priorities for 2022-2025

Background and Discussion
CalOptima was created by the Orange County Board of Supervisors in 1993 as a County Organized Health System (COHS) to meet the needs or Orange County residents and providers in the Medicaid system.

In July of 1994, the CalOptima Board of Directors (Board) adopted the Mission, Goals, and Objective Statement for O.P.T.I.M.A as developed by the Provider Advisory Committee and the Consumer/Beneficiary Advisory Committee.

At that time, the Board wanted to ensure that the statement regarding the inclusion of the County-responsible indigent population in O.P.T.I.M.A was linked to the availability of adequate funding for services provided to this population.

The following mission was adopted and defined in Policy #AA. 1201:

- Mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima also adopted the following vision statement:

- To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

In 2013, during a strategic planning session conducted by the Board updating the mission was considered. Ultimately, it was agreed up on that the original mission statement did not require any changes.

Today, CalOptima is the single largest health insurer in Orange County, providing coverage for one in four residents through four programs:

- Medi-Cal
- OneCare
- OneCare Connect

- PACE

On March 17, 2022, the Board formally adopted new mission and vision statements.

- Mission-To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision-By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Beginning in December of 2021, staff developed five strategic priorities and tactical priorities. Over the last six months, CalOptima has sought feedback from advisory committees, health networks, hospitals, and clinics among others. The five strategic priority areas are as follows:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountability and Results Tracking
- Future Growth

The strategic priority areas and tactical priorities will support planning and development for CalOptima through 2025. Staff will return to the Board with a Strategic Plan using these priorities for approval.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Development of the proposed Strategic Priority Areas is consistent with the direction provided by the Board of Directors to support planning and development of CalOptima programs and initiatives.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Strategic Priorities One Pager
2. Resolution of New Mission and Vision Statement for CalOptima

/s/ Michael Hunn — *05/27/2022*
Authorized Signature — **Date**

Mission	*To serve member health with excellence and dignity, respecting the value and needs of each person.*				
Vision	*By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.*				
Core Strategy	**The 'inter-agency' co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision.**				
Strategic Priorities 2022-2025	**Organizational and Leadership Development**	**Overcoming Health Disparities**	**Finance and Resource Allocation**	**Accountabilities & Results Tracking**	**Future Growth**
Tactical Priorities 2022-2025	• Cultural Alignment throughout CalOptima • Talent Development & Succession Planning • Effective & Efficient Organizational Structures • Aligned Operating Systems & Structures • Staff Leadership Development Institutes (Training) & Executive Coaching • Organizational Excellence Annual Priorities • On-going updated Policies & Procedures • Governance & Regulatory Compliance Trainings • Board Priorities	• CalOptima's 'Voice & Influence' • Local, Federal & State Advocacy • Collaboration with the County, HCA, BeWell, the Networks and Community Based Organizations • Support for Community Clinics & Safety Net Providers • Medical Affairs Value Based Care Delivery • CalAIM initiatives • Focus on Equity & Communities Impacted by Health Inequities • Co-Created Needs Assessment within Equity Communities & Neighborhoods • ITS Architecture that supports the Core Strategy • DHCS Comprehensive Quality Strategy	*Operating Budget Priorities* • Balanced Operating Budget • New Programs & Services Budgeting (CalAIM, DHCS Quality Strategy) • Fiscal Strategic Plan Priorities (KPI/KFI) • Quarterly Budget Reconciliation *Capital Budget Priorities* • Capital Planning & Asset Management, including Real-Estate Management and Acquisition(s) • New ITS Architecture *New Policy and Program Development based on Funding* • Reserve/Spending Policies & Priorities • Aligned Incentives for Network Quality & Compliance • Contracting & Vendor/Provider Management	• Updated By-Laws • Executive Priorities & Outcomes • COBAR Clarity • Inter-Agency Team Priorities • Public/Private Implementation Work Group • Resource Allocation for Inter-Agency Initiatives • Partner CalAIM Opportunities for Outcomes Metrics • Research Analytics for Efficacy Reporting (Metrics of Success) • Regular Board Training Sessions	• Member Access to Quality Care • Participate in Covered California • Site Utilization (PACE etc.) • Services/Programs Aligned with Future Reimbursements from DHCS and CMS • Demographic & Analytics by Micro-Community • ITS Data Sharing to benefit the member • Implement Programs & Services (CalAIM) & Plan for Site Locations • Industry Trends Analysis (Trade Associations, Lobbyists etc.) • Enhanced ITS security posture

DRAFT STRATEGIC AND TACTICAL PRIORITIES May_2022

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RESOLUTION NO. 22-0317-01

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

RESOLUTION FOR MISSION AND VISION STATEMENT

WHEREAS, the governing body of the Orange County Health Authority, dba CalOptima, ("CalOptima") adopted Mission, Goals, and Objective Statement O.P.T.I.M.A in July of 1994;

WHEREAS, this mission statement adopted in 1994 stated, the mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

WHEREAS, the adoption of the mission statement was reflected in Policy #AA. 1201;

WHEREAS, the governing body of CalOptima has adopted a new mission and vision statement on March 17, 2022 and will be reflected in Policy #AA. 1201;

WHEREAS, the governing body adopted CalOptima's new mission and vision statement as follows;

- Mission: To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision: By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

NOW, THEREFORE, BE IT RESOLVED that the governing body of CalOptima adopts a new mission and vision statement.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 17th day of March 2022.

AYES: Becerra, Chaffee, Contratto, Corwin, Do, Mayorga, Schoeffel, Shivers

NOES: None

ABSENT: Tran

ABSTAIN: None

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

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

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
22. Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund

Contacts
Michael Hunn, Chief Executive Officer (657) 900-1481
Yunkyung Kim, Chief Operating Officer (714) 923-8834

Recommended Actions
1. Create a restricted CalOptima Health Provider Workforce Development Fund in the amount of $50 million from existing reserves to support the education, training, recruitment, and retention of safety net providers in Orange County;
2. Direct the Chief Executive Officer to create a 5-year Provider Workforce Development Plan for the local safety net provider community; and
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
The issue of health care provider shortages is one of the biggest challenges facing CalOptima Health and its community. In 2019, the California Future Health Workforce Commission projected that within 10 years, California would face a shortfall of more than 4,100 primary care clinicians and 600,000 home care workers, and would only have two-thirds of the psychiatrists it needs (Final Report of the California Future Health Workforce Commission, February 2019). Additionally, although California's population is becoming increasingly diverse, the health workforce does not reflect those demographics. These shortages and disparities are more pronounced in Medi-Cal, and projected workforce shortages have accelerated since the COVID-19 pandemic.

Discussion
CalOptima Health staff requests that the Board of Directors (Board) create a dedicated restricted reserve fund in the amount of $50 million to help address this looming crisis in the community. The funding will be used to create opportunities for education, training, recruitment, and retention of providers needed to serve CalOptima Health members.

Further, staff requests the Board to direct the Chief Executive Officer to develop a 5-year plan for local provider workforce development to include priority provider areas, funding strategies, and implementation plans for the Board's review and approval. CalOptima Health's plan will include learnings from existing statewide health workforce initiatives and engagement of local provider and member communities.

Fiscal Impact
An appropriation of up to $50 million from existing reserves will fund the restricted CalOptima Health Provider Workforce Development Fund.

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Rationale for Recommendation
The recommended action will support ongoing access to quality health providers for CalOptima Health's diverse membership.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
N/A

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

CalOptima Health Workforce Development Fund Notice of Funding Opportunity

Round 1: Increasing the Health Care Workforce Pipeline through Educational Investments

CalOptima Health solicits grant applications to increase the pipeline of health care professionals serving CalOptima Health members.

Application Deadline — 1/31/2024 (5:00 p.m. PST)

Background

CalOptima Health's mission is to serve member health with excellence and dignity, respecting the value and needs of each person. Health care workforce shortages in Orange County and statewide are significant, and investment is needed to increase the number of health professionals in Orange County. To address these challenges, the CalOptima Health Board approved an investment of $50 million over five years to create the Workforce Development Fund to increase the supply of safety net providers serving CalOptima Health members in Orange County. Through the Workforce Development Fund, CalOptima Health is committed to increasing the number of providers who are needed to serve Orange County's most vulnerable population.

CalOptima Health engaged in a robust stakeholder listening process to inform the design of the Workforce Development Fund strategy and plan. One of the key challenges highlighted through the stakeholder engagement process was the need for greater investment to expand educational opportunities to increase the pipeline of health professionals in Orange County. To address this challenge, the first round of funding made available under the Workforce Development Fund will provide up to $10 million in grant funding to increase the health care workforce pipeline through educational investments. A second round of funding will focus on investments in workforce development innovation under a Workforce Training & Development Innovation Fund. This first funding opportunity for workforce development round one grants will be **open for applications December 15, 2023 – January 31, 2024.**

Description of Project Grant Funding Opportunity

A key driver of growing the health care workforce in Orange County is the pipeline of students that enter health professions. To increase this pipeline of students and strengthen educational affordability

and opportunity to enter health professions, this grant funding opportunity will provide funds for initiatives and programs that increase the pipeline of health professionals. Priority for these educational investments will be given to projects that focus on the health professional workforce in the areas of nursing, behavioral health, primary care (nurse practitioners and physician assistants), and allied health professions. This funding opportunity will focus on non-physician professions.

Eligible projects or programs focused on increasing the health care professional pipeline could include, but not be limited to:

- Pipeline programs from high school into higher education focused on health care professions with commitment to serve Orange County.
- Stipend programs to incentivize students from underrepresented populations and low-income students to participate in health professional programs with a commitment to serve Orange County.
- Stipend programs focused on recruiting students into health care workforce shortage professions.
- Funding to expand existing health care higher education training and education programs to additional cohorts in areas of workforce shortage.
- Investments to expand clinical rotations to a greater number of students.
- Investments to develop and recruit faculty among health professions, including nurse educators, and others.

Grant Amounts and Duration

The CalOptima Health Workforce Development Fund will invest $50 million over five years across several focus areas. Grant award requests must be proposed in the Grant Application. Any approved grant requests under this funding opportunity must avoid supplanting or replacing existing Federal, State, and/or CalOptima Health funding sources for workforce development initiatives.

If applicable, applicants may apply for more than one round of funding as it becomes available. For awarded grants, payment is made in full upon completed execution of the grant agreement.

Entities Eligible to Apply

- Eligible entities to receive this funding would be educational institutions or partnerships among educational institutions and community or provider organizations.
- Applicants must propose projects or programs that align with the funding opportunity in this document and the Grant Application.
- Applicants that previously received funding from CalOptima Health must be in good standing with the terms of that contract or grant agreement to be eligible for new funding.
- Applicants are strongly encouraged to apply for funds when they are ready to implement the activity proposed for funding.

Proposal Evaluation Criteria

	Criterion	Maximum Points	Description of Basis for Assigning Points
1	Funding Sources	Pass/ Fail	• Does not supplant other available Federal, State or CalOptima Health opportunities/sources.
2	CalOptima Health core mission and value alignment	10	• Project is inclusive and provides opportunity for more CalOptima Health members to be served with excellence and dignity.
3	Project Implementation	10	• Plan is complete and includes specific SMART objectives and defined measures of success.
4	Budget and Financial Management	10	• Budget and financial plan are sound and aligned with the objectives of the project. • Identifies potential funding sources for sustainability of the project/program after the end of the grant agreement.
5	Equity	20	• Project aims to increase representation of underrepresented groups in health professions. • Project allows for a wide representation to enter and/or advance in health care.
6	Increased number of health professionals	20	• Addresses identified shortages in the health care workforce serving CalOptima Health members. • Addresses affordability of education and employment pathways. • Demonstrates how the project increases the number of health professionals in Orange County.
7	Capacity of program	10	• Grantee's demonstrated experience and capacity to perform the program.
8	Alignment with CalOptima investments	20	• Proposed program fills an unmet need within the CalOptima Health investment and grantmaking portfolio. • Project leverages available funding partners.
	Total Earnable Points	**100**	

Timeline

Activity	Date
Notice of Funding Opportunity Released and Portal Opens	12/15/2023 at 9 a.m.
Bidder's Conference *(virtual)*	12/18/2023 at 10 a.m.
Questions Posted from Bidder's Conference	12/22/2023
Application Deadline	**1/31/2024 at 5 p.m.**
Internal Review	2/1/2024 - 2/12/2024
CalOptima Health Board of Directors Meeting	**3/7/2024**
Announcement of Approved Grants	3/8/2024
Grant Agreements Processed	3/11/2024 - 4/1/2024
Grants Start Date	4/1/2024

Documents and Portal Access

All documents related to this Notice of Funding Opportunity and application portal access will be made available at this site:
[insert link]

Bidder's Conference

Join our Bidder's Conference for this funding opportunity by registering below:

Bidder's Conference
Date and Time: Monday, December 18, 2023, XX a.m.
Link: **[insert link]**

Questions about the funding opportunity or application? Contact Strategic Development at strategicdevelopment@caloptima.org

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
22. Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund

Contacts
Michael Hunn, Chief Executive Officer (657) 900-1481
Yunkyung Kim, Chief Operating Officer (714) 923-8834

Recommended Actions
1. Create a restricted CalOptima Health Provider Workforce Development Fund in the amount of $50 million from existing reserves to support the education, training, recruitment, and retention of safety net providers in Orange County;
2. Direct the Chief Executive Officer to create a 5-year Provider Workforce Development Plan for the local safety net provider community; and
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
The issue of health care provider shortages is one of the biggest challenges facing CalOptima Health and its community. In 2019, the California Future Health Workforce Commission projected that within 10 years, California would face a shortfall of more than 4,100 primary care clinicians and 600,000 home care workers, and would only have two-thirds of the psychiatrists it needs (Final Report of the California Future Health Workforce Commission, February 2019). Additionally, although California's population is becoming increasingly diverse, the health workforce does not reflect those demographics. These shortages and disparities are more pronounced in Medi-Cal, and projected workforce shortages have accelerated since the COVID-19 pandemic.

Discussion
CalOptima Health staff requests that the Board of Directors (Board) create a dedicated restricted reserve fund in the amount of $50 million to help address this looming crisis in the community. The funding will be used to create opportunities for education, training, recruitment, and retention of providers needed to serve CalOptima Health members.

Further, staff requests the Board to direct the Chief Executive Officer to develop a 5-year plan for local provider workforce development to include priority provider areas, funding strategies, and implementation plans for the Board's review and approval. CalOptima Health's plan will include learnings from existing statewide health workforce initiatives and engagement of local provider and member communities.

Fiscal Impact
An appropriation of up to $50 million from existing reserves will fund the restricted CalOptima Health Provider Workforce Development Fund.

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Rationale for Recommendation
The recommended action will support ongoing access to quality health providers for CalOptima Health's diverse membership.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
N/A

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

Provider Workforce Development Round One Grantee Recommendations

Increasing the Health Care Workforce Pipeline through Educational Investments

Board of Directors Meeting

April 4, 2024

Donna Laverdiere, Executive Director, Strategic Development

Our Mission

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

Our Vision

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

Round 1 Funding Opportunity:

Increasing the Health Care Workforce Pipeline through Educational Investments

- **Up to $25 million** in grant funding to increase the health care workforce pipeline through **educational investments**.
- Focus is on **non-physician professions**. Priority areas for investments include nursing, behavioral health, primary care (nurse practitioners and physician assistants), and allied health.
- Eligible entities were **educational institutions** or **partnerships among educational institutions and community or provider organizations**.

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Summary of Applications Received & Review Process

- Received 30 applications totaling $96.5 million that spanned identified workforce shortage areas.
- Based on the breadth and scope of applications received, the Board approved an increase for Round 1 grant funding to up to $25 million from the original $10 million allocation.

Workforce Shortage Area	Number of Applications	Total Grant Funds Requested
Nursing	6	$39,854,986
Varied Professions	9	$25,562,703
Behavioral Health	10	$14,729,363
Allied Health	4	$10,712,873
Primary Care	1	$5,684,162
Total	***30***	***$96,544,087***

Evaluation Criteria

	Criterion	Maximum Points	Description of Basis for Assigning Points
1	Funding Sources	Yes/No	• Does not supplant other available Federal, State or CalOptima Health opportunities/sources.
2	CalOptima Health core mission and value alignment	10	• Project is inclusive and provides opportunity for more CalOptima Health members to be served with excellence and dignity.
3	Project Implementation	10	• Plan is complete and includes specific SMART objectives and defined measures of success.
4	Budget and Financial Management	10	• Budget and financial plan are sound and aligned with the objectives of the project. • Identifies potential funding sources for sustainability of the project/program after the end of the grant agreement.
5	Equity	20	• Project aims to increase representation of underrepresented groups in health professions. • Project allows for a wide representation to enter and/or advance in health care.
6	Increased number of health professionals	20	• Addresses identified shortages in the health care workforce serving CalOptima Health members. • Addresses affordability of education and employment pathways. • Demonstrates how the project increases the number of health professionals in Orange County.
7	Capacity of program	10	• Grantee has demonstrated experience to perform the program. • If applicable, grantee is able to expand the capacity of an existing program.
8	Alignment with CalOptima investments	20	• Proposed program fills an unmet need within the CalOptima Health investment and grantmaking portfolio. • Project leverages available funding partners.
	Total Earnable Points	**100**	

Awardee Recommendations

- Applications that scored 81 points and above through the competitive scoring process are recommended to receive a grant award.
- A maximum grant award per organization of $5 million is recommended to ensure equitable distribution of funds.
- Awards are recommended for 9 applications from 7 organizations based on the competitive scoring process and maximum grant award amount.

Recommended Grant Awards

Organization	Requested Amount	Recomm. Award	Brief Description
Coast Community College District	$2,040,000	$2,040,000	Expanding registered nurse pipeline at Golden West College by 40 students/year and developing a pathway to the radiologic technology certificate program at Orange Coast College for 30 students/year.
Santiago Canyon College (Recommending to fund 3 out of 4 applications)	$1,200,000	$1,200,000	Increase the behavioral technician (BHT) program from 25-50 to 50-100 students annually; medical assistant program from 50 to 175 students annually; and develop a licensed vocational nursing (LVN) curriculum/attain program accreditation to produce 60+ licensed graduates annually.
Sue & Bill Gross School of Nursing, University of California Irvine	$9,126,399	$5,000,000	A program to provide a 1-year externship to prelicensure nursing students and a 1-year residency for Family Nurse Practitioners (FNP) and Psychiatric Mental Health Nurse Practitioners (PMHNP) graduates to address OC's shortage of registered nurses (RN) and primary and behavioral healthcare providers.
Chapman University	$5,684,162	$5,000,000	Providing full tuition physician assistant scholarships, training, and local practice physician assistant education for academically qualified, low-income students.
CSU Fullerton Auxiliary Services Corporation	$9,999,732	$5,000,000	Increase the Concurrent Enrollment Program to an increased number of Associate Degree Nursing to Bachelor of Science in Nursing (BSN) students and an expansion of the BSN program.
Orange County United Way	$1,356,300	$1,356,300	Expand the UpSkill program, focusing on gaps within the healthcare workforce, and provide career coaching, connections to paid training and certification programs, and job placements in the healthcare industry to serve an additional 25 clients each year.
Concordia University, Irvine	$5,629,907	$5,000,000	Increase the Accelerated Bachelor of Science in Nursing (ABSN) program and provide scholarships to pre-nursing students and ABSN students.
	$35,036,500	$24,596,300	

Scoring of All Applications

Organization Name	Proposed Program Title	Score out of 100	Funding Recommendation
Coast Community College District	Orange County Dual Enrollment Nursing and Allied Health Pathways	87.33	Fund
Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Behavior Technicians	87.33	Fund
Sue & Bill Gross School of Nursing, University of California, Irvine	NURSE-OC: University of California, Irvine Nursing Workforce Pipeline through Externships and Residencies in Orange County (OC)	86.50	Fund
Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Licensed Vocation Nurse	84.83	Fund
Chapman University	Reflecting Orange County Communities: Building a Culture of Health through Physician Assistant Scholarships, Training, and Local Practice Physician Assistant Education for Academically Qualified Low Income Students	84.67	Fund
CSU Fullerton Auxiliary Services Corporation (1 of 2 applications)	Expanding Numbers of CSUF Baccalaureate-Prepared Registered Nurses in Orange County	84.50	Fund
Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Medical Assistant	84.17	Fund
CSU Fullerton Auxiliary Services Corporation (2 of 2 applications)	CalOptima Stipend Program for CSUF Accelerated Baccalaureate Nursing Students	83.17	Do Not Fund (Grantee exceeded maximum allowed grant award with highest scoring application)
Orange County United Way	UpSkill OC	83.00	Fund
Concordia University Irvine	Concordia Nursing Pipeline Program	81.83	Fund

Scoring of All Applications (cont.)

Organization Name	Proposed Program Title	Score out of 100	Funding Recommendation
CHOC	Health and Behavioral Health Field Practicum Expansion	80.17	Do Not Fund
Easterseals Southern California	Building Orange County's Mental Health Service Capacity	79.33	Do Not Fund
Big Brothers Big Sisters of Orange County and the Inland Empire	Mentoring Orange County's Next Healthcare Workers	78.83	Do Not Fund
Access California Services	AccessCal's Health Care Workforce Program	78.33	Do Not Fund
John Henry Foundation	Intern Psychologist Workforce Development Program	78.00	Do Not Fund
Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Lactation Education Pathway to International Board Certified Lactation Consultant (IBCLC)	77.83	Do Not Fund
UC Irvine Program in Public Health	Orange County Health Pathways Program	77.83	Do Not Fund
AltaMed Health Services Corporation	AltaMed Orange County Community Health Workforce Pipeline	76.83	Do Not Fund
North Orange County Regional Occupational Program - Adult Career Education	North Orange County ROP Healthcare Workforce Training Expansion Program	76.67	Do Not Fund
The Cambodian Family	Cambodian Mental Health Workforce Development Initiative	75.83	Do Not Fund

Scoring of All Applications (cont.)

Organization Name	Proposed Program Title	Score out of 100	Funding Recommendation
South Orange County Community College District dba Saddleback College	Orange County Surgical Technologist Career Pathway	75.00	Do Not Fund
UCI Susan Samueli Integrative Health Institute	Health and Wellness - Behavioral Health Track Coaching Certificate Program	74.67	Do Not Fund
Seneca Family of Agencies	Seneca Family of Agencies' OC Behavioral Health Clinical Internship Program	72.67	Do Not Fund
YMCA of Orange County	Developmental Disabilities Workforce Development Collaborative	72.67	Do Not Fund
Celebrating Life Community Health Center	Path to Medical Provider for Underserved Populations Academic Award Program	71.83	Do Not Fund
Orange County Asian and Pacific Islander Community Alliance, Inc.	Project VOICE-BH	71.33	Do Not Fund
Anaheim Union High School District	Connecting Students' Strengths, Interests, and Aspirations to Build a Better Healthcare Workforce through Daily Classroom Instruction	70.67	Do Not Fund
Camino Health Center	Camino Pathways	70.17	Do Not Fund
Orange County Department of Education	Orange County Health Careers Center	64.33	Do Not Fund
Sowing Seeds Health, Inc.	Clinical Rotation Position Expansion	63.50	Do Not Fund

CalOptima Health

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Financial Summary

April 30, 2024

Board of Directors Meeting
June 6, 2024

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

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Financial Highlights: April 2024

April 2024					July 2023 - April 2024			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
928,430	839,769	88,661	10.6%	Member Months	9,566,496	9,158,645	407,851	4.5%
415,369,157	318,100,461	97,268,696	30.6%	Revenues	4,048,391,120	3,394,943,442	653,447,678	19.2%
322,594,697	301,986,763	(20,607,934)	(6.8%)	Medical Expenses	3,699,385,794	3,187,898,080	(511,487,714)	(16.0%)
19,592,925	23,225,850	3,632,925	15.6%	Administrative Expenses	185,721,701	213,035,296	27,313,595	12.8%
73,181,535	**(7,112,152)**	**80,293,687**	**1,129.0%**	**Operating Margin**	**163,283,626**	**(5,989,934)**	**169,273,560**	**2,826.0%**
				Non-Operating Income (Loss)				
8,719,966	2,083,330	6,636,636	318.6%	Net Investment Income/Expense	140,204,539	20,833,300	119,371,239	573.0%
(18,126)	(89,380)	71,254	79.7%	Net Rental Income/Expense	(158,876)	(723,799)	564,923	78.0%
5,276	-	5,276	100.0%	Net MCO Tax	818,290	-	818,290	100.0%
-	(1,003,219)	1,003,219	(100.0%)	Grant Expense	(29,485,861)	(30,032,194)	546,333	1.8%
45	-	45	100.0%	Other Income/Expense	(829,928)	-	(829,928)	(100.0%)
8,707,160	**990,731**	**7,716,429**	**778.9%**	**Total Non-Operating Income (Loss)**	**110,548,165**	**(9,922,693)**	**120,470,857**	**1,214.1%**
81,888,695	**(6,121,421)**	**88,010,116**	**1,437.7%**	**Change in Net Assets**	**273,831,790**	**(15,912,627)**	**289,744,417**	**1,820.8%**
77.7%	*94.9%*	*(17.2%)*		*Medical Loss Ratio*	*91.4%*	*93.9%*	*(2.5%)*	
4.7%	*7.3%*	*2.6%*		*Administrative Loss Ratio*	*4.6%*	*6.3%*	*1.7%*	
17.6%	*(2.2%)*	*19.8%*		*Operating Margin Ratio*	*4.0%*	*(0.2%)*	*4.2%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
77.1%	*94.9%*	*(17.8%)*		**MLR (excluding Directed Payments)*	*90.6%*	*93.9%*	*(3.3%)*	
4.7%	*7.3%*	*2.6%*		**ALR (excluding Directed Payments)*	*5.0%*	*6.3%*	*1.3%*	

*CalOptima Health updated the category of Directed Payments per the Department of Health Care Services instructions

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CalOptima Health

Financial Highlights Notes: April 2024

- Notable events/items in April 2024
  - $143.3 million of Hospital Quality Assurance Fee (HQAF) received and will be paid out in May 2024. This was a pass-through item with minimum impact to CalOptima Health's Change in Net Assets.
  - $38.1 million of Housing and Homelessness Incentive Program (HHIP) received. The revenue was recognized in April 2024.

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CalOptima Health

FY 2023-24: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) April 2024: $81.9 million, favorable to budget $88.0 million or 1,437.7%
  - Year To Date (YTD) July 2023 – April 2024: $273.8 million, favorable to budget $289.7 million or 1,820.8% due to favorable performance and net investment income
- Enrollment
  - MTD: 928,430 members, favorable to budget 88,661 or 10.6%
  - YTD: 9,566,496 member months, favorable to budget 407,851 or 4.5%

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CalOptima Health

FY 2023-24: Management Summary (cont.)

- Revenue
  - MTD: $415.4 million, favorable to budget $97.3 million or 30.6% driven by the Medi-Cal (MC) Line of Business (LOB)
    - Due to HHIP, prior period Proposition 56 Risk Corridor, favorable enrollment, membership mix and capitation rates from the Department of Health Care Services (DHCS)
  - YTD: $4,048.4 million, favorable to budget $653.4 million or 19.2%
    - Driven primarily by Hospital Directed Payments (DP), CalAIM Incentive Payment Program (IPP), HHIP, favorable membership mix and capitation rates from DHCS

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CalOptima Health

FY 2023-24: Management Summary (cont.)

- Medical Expenses
  - MTD: $322.6 million, unfavorable to budget $20.6 million or 6.8%
    - Professional Claims expense unfavorable variance of $21.3 million due to volume and Community Support (CS) services
  - YTD: $3,699.4 million, unfavorable to budget $511.5 million or 16.0%
    - Driven primarily by Hospital DP, post Public Health Emergency (PHE) payments, CS services, and HHIP

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CalOptima Health

FY 2023-24: Management Summary (cont.)

- Administrative Expenses
  - MTD: $19.6 million, favorable to budget $3.6 million or 15.6%
  - YTD: $185.7 million, favorable to budget $27.3 million or 12.8%

- Non-Operating Income (Loss)
  - MTD: $8.7 million, favorable to budget $7.7 million or 778.9% due primarily to net investment income
  - YTD: $110.5 million, favorable to budget $120.5 million or 1,214.1% due primarily to net investment income

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CalOptima Health

FY 2023-24: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 77.7% (77.1% excluding DP), Budget 94.9%
  - YTD: Actual 91.4% (90.6% excluding DP), Budget 93.9%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 4.7% (4.7% excluding DP), Budget 7.3%
  - YTD: Actual 4.6% (5.0% excluding DP), Budget 6.3%
- Balance Sheet Ratios
  - Current ratio*: 1.5
  - Board Designated Reserve level: 1.75
  - Net-position: $1.9 billion, including required Tangible Net Equity (TNE) of $121.9 million

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

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CalOptima Health

Enrollment Summary: April 2024

April 2024					July - April 2024			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
139,588	133,499	6,089	4.6%	SPD	1,413,601	1,380,080	33,521	2.4%
278,223	271,255	6,968	2.6%	TANF Child	2,918,566	2,975,178	(56,612)	(1.9%)
136,530	127,986	8,544	6.7%	TANF Adult	1,400,644	1,298,541	102,103	7.9%
2,599	3,116	(517)	(16.6%)	LTC	27,860	31,172	(3,312)	(10.6%)
344,177	275,281	68,896	25.0%	MCE	3,518,363	3,181,376	336,987	10.6%
9,689	10,568	(879)	(8.3%)	WCM	107,520	110,553	(3,033)	(2.7%)
910,806	**821,705**	**89,101**	**10.8%**	**Medi-Cal Total**	**9,386,554**	**8,976,900**	**409,654**	**4.6%**
17,138	**17,568**	**(430)**	**(2.4%)**	**OneCare**	**175,439**	**177,013**	**(1,574)**	**(0.9%)**
486	**496**	**(10)**	**(2.0%)**	**PACE**	**4,503**	**4,732**	**(229)**	**(4.8%)**
481	**568**	**(87)**	**(15.3%)**	**MSSP**	**4,930**	**5,680**	**(750)**	**(13.2%)**
928,430	**839,769**	**88,661**	**10.6%**	**CalOptima Health Total**	**9,566,496**	**9,158,645**	**407,851**	**4.5%**

*CalOptima Health Total does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: April 2024 MTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	566,629	344,177	910,806	17,138		486	481	928,430
REVENUES								
Capitation Revenue	$ 219,949,135	$ 150,651,807	$ 370,600,942	$ 39,949,618	$ -	$ 4,601,907	$ 216,690	$ 415,369,157
Total Operating Revenue	**219,949,135**	**150,651,807**	**370,600,942**	**39,949,618**	**-**	**4,601,907**	**216,690**	**415,369,157**
MEDICAL EXPENSES								
Provider Capitation	55,984,411	44,978,348	100,962,759	19,864,319				120,827,078
Claims	75,584,479	48,400,861	123,985,340	5,741,513	1,088	1,896,089		131,624,031
MLTSS	36,003,404	4,332,952	40,336,355		(1,112)	(12,113)	31,744	40,354,874
Prescription Drugs	-			7,755,519		560,389		8,315,908
Case Mgmt & Other Medical	11,258,109	7,409,742	18,667,851	1,489,583	3,218	1,156,627	155,527	21,472,806
Total Medical Expenses	**178,830,403**	**105,121,904**	**283,952,307**	**34,850,933**	**3,194**	**3,600,992**	**187,271**	**322,594,697**
Medical Loss Ratio	*81.3%*	*69.8%*	*76.6%*	*87.2%*	*0.0%*	*78.2%*	*86.4%*	*77.7%*
GROSS MARGIN	**41,118,732**	**45,529,904**	**86,648,636**	**5,098,685**	**(3,194)**	**1,000,915**	**29,419**	**92,774,460**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			10,842,242	995,250		166,340	81,473	12,085,305
Non-Salary Operating Expenses			3,221,578	294,257		1,900	1,344	3,519,080
Depreciation & Amortization			777,427			1,064		778,491
Other Operating Expenses			2,727,978	121,488		6,150	7,459	2,863,075
Indirect Cost Allocation, Occupancy			(630,302)	955,987		15,027	6,263	346,975
Total Administrative Expenses			**16,938,923**	**2,366,982**	**-**	**190,481**	**96,539**	**19,592,925**
Administrative Loss Ratio			*4.6%*	*5.9%*	*0.0%*	*4.1%*	*44.6%*	*4.7%*
Operating Income/(Loss)			**69,709,712**	**2,731,703**	**(3,194)**	**810,434**	**(67,120)**	**73,181,535**
Investments and Other Non-Operating			5,321					8,707,160
CHANGE IN NET ASSETS			**$ 69,715,033**	**$ 2,731,703**	**$ (3,194)**	**$ 810,434**	**$ (67,120)**	**$ 81,888,695**
BUDGETED CHANGE IN NET ASSETS			(4,616,452)	(2,434,242)	-	14,128	(75,586)	(6,121,421)
Variance to Budget - Fav/(Unfav)			$ 74,331,485	$ 5,165,945	$ (3,194)	$ 796,306	$ 8,466	$ 88,010,116

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CalOptima Health

Consolidated Revenue & Expenses: April 2024 YTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	5,868,191	3,518,363	9,386,554	175,439		4,503	4,930	9,566,496
REVENUES								
Capitation Revenue	$ 2,163,158,922	$ 1,511,896,563	$3,675,055,485	$ 333,470,504	$ (1,367,196)	$ 39,092,754	$ 2,139,574	$ 4,048,391,120
Total Operating Revenue	**2,163,158,922**	**1,511,896,563**	**3,675,055,485**	**333,470,504**	**(1,367,196)**	**39,092,754**	**2,139,574**	**4,048,391,120**
MEDICAL EXPENSES								
Provider Capitation	590,682,358	473,847,166	1,064,529,524	143,259,427				1,207,788,951
Claims	767,249,245	486,343,781	1,253,593,026	64,889,082	33,196	16,134,506		1,334,649,810
MLTSS	431,558,917	56,924,483	488,483,400	-	(21,588)	1,937	256,719	488,720,469
Prescription Drugs	(11,660)		(11,660)	80,376,408	(1,822,942)	4,988,811		83,530,616
Case Mgmt & Other Medical	340,830,038	217,368,414	558,198,452	13,417,913	77,312	11,535,953	1,466,318	584,695,948
Total Medical Expenses	**2,130,308,898**	**1,234,483,844**	**3,364,792,741**	**301,942,830**	**(1,734,022)**	**32,661,207**	**1,723,038**	**3,699,385,794**
Medical Loss Ratio	*98.5%*	*81.7%*	*91.6%*	*90.5%*	*126.8%*	*83.5%*	*80.5%*	*91.4%*
GROSS MARGIN	**32,850,025**	**277,412,719**	**310,262,744**	**31,527,674**	**366,826**	**6,431,547**	**416,536**	**349,005,326**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			108,636,931	9,963,021	(0)	1,631,732	930,288	121,161,971
Non-Salary Operating Expenses			26,546,260	3,390,775	(4,364)	375,243	13,382	30,321,296
Depreciation & Amortization			6,471,124			11,301		6,482,425
Other Operating Expenses			23,325,251	653,574		85,070	59,289	24,123,183
Indirect Cost Allocation, Occupancy			(6,139,879)	9,559,866		150,211	62,628	3,632,825
Total Administrative Expenses			**158,839,687**	**23,567,237**	**(4,364)**	**2,253,556**	**1,065,585**	**185,721,701**
Administrative Loss Ratio			*4.3%*	*7.1%*	*0.3%*	*5.8%*	*49.8%*	*4.6%*
Operating Income/(Loss)			**151,423,056**	**7,960,438**	**371,190**	**4,177,991**	**(649,049)**	**163,283,626**
Investments and Other Non-Operating			(11,638)					110,548,165
CHANGE IN NET ASSETS			**$ 151,411,419**	**$ 7,960,438**	**$ 371,190**	**$ 4,177,991**	**$ (649,049)**	**$ 273,831,790**
BUDGETED CHANGE IN NET ASSETS			17,573,127	(22,925,874)	-	94,610	(731,797)	(15,912,627)
Variance to Budget - Fav/(Unfav)			$ 133,838,292	$ 30,886,312	$ 371,190	$ 4,083,381	$ 82,748	$ 289,744,417

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CalOptima Health

Balance Sheet: As of April 2024

ASSETS	
Current Assets	
Operating Cash	$941,163,737
Short-term Investments	1,905,883,695
Receivables & Other Current Assets	704,489,938
Total Current Assets	**3,551,537,370**
Capital Assets	
Capital Assets	175,294,970
Less Accumulated Depreciation	(79,159,065)
Capital Assets, Net of Depreciation	96,135,905
Other Assets	
Restricted Deposits	300,000
Board Designated Reserve	629,817,043
Total Other Assets	**630,117,043**
TOTAL ASSETS	**4,277,790,317**
Deferred Outflows	**75,969,067**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,353,759,384**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$199,567,396
Medical Claims Liability	1,929,896,907
Capitation and Withholds	150,416,305
Other Current Liabilities	42,018,585
Total Current Liabilities	**2,321,899,193**
Other Liabilities	
GASB 96 Subscription Liabilities	16,955,572
Postemployment Health Care Plan	19,425,914
Net Pension Liabilities	40,465,145
Total Other Liabilities	**76,846,631**
TOTAL LIABILITIES	**2,398,745,824**
Deferred Inflows	**11,175,516**
Net Position	
Required TNE	121,870,721
Funds in Excess of TNE	1,821,967,323
TOTAL NET POSITION	**1,943,838,044**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**4,353,759,384**

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CalOptima Health

Board Designated Reserve and TNE Analysis: As of April 2024

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	251,188,386				
	Tier 1 - MetLife	248,862,701				
Board Designated Reserve		500,051,088	380,838,607	596,285,462	119,212,480	(96,234,375)
	Tier 2 - Payden & Rygel	65,049,541				
	Tier 2 - MetLife	64,716,414				
TNE Requirement		129,765,955	121,870,721	121,870,721	7,895,234	7,895,234
	Consolidated:	**629,817,043**	**502,709,328**	**718,156,183**	**127,107,715**	**(88,339,140)**
	Current reserve level	*1.75*	*1.40*	*2.00*		

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CalOptima Health

Spending Plan: As of April 2024

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date
	Total Net Position @ 4/30/2024	**$1,943.8**		
Resources Assigned	Board Designated Reserve[1]	**$629.8**		
	Capital Assets, net of Depreciation[2]	**$96.1**		
Resources Allocated[3]	Homeless Health Initiative[4]	$19.2	$61.7	$42.5
	Housing and Homelessness Incentive Program[4]	26.5	87.4	60.8
	Intergovernmental Transfers (IGT)	58.4	111.7	53.3
	Digital Transformation and Workplace Modernization	54.9	100.0	45.1
	Mind OC Grant (Orange)	0.0	1.0	1.0
	CalFresh Outreach Strategy	0.8	2.0	1.2
	CalFresh and Redetermination Outreach Strategy	3.0	6.0	3.0
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0
	Mind OC Grant (Irvine)	0.0	15.0	15.0
	OneCare Member Health Rewards and Incentives	0.3	0.5	0.2
	General Awareness Campaign	2.2	4.7	2.5
	Member Health Needs Assessment	1.1	1.3	0.2
	Five-Year Hospital Quality Program Beginning MY 2023	139.7	153.5	13.8
	Medi-Cal Annual Wellness Initiative	2.1	3.8	1.7
	Skilled Nursing Facility Access Program	10.0	10.0	0.0
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0
	National Alliance for Mental Illness Orange County Peer Support Program	4.0	5.0	1.0
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4
	Stipend Program for Master of Social Work Students	0.0	5.0	5.0
	Wellness & Prevention Program	2.1	2.7	0.6
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0
	Distribution Event- Naloxone	2.5	15.0	12.5
	Garden Grove Bldg. Improvement	10.2	10.5	0.3
	Post-Pandemic Supplemental	32.1	107.5	75.4
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0
	Outreach Strategy for newly eligible Adult Expansion members	4.7	5.0	0.3
	Quality Initiatives from unearned Pay for Value Program	23.3	23.3	0.0
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	1.0	1.0	0.0
	Subtotal:	**$535.6**	**$891.6**	**$356.0**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$682.3**		

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 112 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated
[4] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives. Amount reported includes only portion funded by reserves

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CalOptima Health

Homeless Health Initiative and Allocated Funds: As of April 2024

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	767,174	196,087
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,421,240	6,467,674
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	4,689,347	5,387,305
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$42,536,714**	**$59,263,286**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$42,536,714**	**$19,163,286**

Notes:

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

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

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CalOptima Health

Housing and Homelessness Incentive Program
As of April 2024

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	34,850,994	23,592,387	11,258,607	38,080,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	60,838,915	26,545,615	-
Total	**160,315,719**	**122,235,524**	**84,431,302**	**37,804,222**	**38,080,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	800,000	411,350	388,650	HHI
Consultant	600,000	-	600,000	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	2,922,299	1,099,013	HHI & DHCS
Infrastructure Projects	5,832,314	5,321,731	510,583	HHI
Capital Projects	98,247,369	73,300,000	24,947,369	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	-	10,184,530	DHCS
Non-Profit Healthcare Academy	350,000	275,923	74,077	DHCS
Total of Approved Initiatives	**122,235,524[2]**	**$84,431,302**	**$37,804,222**	

Notes:

[1] Total funding $122.2 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $34.9 million from DHCS HHIP incentive payments

[2] CalOptima Health received the last payment of $38.1 million from DHCS in April, 2024 after the acceptance of the Medicaid Managed Care Plan (MCP) submission 2 and the MCP's performance on applicable measures

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UNAUDITED FINANCIAL STATEMENTS

April 30, 2024

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CalOptima Health - Consolidated
Financial Highlights
For the Ten Months Ending April 30, 2024

April 2024					July 2023 - April 2024			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
928,430	839,769	88,661	10.6%	Member Months	9,566,496	9,158,645	407,851	4.5%
415,369,157	318,100,461	97,268,696	30.6%	Revenues	4,048,391,120	3,394,943,442	653,447,678	19.2%
322,594,697	301,986,763	(20,607,934)	(6.8%)	Medical Expenses	3,699,385,794	3,187,898,080	(511,487,714)	(16.0%)
19,592,925	23,225,850	3,632,925	15.6%	Administrative Expenses	185,721,701	213,035,296	27,313,595	12.8%
73,181,535	**(7,112,152)**	**80,293,687**	**1,129.0%**	**Operating Margin**	**163,283,626**	**(5,989,934)**	**169,273,560**	**2,826.0%**
				Non-Operating Income (Loss)				
8,719,966	2,083,330	6,636,636	318.6%	Net Investment Income/Expense	140,204,539	20,833,300	119,371,239	573.0%
(18,126)	(89,380)	71,254	79.7%	Net Rental Income/Expense	(158,876)	(723,799)	564,923	78.0%
5,276	-	5,276	100.0%	Net MCO Tax	818,290	-	818,290	100.0%
-	(1,003,219)	1,003,219	(100.0%)	Grant Expense	(29,485,861)	(30,032,194)	546,333	1.8%
45	-	45	100.0%	Other Income/Expense	(829,928)	-	(829,928)	(100.0%)
8,707,160	**990,731**	**7,716,429**	**778.9%**	**Total Non-Operating Income (Loss)**	**110,548,165**	**(9,922,693)**	**120,470,857**	**1,214.1%**
81,888,695	**(6,121,421)**	**88,010,116**	**1,437.7%**	**Change in Net Assets**	**273,831,790**	**(15,912,627)**	**289,744,417**	**1,820.8%**
77.7%	*94.9%*	*(17.2%)*		*Medical Loss Ratio*	*91.4%*	*93.9%*	*(2.5%)*	
4.7%	*7.3%*	*2.6%*		*Administrative Loss Ratio*	*4.6%*	*6.3%*	*1.7%*	
17.6%	*(2.2%)*	*19.8%*		*Operating Margin Ratio*	*4.0%*	*(0.2%)*	*4.2%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
77.1%	*94.9%*	*(17.8%)*		**MLR (excluding Directed Payments)*	*90.6%*	*93.9%*	*(3.3%)*	
4.7%	*7.3%*	*2.6%*		**ALR (excluding Directed Payments)*	*5.0%*	*6.3%*	*1.3%*	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health - Consolidated
Full Time Employee Data
For the Ten Months Ending April 30, 2024

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,268	1,341	73
OneCare	176	194	18
PACE	107	115	8
MSSP	19	24	5
Total	1,570	1,673	103

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	12,585	13,479	894
OneCare	1,798	1,959	161
PACE	1,051	1,072	21
MSSP	195	235	40
Total	15,629	16,745	1,116

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	718	613	(105)
OneCare	97	91	(6)
PACE	5	4	(1)
MSSP	26	24	(2)
Consolidated	591	502	(89)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	746	666	(80)
OneCare	98	90	(8)
PACE	4	4	0
MSSP	25	24	(1)
Consolidated	612	547	(65)

Open FTE			
	Total	Medical	Admin
Medi-Cal	99	43	56
OneCare	10	8	2
PACE	4	3	1
MSSP	3	2	1
Total	116	56	60

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

MEMBER MONTHS	928,430		839,769		88,661	
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$370,600,942	$406.89	$281,134,135	$342.14	$89,466,807	$64.75
OneCare	39,949,618	2,331.05	32,415,052	1,845.12	7,534,566	485.93
OneCare Connect	-		-		-	-
PACE	4,601,907	9,468.95	4,297,756	8,664.83	304,151	804.12
MSSP	216,690	450.50	253,518	446.33	(36,828)	4.17
Total Operating Revenue	415,369,157	447.39	318,100,461	378.80	97,268,696	68.59
MEDICAL EXPENSES						
Medi-Cal	283,952,307	311.76	265,898,792	323.59	(18,053,515)	11.83
OneCare	34,850,933	2,033.55	31,840,740	1,812.43	(3,010,193)	(221.12)
OneCare Connect	3,194				(3,194)	-
PACE	3,600,992	7,409.45	4,028,540	8,122.06	427,548	712.61
MSSP	187,271	389.34	218,691	385.02	31,420	(4.32)
Total Medical Expenses	322,594,697	347.46	301,986,763	359.61	(20,607,934)	12.15
GROSS MARGIN	92,774,460	99.93	16,113,698	19.19	76,660,762	80.74
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	12,085,305	13.02	12,832,476	15.28	747,171	2.26
Professional Fees	732,733	0.79	1,186,033	1.41	453,300	0.62
Purchased Services	2,351,957	2.53	3,172,222	3.78	820,265	1.25
Printing & Postage	434,389	0.47	879,614	1.05	445,225	0.58
Depreciation & Amortization	778,491	0.84	400,900	0.48	(377,591)	(0.36)
Other Expenses	2,863,075	3.08	4,309,726	5.13	1,446,651	2.05
Indirect Cost Allocation, Occupancy	346,975	0.37	444,879	0.53	97,904	0.16
Total Administrative Expenses	19,592,925	21.10	23,225,850	27.66	3,632,925	6.56
NET INCOME (LOSS) FROM OPERATIONS	73,181,535	78.82	(7,112,152)	(8.47)	80,293,687	87.29
INVESTMENT INCOME						
Interest Income	14,680,524	15.81	2,083,330	2.48	12,597,194	13.33
Realized Gain/(Loss) on Investments	(28,790)	(0.03)	-	-	(28,790)	(0.03)
Unrealized Gain/(Loss) on Investments	(5,931,768)	(6.39)	-	-	(5,931,768)	(6.39)
Total Investment Income	8,719,966	9.39	2,083,330	2.48	6,636,636	6.91
NET RENTAL INCOME/EXPENSE	(18,126)	(0.02)	(89,380)	(0.11)	71,254	0.09
NET MCO TAX	5,276	0.01	-	-	5,276	0.01
GRANT EXPENSE	-	-	(1,003,219)	(1.19)	1,003,219	1.19
OTHER INCOME/EXPENSE	45	-	-	-	45	-
CHANGE IN NET ASSETS	**81,888,695**	**88.20**	**(6,121,421)**	**(7.29)**	**88,010,116**	**95.49**
MEDICAL LOSS RATIO	**77.7%**		**94.9%**		**(17.2%)**	
ADMINISTRATIVE LOSS RATIO	**4.7%**		**7.3%**		**2.6%**	

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

MEMBER MONTHS	9,566,496		9,158,645		407,851	
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$3,675,055,485	$391.52	$3,032,097,745	$337.77	$642,957,740	$53.75
OneCare	333,470,504	1,900.78	319,643,911	1,805.77	13,826,593	95.01
OneCare Connect	(1,367,196)		-		(1,367,196)	0.00
PACE	39,092,754	8,681.49	40,666,606	8,593.96	(1,573,852)	87.53
MSSP	2,139,574	433.99	2,535,180	446.33	(395,606)	(12.34)
Total Operating Revenue	4,048,391,120	423.18	3,394,943,442	370.68	653,447,678	52.50
MEDICAL EXPENSES						
Medi-Cal	3,364,792,741	358.47	2,831,736,795	315.45	(533,055,946)	(43.02)
OneCare	301,942,830	1,721.07	315,614,297	1,783.00	13,671,467	61.93
OneCare Connect	(1,734,022)				1,734,022	0.00
PACE	32,661,207	7,253.21	38,365,188	8,107.61	5,703,981	854.40
MSSP	1,723,038	349.50	2,181,800	384.12	458,762	34.62
Total Medical Expenses	3,699,385,794	386.70	3,187,898,080	348.08	(511,487,714)	(38.62)
GROSS MARGIN	349,005,326	36.48	207,045,362	22.60	141,959,964	13.88
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	121,161,971	12.67	125,530,273	13.71	4,368,302	1.04
Professional Fees	8,170,334	0.85	11,274,621	1.23	3,104,287	0.38
Purchased Services	16,967,235	1.77	24,284,608	2.65	7,317,373	0.88
Printing & Postage	5,183,727	0.54	6,024,765	0.66	841,038	0.12
Depreciation & Amortization	6,482,425	0.68	4,009,000	0.44	(2,473,425)	(0.24)
Other Expenses	24,123,183	2.52	37,463,239	4.09	13,340,056	1.57
Indirect Cost Allocation, Occupancy	3,632,825	0.38	4,448,790	0.49	815,965	0.11
Total Administrative Expenses	185,721,701	19.41	213,035,296	23.26	27,313,595	3.85
NET INCOME (LOSS) FROM OPERATIONS	163,283,626	17.07	(5,989,934)	(0.65)	169,273,560	17.72
INVESTMENT INCOME						
Interest Income	133,202,122	13.92	20,833,300	2.27	112,368,822	11.65
Realized Gain/(Loss) on Investments	(4,004,133)	(0.42)	-	0.00	(4,004,133)	(0.42)
Unrealized Gain/(Loss) on Investments	11,006,550	1.15	-	0.00	11,006,550	1.15
Total Investment Income	140,204,539	14.66	20,833,300	2.27	119,371,239	12.39
NET RENTAL INCOME/EXPENSE	(158,876)	(0.02)	(723,799)	(0.08)	564,923	0.06
NET MCO TAX	818,290	0.09	-	0.00	818,290	0.09
GRANT EXPENSE	(29,485,861)	(3.08)	(30,032,194)	(3.28)	546,333	0.20
OTHER INCOME/EXPENSE	(829,928)	(0.09)	-	0.00	(829,928)	(0.09)
CHANGE IN NET ASSETS	**273,831,790**	**28.62**	**(15,912,627)**	**(1.74)**	**289,744,417**	**30.36**
MEDICAL LOSS RATIO	**91.4%**		**93.9%**		**(2.5%)**	
ADMINISTRATIVE LOSS RATIO	**4.6%**		**6.3%**		**1.7%**	

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

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	566,629	344,177	910,806	17,138		486	481	928,430
REVENUES								
Capitation Revenue	$ 219,949,135	$ 150,651,807	$ 370,600,942	$ 39,949,618	$ -	$ 4,601,907	$ 216,690	$ 415,369,157
Total Operating Revenue	**219,949,135**	**150,651,807**	**370,600,942**	**39,949,618**	**-**	**4,601,907**	**216,690**	**415,369,157**
MEDICAL EXPENSES								
Provider Capitation	55,984,411	44,978,348	100,962,759	19,864,319				120,827,078
Claims	75,584,479	48,400,861	123,985,340	5,741,513	1,088	1,896,089		131,624,031
MLTSS	36,003,404	4,332,952	40,336,355		(1,112)	(12,113)	31,744	40,354,874
Prescription Drugs	-			7,755,519		560,389		8,315,908
Case Mgmt & Other Medical	11,258,109	7,409,742	18,667,851	1,489,583	3,218	1,156,627	155,527	21,472,806
Total Medical Expenses	**178,830,403**	**105,121,904**	**283,952,307**	**34,850,933**	**3,194**	**3,600,992**	**187,271**	**322,594,697**
Medical Loss Ratio	*81.3%*	*69.8%*	*76.6%*	*87.2%*	*0.0%*	*78.2%*	*86.4%*	*77.7%*
GROSS MARGIN	**41,118,732**	**45,529,904**	**86,648,636**	**5,098,685**	**(3,194)**	**1,000,915**	**29,419**	**92,774,460**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			10,842,242	995,250		166,340	81,473	12,085,305
Non-Salary Operating Expenses			3,221,578	294,257		1,900	1,344	3,519,080
Depreciation & Amortization			777,427			1,064		778,491
Other Operating Expenses			2,727,978	121,488		6,150	7,459	2,863,075
Indirect Cost Allocation, Occupancy			(630,302)	955,987		15,027	6,263	346,975
Total Administrative Expenses			**16,938,923**	**2,366,982**	**-**	**190,481**	**96,539**	**19,592,925**
Administrative Loss Ratio			*4.6%*	*5.9%*	*0.0%*	*4.1%*	*44.6%*	*4.7%*
Operating Income/(Loss)			**69,709,712**	**2,731,703**	**(3,194)**	**810,434**	**(67,120)**	**73,181,535**
Investments and Other Non-Operating			5,321					8,707,160
CHANGE IN NET ASSETS			**$ 69,715,033**	**$ 2,731,703**	**$ (3,194)**	**$ 810,434**	**$ (67,120)**	**$ 81,888,695**
BUDGETED CHANGE IN NET ASSETS			(4,616,452)	(2,434,242)	-	14,128	(75,586)	(6,121,421)
Variance to Budget - Fav/(Unfav)			$ 74,331,485	$ 5,165,945	$ (3,194)	$ 796,306	$ 8,466	$ 88,010,116

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

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	5,868,191	3,518,363	9,386,554	175,439		4,503	4,930	9,566,496
REVENUES								
Capitation Revenue	$ 2,163,158,922	$ 1,511,896,563	$ 3,675,055,485	$ 333,470,504	$ (1,367,196)	$ 39,092,754	$ 2,139,574	$ 4,048,391,120
Total Operating Revenue	**2,163,158,922**	**1,511,896,563**	**3,675,055,485**	**333,470,504**	**(1,367,196)**	**39,092,754**	**2,139,574**	**4,048,391,120**
MEDICAL EXPENSES								
Provider Capitation	590,682,358	473,847,166	1,064,529,524	143,259,427				1,207,788,951
Claims	767,249,245	486,343,781	1,253,593,026	64,889,082	33,196	16,134,506		1,334,649,810
MLTSS	431,558,917	56,924,483	488,483,400	-	(21,588)	1,937	256,719	488,720,469
Prescription Drugs	(11,660)		(11,660)	80,376,408	(1,822,942)	4,988,811		83,530,616
Case Mgmt & Other Medical	340,830,038	217,368,414	558,198,452	13,417,913	77,312	11,535,953	1,466,318	584,695,948
Total Medical Expenses	**2,130,308,898**	**1,234,483,844**	**3,364,792,741**	**301,942,830**	**(1,734,022)**	**32,661,207**	**1,723,038**	**3,699,385,794**
Medical Loss Ratio	*98.5%*	*81.7%*	*91.6%*	*90.5%*	*126.8%*	*83.5%*	*80.5%*	*91.4%*
GROSS MARGIN	**32,850,025**	**277,412,719**	**310,262,744**	**31,527,674**	**366,826**	**6,431,547**	**416,536**	**349,005,326**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			108,636,931	9,963,021	(0)	1,631,732	930,288	121,161,971
Non-Salary Operating Expenses			26,546,260	3,390,775	(4,364)	375,243	13,382	30,321,296
Depreciation & Amortization			6,471,124			11,301		6,482,425
Other Operating Expenses			23,325,251	653,574		85,070	59,289	24,123,183
Indirect Cost Allocation, Occupancy			(6,139,879)	9,559,866		150,211	62,628	3,632,825
Total Administrative Expenses			**158,839,687**	**23,567,237**	**(4,364)**	**2,253,556**	**1,065,585**	**185,721,701**
Administrative Loss Ratio			*4.3%*	*7.1%*	*0.3%*	*5.8%*	*49.8%*	*4.6%*
Operating Income/(Loss)			**151,423,056**	**7,960,438**	**371,190**	**4,177,991**	**(649,049)**	**163,283,626**
Investments and Other Non-Operating			(11,638)					110,548,165
CHANGE IN NET ASSETS			**$ 151,411,419**	**$ 7,960,438**	**$ 371,190**	**$ 4,177,991**	**$ (649,049)**	**$ 273,831,790**
BUDGETED CHANGE IN NET ASSETS			17,573,127	(22,925,874)	-	94,610	(731,797)	(15,912,627)
Variance to Budget - Fav/(Unfav)			$ 133,838,292	$ 30,886,312	$ 371,190	$ 4,083,381	$ 82,748	$ 289,744,417

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CalOptima Health

Unaudited Financial Statements as of April 30, 2024

MONTHLY RESULTS:

- Change in Net Assets is $81.9 million, favorable to budget $88.0 million
- Operating surplus is $73.2 million, with a surplus in non-operating income of $8.7 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $273.8 million, $289.7 million favorable to budget
- Operating surplus is $163.3 million, with a surplus in non-operating income of $110.5 million

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

April 2024				July 2023 - April 2024		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
69.7	(4.6)	74.3	Medi-Cal	151.4	17.6	133.8
2.7	(2.4)	5.1	OneCare	8.0	(22.9)	30.9
0.0	0.0	0.0	OCC	0.4	0.0	0.4
0.8	0.0	0.8	PACE	4.2	0.1	4.1
(0.1)	(0.1)	0.0	MSSP	(0.6)	(0.7)	0.1
73.2	**(7.1)**	**80.3**	**Total Operating Income (Loss)**	**163.3**	**(6.0)**	**169.3**
			Non-Operating Income (Loss)			
8.7	2.1	6.6	Net Investment Income/Expense	140.2	20.8	119.4
0.0	(0.1)	0.1	Net Rental Income/Expense	(0.2)	(0.7)	0.5
0.0	0.0	0.0	Net Operating Tax	0.8	0.0	0.8
0.0	(1.0)	1.0	Grant Expense	(29.5)	(30.0)	0.5
0.0	0.0	0.0	Net QAF & IGT Income/Expense	0.0	0.0	0.0
0.0	0.0	0.0	Other Income/Expense	(0.8)	0.0	(0.8)
8.7	**1.0**	**7.6**	**Total Non-Operating Income/(Loss)**	**110.5**	**(9.9)**	**120.4**
81.9	**(6.1)**	**88.0**	**TOTAL**	**273.8**	**(15.9)**	**289.7**

CalOptima Health - Consolidated
Enrollment Summary
For the Ten Months Ending April 30, 2024

April 2024					July 2023 - April 2024			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
139,588	133,499	6,089	4.6%	SPD	1,413,601	1,380,080	33,521	2.4%
278,223	271,255	6,968	2.6%	TANF Child	2,918,566	2,975,178	(56,612)	(1.9%)
136,530	127,986	8,544	6.7%	TANF Adult	1,400,644	1,298,541	102,103	7.9%
2,599	3,116	(517)	(16.6%)	LTC	27,860	31,172	(3,312)	(10.6%)
344,177	275,281	68,896	25.0%	MCE	3,518,363	3,181,376	336,987	10.6%
9,689	10,568	(879)	(8.3%)	WCM	107,520	110,553	(3,033)	(2.7%)
910,806	**821,705**	**89,101**	**10.8%**	**Medi-Cal Total**	**9,386,554**	**8,976,900**	**409,654**	**4.6%**
17,138	**17,568**	**(430)**	**(2.4%)**	**OneCare**	**175,439**	**177,013**	**(1,574)**	**(0.9%)**
486	**496**	**(10)**	**(2.0%)**	**PACE**	**4,503**	**4,732**	**(229)**	**(4.8%)**
481	**568**	**(87)**	**(15.3%)**	**MSSP**	**4,930**	**5,680**	**(750)**	**(13.2%)**
928,430	**839,769**	**88,661**	**10.6%**	**CalOptima Health Total**	**9,566,496**	**9,158,645**	**407,851**	**4.5%**
				Enrollment (by Network)				
302,814	294,743	8,071	2.7%	HMO	2,813,160	2,813,549	(389)	(0.0%)
181,882	165,522	16,360	9.9%	PHC	1,868,584	1,753,468	115,116	6.6%
146,822	119,716	27,106	22.6%	Shared Risk Group	1,954,607	1,823,386	131,221	7.2%
279,288	241,724	37,564	15.5%	Fee for Service	2,750,203	2,586,497	163,706	6.3%
910,806	**821,705**	**89,101**	**10.8%**	**Medi-Cal Total**	**9,386,554**	**8,976,900**	**409,654**	**4.6%**
17,138	**17,568**	**(430)**	**(0)**	**OneCare**	**175,439**	**177,013**	**(1,574)**	**(0)**
486	**496**	**(10)**	**(2.0%)**	**PACE**	**4,503**	**4,732**	**(229)**	**(4.8%)**
481	**568**	**(87)**	**(15.3%)**	**MSSP**	**4,930**	**5,680**	**(750)**	**(13.2%)**
928,430	**839,769**	**88,661**	**10.6%**	**CalOptima Health Total**	**9,566,496**	**9,158,645**	**407,851**	**4.5%**

Note:* Total membership does not include MSSP

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CalOptima Health
Enrollment Trend by Network
Fiscal Year 2024

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD Actual	YTD Budget	Variance
HMOs															
SPD	14,267	14,287	14,179	14,193	14,222	14,337	16,258	16,563	16,462	16,482			151,250	147,031	4,219
TANF Child	69,607	69,928	69,010	69,620	69,177	68,696	65,998	65,784	76,870	68,123			692,813	797,634	(104,821)
TANF Adult	50,979	51,388	50,896	50,392	49,538	48,637	61,010	63,447	52,817	59,234			538,338	542,663	(4,325)
LTC		1			(1)	1	1	1					3		3
MCE	132,523	133,978	131,301	130,441	129,207	127,361	154,424	157,160	159,033	157,664			1,413,092	1,305,391	107,701
WCM	2,050	2,095	2,021	2,041	2,019	1,982	1,438	1,406	1,301	1,311			17,664	20,830	(3,166)
Total	269,426	271,677	267,407	266,687	264,162	261,014	299,129	304,361	306,483	302,814			2,813,160	2,813,549	**(389)**
PHCs															
SPD	4,581	4,599	4,623	4,588	4,705	4,770	4,525	4,754	4,731	4,693			46,569	42,710	3,859
TANF Child	147,946	148,557	145,969	145,186	144,127	143,149	142,068	141,456	154,158	143,416			1,456,032	1,395,868	60,164
TANF Adult	8,999	9,050	9,404	8,885	8,692	8,451	8,540	8,619	(4,493)	4,492			70,639	36,488	34,151
LTC										1			1		1
MCE	23,230	23,489	22,708	22,540	22,400	22,185	22,237	22,769	23,127	22,825			227,510	209,947	17,563
WCM	6,919	6,974	6,900	6,829	7,044	6,799	6,789	6,585	6,539	6,455			67,833	68,455	(622)
Total	191,675	192,669	189,604	188,028	186,968	185,354	184,159	184,183	184,062	181,882			1,868,584	1,753,468	**115,116**
Shared Risk Groups															
SPD	11,210	11,137	11,111	10,982	10,833	10,803	6,448	6,775	6,798	6,802			92,899	90,361	2,538
TANF Child	55,211	55,471	54,427	53,505	52,934	52,285	31,419	31,364	36,668	32,982			456,266	480,734	(24,468)
TANF Adult	43,118	43,425	42,894	42,250	41,524	40,564	26,809	29,619	27,157	30,357			367,717	318,887	48,830
LTC	1	1			2	2		2		2			10		10
MCE	124,149	125,749	122,600	121,935	120,343	117,859	70,007	72,870	76,078	75,930			1,027,520	922,554	104,966
WCM	1,234	1,247	1,180	1,165	1,190	1,129	800	768	733	749			10,195	10,850	(655)
Total	**234,923**	**237,030**	**232,212**	**229,837**	**226,826**	**222,642**	**135,483**	**141,398**	**147,434**	**146,822**			**1,954,607**	**1,823,386**	**131,221**
Fee for Service (Dual)															
SPD	99,242	99,832	99,750	99,630	100,115	100,302	93,362	95,142	95,771	96,712			979,858	973,464	6,394
TANF Child									6	3			9	20	(11)
TANF Adult	2,442	2,397	2,370	2,307	2,247	2,150	1,888	1,694	1,604	1,473			20,572	24,501	(3,929)
LTC	2,661	2,630	2,612	2,492	2,525	2,421	2,411	2,350	2,239	2,302			24,643	27,480	(2,837)
MCE	8,968	9,230	9,418	9,312	9,117	8,759	7,761	7,209	6,465	5,971			82,210	89,320	(7,110)
WCM	15	14	14	13	13	10	6	7	7	6			105	180	(75)
Total	**113,328**	**114,103**	**114,164**	**113,754**	**114,017**	**113,642**	**105,428**	**106,402**	**106,092**	**106,467**			**1,107,397**	**1,114,965**	**(7,568)**
Fee for Service (Non-Dual - Total)															
SPD	13,519	13,778	13,957	13,921	14,278	14,643	14,683	14,612	14,735	14,899			143,025	126,514	16,511
TANF Child	29,143	30,159	31,025	29,500	29,973	30,070	31,492	31,523	36,862	33,699			313,446	300,922	12,524
TANF Adult	37,044	37,794	37,966	37,126	36,903	36,189	54,765	47,862	36,755	40,974			403,378	376,002	27,376
LTC	349	360	345	327	318	331	316	263	300	294			3,203	3,692	(489)
MCE	70,923	73,165	72,983	71,223	71,263	71,175	90,156	84,788	80,568	81,787			768,031	654,164	113,867
WCM	1,164	1,259	1,212	1,129	1,166	1,114	1,161	1,224	1,126	1,168			11,723	10,238	1,485
Total	**152,142**	**156,515**	**157,488**	**153,226**	**153,901**	**153,522**	**192,573**	**180,272**	**170,346**	**172,821**			**1,642,806**	**1,471,532**	**171,274**
Grand Totals															
SPD	142,819	143,633	143,620	143,314	144,153	144,855	135,276	137,846	138,497	139,588			1,413,601	1,380,080	33,521
TANF Child	301,907	304,115	300,431	297,811	296,211	294,200	270,977	270,127	304,564	278,223			2,918,566	2,975,178	(56,612)
TANF Adult	142,582	144,054	143,530	140,960	138,904	135,991	153,012	151,241	113,840	136,530			1,400,644	1,298,541	102,103
LTC	3,011	2,992	2,957	2,819	2,844	2,755	2,728	2,616	2,539	2,599			27,860	31,172	(3,312)
MCE	359,793	365,611	359,010	355,451	352,330	347,339	344,585	344,796	345,271	344,177			3,518,363	3,181,376	336,987
WCM	11,382	11,589	11,327	11,177	11,432	11,034	10,194	9,990	9,706	9,689			107,520	110,553	(3,033)
Total MediCal MM	**961,494**	**971,994**	**960,875**	**951,532**	**945,874**	**936,174**	**916,772**	**916,616**	**914,417**	**910,806**			**9,386,554**	**8,976,900**	**409,654**
OneCare	**17,695**	**17,815**	**17,836**	**17,757**	**17,648**	**17,593**	**17,380**	**17,300**	**17,277**	**17,138**			**175,439**	**177,013**	**(1,574)**
PACE	**429**	**432**	**437**	**442**	**446**	**447**	**453**	**457**	**474**	**486**			**4,503**	**4,732**	**(229)**
MSSP	**503**	**500**	**503**	**494**	**491**	**494**	**492**	**488**	**484**	**481**			**4,930**	**5,680**	**(750)**
Grand Total	**979,618**	**990,241**	**979,148**	**969,731**	**963,968**	**954,214**	**934,605**	**934,373**	**932,168**	**928,430**			**9,566,496**	**9,158,645**	**407,851**

Note:* Total membership does not include MSSP

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ENROLLMENT:

Overall, April enrollment was 928,430

- Favorable to budget 88,661 or 10.6%
- Decreased 3,738 from Prior Month (PM) (March 2024)
- Decreased 56,556 or 5.7% from Prior Year (PY) (April 2023)

Medi-Cal enrollment was 910,806

- Favorable to budget 89,101 or 10.8% due to disenrollment being slower than originally anticipated based on the current economic conditions and expanded renewal outreach efforts.
- Medi-Cal Expansion (MCE) favorable to budget 68,896
- Temporary Assistance for Needy Families (TANF) favorable to budget 15,512
- Seniors and Persons with Disabilities (SPD) favorable to budget 6,089
- Whole Child Model (WCM) unfavorable to budget 879
- Long-Term Care (LTC) unfavorable to budget 517
- Decreased 3,611 from PM

OneCare enrollment was 17,138

- Unfavorable to budget 430 or 2.4%
- Decreased 139 from PM

PACE enrollment was 486

- Unfavorable to budget 10 or 2.0%
- Increased 12 from PM

MSSP enrollment was 481

- Unfavorable to budget 87 or 15.3% due to MSSP currently being understaffed. There is a staff to member ratio that must be met.
- Decreased 3 from PM

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

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
910,806	**821,705**	**89,101**	**10.8%**	**Member Months**	**9,386,554**	**8,976,900**	**409,654**	**4.6%**
				Revenues				
370,600,942	281,134,135	89,466,807	31.8%	Medi-Cal Capitation Revenue	3,675,055,485	3,032,097,745	642,957,740	21.2%
370,600,942	**281,134,135**	**89,466,807**	**31.8%**	**Total Operating Revenue**	**3,675,055,485**	**3,032,097,745**	**642,957,740**	**21.2%**
				Medical Expenses				
100,962,759	97,245,029	(3,717,730)	(3.8%)	Provider Capitation	1,064,529,524	1,021,167,487	(43,362,037)	(4.2%)
60,614,129	62,069,870	1,455,741	2.3%	Facilities Claims	672,119,569	700,398,785	28,279,216	4.0%
63,371,212	42,142,170	(21,229,042)	(50.4%)	Professional Claims	581,473,457	450,094,939	(131,378,518)	(29.2%)
40,336,355	49,635,551	9,299,196	18.7%	MLTSS	488,483,400	507,983,107	19,499,707	3.8%
-	-	-	0.0%	Prescription Drugs	(11,660)	-	11,660	100.0%
7,840,224	5,817,956	(2,022,268)	(34.8%)	Incentive Payments	158,572,142	65,783,996	(92,788,146)	(141.0%)
7,226,803	7,999,891	773,088	9.7%	Medical Management	68,679,429	76,257,245	7,577,816	9.9%
3,600,824	988,325	(2,612,499)	(264.3%)	Other Medical Expenses	330,946,882	10,051,236	(320,895,646)	(3,192.6%)
283,952,307	**265,898,792**	**(18,053,515)**	**(6.8%)**	**Total Medical Expenses**	**3,364,792,741**	**2,831,736,795**	**(533,055,946)**	**(18.8%)**
86,648,636	**15,235,343**	**71,413,293**	**468.7%**	**Gross Margin**	**310,262,744**	**200,360,950**	**109,901,794**	**54.9%**
				Administrative Expenses				
10,842,242	11,331,395	489,153	4.3%	Salaries, Wages & Employee Benefits	108,636,931	111,119,337	2,482,406	2.2%
666,900	1,134,796	467,896	41.2%	Professional Fees	7,451,762	10,552,251	3,100,489	29.4%
2,194,186	2,828,037	633,851	22.4%	Purchased Services	14,978,639	21,431,691	6,453,052	30.1%
360,493	526,030	165,537	31.5%	Printing & Postage	4,115,859	4,483,640	367,781	8.2%
777,427	400,000	(377,427)	(94.4%)	Depreciation & Amortization	6,471,124	4,000,000	(2,471,124)	(61.8%)
2,727,978	4,157,628	1,429,650	34.4%	Other Operating Expenses	23,325,251	36,461,814	13,136,563	36.0%
(630,302)	(526,091)	104,211	19.8%	Indirect Cost Allocation, Occupancy	(6,139,879)	(5,260,910)	878,969	16.7%
16,938,923	**19,851,795**	**2,912,872**	**14.7%**	**Total Administrative Expenses**	**158,839,687**	**182,787,823**	**23,948,136**	**13.1%**
				Non-Operating Income (Loss)				
5,276	-	5,276	100.0%	Net Operating Tax	818,290	-	818,290	100.0%
45	-	45	100.0%	Other Income/Expense	(829,928)	-	(829,928)	(100.0%)
5,321	**-**	**5,321**	**100.0%**	**Total Non-Operating Income (Loss)**	**(11,638)**	**-**	**(11,638)**	**(100.0%)**
69,715,033	**(4,616,452)**	**74,331,485**	**1,610.1%**	**Change in Net Assets**	**151,411,419**	**17,573,127**	**133,838,292**	**761.6%**
76.6%	***94.6%***	***(18.0%)***		***Medical Loss Ratio***	***91.6%***	***93.4%***	***(1.8%)***	
4.6%	***7.1%***	***2.5%***		***Admin Loss Ratio***	***4.3%***	***6.0%***	***1.7%***	

MEDI-CAL INCOME STATEMENT– APRIL MONTH:

REVENUES of $370.6 million are favorable to budget $89.5 million driven by:

- Favorable volume related variance of $30.5 million
- Favorable price related variance of $59.0 million
  - $38.1 million of Housing and Homelessness Incentive Program (HHIP) revenue
  - $14.6 million due to favorable capitation rates and enrollment mix
  - $13.0 million due to prior period Proposition 56 risk corridors by the Department of Health Care Services (DHCS)
  - Offset by $5.1 million from Enhanced Care Management (ECM) and Proposition 56 risk corridors

MEDICAL EXPENSES of $284.0 million are unfavorable to budget $18.1 million driven by:

- Unfavorable volume related variance of $28.8 million
- Favorable price related variance of $10.8 million
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $14.7 million due to lower than expected utilization
  - Facilities Claims expense favorable variance of $8.2 million
  - Provider Capitation expense favorable variance of $6.8 million
  - Medical Management expense favorable variance of $1.6 million
  - Offset by:
    - Professional Claims expense unfavorable variance of $16.7 million due primarily to Community Support (CS) services
    - Other Medical expense unfavorable variance of $2.5 million
    - Incentive Payments expense unfavorable variance of $1.4 million

ADMINISTRATIVE EXPENSES of $16.9 million are favorable to budget $2.9 million driven by:

- Non-Salary expenses favorable to budget $2.4 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.5 million

CHANGE IN NET ASSETS is $69.7 million, favorable to budget $74.3 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
17,138	**17,568**	**(430)**	**(2.4%)**	**Member Months**	**175,439**	**177,013**	**(1,574)**	**(0.9%)**
				Revenues				
32,096,532	23,627,237	8,469,295	35.8%	Medicare Part C Revenue	248,563,989	231,926,546	16,637,443	7.2%
7,853,085	8,787,815	(934,730)	(10.6%)	Medicare Part D Revenue	84,906,515	87,717,365	(2,810,850)	(3.2%)
39,949,618	**32,415,052**	**7,534,566**	**23.2%**	**Total Operating Revenue**	**333,470,504**	**319,643,911**	**13,826,593**	**4.3%**
				Medical Expenses				
19,864,319	15,305,662	(4,558,657)	(29.8%)	Provider Capitation	143,259,427	140,006,045	(3,253,382)	(2.3%)
4,252,772	3,734,946	(517,826)	(13.9%)	Inpatient	49,286,590	46,534,407	(2,752,183)	(5.9%)
1,488,741	1,231,495	(257,246)	(20.9%)	Ancillary	15,602,492	13,750,204	(1,852,288)	(13.5%)
-	80,990	80,990	100.0%	MLTSS	-	816,028	816,028	100.0%
7,755,519	9,869,272	2,113,753	21.4%	Prescription Drugs	80,376,408	98,310,021	17,933,613	18.2%
549,003	364,032	(184,971)	(50.8%)	Incentive Payments	3,434,431	3,687,489	253,058	6.9%
940,580	1,254,343	313,763	25.0%	Medical Management	9,982,132	12,510,103	2,527,971	20.2%
-	-	-	0.0%	Other Medical Expenses	1,350	-	(1,350)	(100.0%)
34,850,933	**31,840,740**	**(3,010,193)**	**(9.5%)**	**Total Medical Expenses**	**301,942,830**	**315,614,297**	**13,671,467**	**4.3%**
5,098,685	**574,312**	**4,524,373**	**787.8%**	**Gross Margin**	**31,527,674**	**4,029,614**	**27,498,060**	**682.4%**
				Administrative Expenses				
995,250	1,193,988	198,738	16.6%	Salaries, Wages & Employee Benefits	9,963,021	11,703,031	1,740,010	14.9%
64,500	45,000	(19,500)	(43.3%)	Professional Fees	385,523	660,000	274,477	41.6%
156,572	327,728	171,156	52.2%	Purchased Services	1,948,330	2,753,350	805,020	29.2%
73,185	358,847	285,662	79.6%	Printing & Postage	1,056,922	1,518,755	461,833	30.4%
121,488	134,408	12,920	9.6%	Other Operating Expenses	653,574	834,522	180,948	21.7%
955,987	948,583	(7,404)	(0.8%)	Indirect Cost Allocation, Occupancy	9,559,866	9,485,830	(74,036)	(0.8%)
2,366,982	**3,008,554**	**641,572**	**21.3%**	**Total Administrative Expenses**	**23,567,237**	**26,955,488**	**3,388,251**	**12.6%**
2,731,703	**(2,434,242)**	**5,165,945**	**212.2%**	**Change in Net Assets**	**7,960,438**	**(22,925,874)**	**30,886,312**	**134.7%**
87.2%	***98.2%***	***(11.0%)***		***Medical Loss Ratio***	***90.5%***	***98.7%***	***(8.2%)***	
5.9%	***9.3%***	***3.4%***		***Admin Loss Ratio***	***7.1%***	***8.4%***	***1.3%***	

ONECARE INCOME STATEMENT– APRIL MONTH:

REVENUES of $39.9 million are favorable to budget $7.5 million driven by:

- Unfavorable volume related variance of $0.8 million
- Favorable price related variance of $8.3 million due to CY 2024 Hierarchical Condition Category (HCC) estimate

MEDICAL EXPENSES of $34.9 million are unfavorable to budget $3.0 million driven by:

- Favorable volume related variance of $0.8 million
- Unfavorable price related variance of $3.8 million
  - Provider Capitation expense unfavorable variance of $4.9 million due to CY 2024 HCC estimate
  - Inpatient expense unfavorable variance of $0.6 million
  - Offset by Prescription Drugs expense favorable variance of $1.9 million

ADMINISTRATIVE EXPENSES of $2.4 million are favorable to budget $0.6 million driven by:

- Non-Salary expenses favorable to budget $0.4 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is $2.7 million, favorable to budget $5.2 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Ten Months Ending April 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
-	-	-	**0.0%**	**Member Months**	-	-	-	**0.0%**
				Revenues				
-	-	-	0.0%	Medi-Cal Revenue	22,753	-	22,753	100.0%
-	-	-	0.0%	Medicare Part D Revenue	(1,389,949)	-	(1,389,949)	(100.0%)
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**(1,367,196)**	**-**	**(1,367,196)**	**(100.0%)**
				Medical Expenses				
(8,037)	-	8,037	100.0%	Facilities Claims	(569,482)	-	569,482	100.0%
9,126	-	(9,126)	(100.0%)	Ancillary	602,677	-	(602,677)	(100.0%)
(1,112)	-	1,112	100.0%	MLTSS	(21,588)	-	21,588	100.0%
-	-	-	0.0%	Prescription Drugs	(1,822,942)	-	1,822,942	100.0%
3,218	-	(3,218)	(100.0%)	Incentive Payments	129,914	-	(129,914)	(100.0%)
-	-	-	0.0%	Medical Management	(52,602)	-	52,602	100.0%
3,194	**-**	**(3,194)**	**(100.0%)**	**Total Medical Expenses**	**(1,734,022)**	**-**	**1,734,022**	**100.0%**
(3,194)	**-**	**(3,194)**	**(100.0%)**	**Gross Margin**	**366,826**	**-**	**366,826**	**100.0%**
				Administrative Expenses				
-	-	-	0.0%	Purchased Services	(4,364)	-	4,364	100.0%
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**(4,364)**	**-**	**4,364**	**100.0%**
(3,194)	**-**	**(3,194)**	**(100.0%)**	**Change in Net Assets**	**371,190**	**-**	**371,190**	**100.0%**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***126.8%***	***0.0%***	***126.8%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.3%***	***0.0%***	***(0.3%)***	

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CalOptima Health
PACE
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
486	**496**	(10)	(2.0%)	**Member Months**	**4,503**	**4,732**	**(229)**	**(4.8%)**
				Revenues				
3,070,759	3,233,917	(163,158)	(5.0%)	Medi-Cal Capitation Revenue	28,980,750	30,756,802	(1,776,052)	(5.8%)
1,211,479	836,949	374,530	44.7%	Medicare Part C Revenue	7,408,554	7,747,100	(338,546)	(4.4%)
319,669	226,890	92,779	40.9%	Medicare Part D Revenue	2,703,450	2,162,704	540,746	25.0%
4,601,907	**4,297,756**	**304,151**	**7.1%**	**Total Operating Revenue**	**39,092,754**	**40,666,606**	**(1,573,852)**	**(3.9%)**
				Medical Expenses				
1,156,627	1,297,320	140,693	10.8%	Medical Management	11,535,953	12,219,326	683,373	5.6%
913,022	954,380	41,358	4.3%	Facilities Claims	6,955,553	9,177,153	2,221,600	24.2%
755,487	877,687	122,200	13.9%	Professional Claims	6,907,634	8,707,360	1,799,726	20.7%
560,389	502,845	(57,544)	(11.4%)	Prescription Drugs	4,988,811	4,726,496	(262,315)	(5.5%)
(12,113)	122,077	134,190	109.9%	MLTSS	1,937	1,199,602	1,197,665	99.8%
227,579	274,231	46,652	17.0%	Patient Transportation	2,271,319	2,335,251	63,932	2.7%
3,600,992	**4,028,540**	**427,548**	**10.6%**	**Total Medical Expenses**	**32,661,207**	**38,365,188**	**5,703,981**	**14.9%**
1,000,915	**269,216**	**731,699**	**271.8%**	**Gross Margin**	**6,431,547**	**2,301,418**	**4,130,129**	**179.5%**
				Administrative Expenses				
166,340	212,981	46,641	21.9%	Salaries, Wages & Employee Benefits	1,631,732	1,785,738	154,006	8.6%
-	4,904	4,904	100.0%	Professional Fees	319,715	49,040	(270,675)	(551.9%)
1,189	16,457	15,268	92.8%	Purchased Services	44,582	99,567	54,985	55.2%
711	(5,263)	(5,974)	(113.5%)	Printing & Postage	10,946	22,370	11,424	51.1%
1,064	900	(164)	(18.2%)	Depreciation & Amortization	11,301	9,000	(2,301)	(25.6%)
6,150	10,247	4,097	40.0%	Other Operating Expenses	85,070	92,473	7,403	8.0%
15,027	14,862	(165)	(1.1%)	Indirect Cost Allocation, Occupancy	150,211	148,620	(1,591)	(1.1%)
190,481	**255,088**	**64,607**	**25.3%**	**Total Administrative Expenses**	**2,253,556**	**2,206,808**	**(46,748)**	**(2.1%)**
810,434	**14,128**	**796,306**	**5,636.4%**	**Change in Net Assets**	**4,177,991**	**94,610**	**4,083,381**	**4,316.0%**
78.2%	***93.7%***	***(15.5%)***		***Medical Loss Ratio***	***83.5%***	***94.3%***	***(10.8%)***	
4.1%	***5.9%***	***1.8%***		***Admin Loss Ratio***	***5.8%***	***5.4%***	***(0.4%)***	

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

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
481	**568**	**(87)**	**(15.3%)**	**Member Months**	**4,930**	**5,680**	**(750)**	**(13.2%)**
				Revenues				
216,690	253,518	(36,828)	(14.5%)	Revenue	2,139,574	2,535,180	(395,606)	(15.6%)
216,690	**253,518**	**(36,828)**	**(14.5%)**	**Total Operating Revenue**	**2,139,574**	**2,535,180**	**(395,606)**	**(15.6%)**
				Medical Expenses				
155,527	185,734	30,207	16.3%	Medical Management	1,466,318	1,852,230	385,912	20.8%
31,744	32,957	1,213	3.7%	Waiver Services	256,719	329,570	72,851	22.1%
155,527	185,734	30,207	16.3%	Total Medical Management	1,466,318	1,852,230	385,912	20.8%
31,744	32,957	1,213	3.7%	Total Waiver Services	256,719	329,570	72,851	22.1%
187,271	**218,691**	**31,420**	**14.4%**	**Total Program Expenses**	**1,723,038**	**2,181,800**	**458,762**	**21.0%**
29,419	**34,827**	**(5,408)**	**(15.5%)**	**Gross Margin**	**416,536**	**353,380**	**63,156**	**17.9%**
				Administrative Expenses				
81,473	94,112	12,639	13.4%	Salaries, Wages & Employee Benefits	930,288	922,167	(8,121)	(0.9%)
1,333	1,333	(0)	(0.0%)	Professional Fees	13,333	13,330	(3)	(0.0%)
11	-	(11)	(100.0%)	Purchased Services	48	-	(48)	(100.0%)
7,459	7,443	(16)	(0.2%)	Other Operating Expenses	59,289	74,430	15,141	20.3%
6,263	7,525	1,262	16.8%	Indirect Cost Allocation, Occupancy	62,628	75,250	12,622	16.8%
96,539	**110,413**	**13,874**	**12.6%**	**Total Administrative Expenses**	**1,065,585**	**1,085,177**	**19,592**	**1.8%**
(67,120)	**(75,586)**	**8,466**	**11.2%**	**Change in Net Assets**	**(649,049)**	**(731,797)**	**82,748**	**11.3%**
86.4%	***86.3%***	***0.1%***		***Medical Loss Ratio***	***80.5%***	***86.1%***	***(5.6%)***	
44.6%	***43.6%***	***(1.0%)***		***Admin Loss Ratio***	***49.8%***	***42.8%***	***(7.0%)***	

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

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
40,122	50,473	10,351	20.5%	Purchased Services	447,034	390,330	(56,704)	(14.5%)
179,565	211,000	31,435	14.9%	Depreciation & Amortization	1,784,924	2,110,000	325,076	15.4%
24,795	34,000	9,205	27.1%	Insurance Expense	229,619	340,000	110,381	32.5%
126,139	138,702	12,563	9.1%	Repair & Maintenance	1,221,766	1,501,420	279,654	18.6%
41,765	57,859	16,094	27.8%	Other Operating Expenses	575,121	578,590	3,470	0.6%
(412,385)	(492,034)	(79,649)	(16.2%)	Indirect Cost Allocation, Occupancy	(4,258,463)	(4,920,340)	(661,877)	(13.5%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

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

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
156,423	133,810	22,613	16.9%	Rental Income	1,568,320	1,338,100	230,220	17.2%
156,423	**133,810**	**22,613**	**16.9%**	**Total Operating Revenue**	**1,568,320**	**1,338,100**	**230,220**	**17.2%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
38,360	31,141	(7,219)	(23.2%)	Purchased Services	293,568	215,350	(78,218)	(36.3%)
34,573	40,000	5,427	13.6%	Depreciation & Amortization	345,729	400,000	54,271	13.6%
8,135	10,091	1,956	19.4%	Insurance Expense	77,921	100,910	22,989	22.8%
31,850	60,845	28,995	47.7%	Repair & Maintenance	442,691	704,510	261,819	37.2%
14,665	24,446	9,781	40.0%	Other Operating Expenses	229,529	244,460	14,931	6.1%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
127,584	**166,523**	**38,939**	**23.4%**	**Total Administrative Expenses**	**1,389,438**	**1,665,230**	**275,792**	**16.6%**
28,840	**(32,713)**	**61,553**	**188.2%**	**Change in Net Assets**	**178,882**	**(327,130)**	**506,012**	**154.7%**

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

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
27,114	56,667	29,553	52.2%	Purchased Services	147,013	396,669	249,656	62.9%
9,397	-	(9,397)	(100.0%)	Depreciation & Amortization	65,782	-	(65,782)	(100.0%)
4,415	-	(4,415)	(100.0%)	Insurance Expense	30,902	-	(30,902)	(100.0%)
4,416	-	(4,416)	(100.0%)	Repair & Maintenance	83,697	-	(83,697)	(100.0%)
1,624	-	(1,624)	(100.0%)	Other Operating Expenses	10,364	-	(10,364)	(100.0%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
46,966	**56,667**	**9,701**	**17.1%**	**Total Administrative Expenses**	**337,759**	**396,669**	**58,910**	**14.9%**
(46,966)	**(56,667)**	**9,701**	**17.1%**	**Change in Net Assets**	**(337,759)**	**(396,669)**	**58,910**	**14.9%**

OTHER PROGRAM INCOME STATEMENTS – APRIL MONTH:

ONECARE CONNECT

- **CHANGE IN NET ASSETS** is ($3,194), unfavorable to budget $3,194 due to PY activities

PACE

- **CHANGE IN NET ASSETS** is $0.8 million, favorable to budget $0.8 million

MSSP

- **CHANGE IN NET ASSETS** is ($67,120), favorable to budget $8,466

NON-OPERATING INCOME STATEMENTS – APRIL MONTH

BUILDING 500

- **CHANGE IN NET ASSETS** is $28,840, favorable to budget $61,553
  - Net of $0.2 million in rental income and $0.1 million in expenses

BUILDING 7900

- **CHANGE IN NET ASSETS** is ($46,966), favorable to budget $9,701

INVESTMENT INCOME

- Favorable variance of $6.6 million due to $12.6 million of interest income offset by $6.0 million of realized and unrealized net loss on investments

CalOptima Health
Balance Sheet
April 30, 2024

		April-24	March-24	$ Change	% Change
ASSETS					
Current Assets					
	Cash and Cash Equivalents	941,163,737	954,540,198	(13,376,462)	(1.4%)
	Short-term Investments	1,905,883,695	1,841,708,213	64,175,481	3.5%
	Premiums due from State of CA and CMS	689,120,563	639,362,826	49,757,738	7.8%
	Prepaid Expenses and Other	15,369,375	12,655,056	2,714,319	21.4%
	Total Current Assets	**3,551,537,370**	**3,448,266,293**	**103,271,076**	**3.0%**
Board Designated Assets					
	Cash and Cash Equivalents	8,475,941	7,449,117	1,026,825	13.8%
	Investments	621,341,101	625,005,502	(3,664,401)	(0.6%)
	Total Board Designated Assets	**629,817,043**	**632,454,619**	**(2,637,576)**	**(0.4%)**
Restricted Deposit		**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net		**96,135,905**	**95,825,696**	**310,209**	**0.3%**
Total Assets		**4,277,790,317**	**4,176,846,608**	**100,943,709**	**2.4%**
Deferred Outflows of Resources					
	Advance Discretionary Payment	49,999,717	49,999,717	-	0.0%
	Net Pension	24,373,350	24,373,350	-	0.0%
	Other Postemployment Benefits	1,596,000	1,596,000	-	0.0%
	Total Deferred Outflows of Resources	**75,969,067**	**75,969,067**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		**4,353,759,384**	**4,252,815,675**	**100,943,709**	**2.4%**
LIABILITIES					
Current Liabilities					
	Medical Claims Liability	1,921,514,612	1,846,169,629	75,344,983	4.1%
	Provider Capitation and Withholds	150,416,305	132,853,518	17,562,786	13.2%
	Accrued Reinsurance Costs to Providers	8,382,295	7,078,962	1,303,334	18.4%
	Unearned Revenue	20,086,592	15,558,304	4,528,288	29.1%
	Accounts Payable and Other	199,567,396	279,399,434	(79,832,038)	(28.6%)
	Accrued Payroll and Employee Benefits and Other	21,908,769	21,749,095	159,674	0.7%
	Deferred Lease Obligations	23,224	26,490	(3,266)	(12.3%)
	Total Current Liabilities	**2,321,899,193**	**2,302,835,432**	**19,063,761**	**0.8%**
GASB 96 Subscription Liabilities		16,955,572	17,007,553	(51,981)	(0.3%)
Postemployment Health Care Plan		19,425,914	19,382,680	43,234	0.2%
Net Pension Liability		40,465,145	40,465,145	-	0.0%
Total Liabilities		**2,398,745,824**	**2,379,690,810**	**19,055,014**	**0.8%**
Deferred Inflows of Resources					
	Net Pension	3,387,516	3,387,516	-	0.0%
	Other Postemployment Benefits	7,788,000	7,788,000	-	0.0%
	Total Deferred Inflows of Resources	**11,175,516**	**11,175,516**	**-**	**0.0%**
Net Position					
	Required TNE	121,870,721	121,388,995	481,726	0.4%
	Funds in excess of TNE	1,821,967,323	1,740,560,354	81,406,969	4.7%
	Total Net Position	**1,943,838,044**	**1,861,949,349**	**81,888,695**	**4.4%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION		**4,353,759,384**	**4,252,815,675**	**100,943,709**	**2.4%**

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BALANCE SHEET – APRIL MONTH:

ASSETS of $4.4 billion increased $101.0 million from March or 2.4%

- Operating Cash and Short-term Investments net increase of $50.8 million due primarily to receipts of $143.3 million for the Hospital Quality Assurance Fee (HQAF) and $38.1 million for HHIP, offset by the Managed Care Organization (MCO) tax payment of $125.5 million
- Premiums due from the State of California (CA) and the Centers for Medicare & Medicaid Services (CMS) increased $49.8 million due to $9.3 million CY 2024 HCC estimates and timing of cash receipts

LIABILITIES of $2.4 billion increased $19.1 million from March or 0.8%

- Medical Claims Liabilities increased $75.3 million due primarily to HQAF accrual of $143.3 million and Intergovernmental Transfer (IGT) payment of $74.2 million
- Provider Capitation and Withholds increased $17.6 million due primarily to CY 2024 HCC estimates and timing of capitation payments
- Unearned Revenue increased $4.5 million due primarily to Student Behavioral Health Incentive Program (SBHIP)
- Accounts Payable and Other decreased $79.8 million due primarily to the MCO tax liability and related payments

NET ASSETS of $1.9 billion, increased $81.9 million from March or 4.4%

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

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	251,188,386				
	Tier 1 - MetLife	248,862,701				
Board Designated Reserve		500,051,088	380,838,607	596,285,462	119,212,480	(96,234,375)
	Tier 2 - Payden & Rygel	65,049,541				
	Tier 2 - MetLife	64,716,414				
TNE Requirement		129,765,955	121,870,721	121,870,721	7,895,234	7,895,234
	Consolidated:	**629,817,043**	**502,709,328**	**718,156,183**	**127,107,715**	**(88,339,140)**
	Current reserve level	*1.75*	*1.40*	*2.00*		

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CalOptima Health
Statement of Cash Flow
April 30, 2024

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	81,888,695	273,831,790
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation & Amortization	1,002,026	8,678,859
Changes in assets and liabilities:		
Prepaid expenses and other	(2,714,319)	(308,672)
Capitation receivable	(49,757,738)	(215,196,865)
Medical claims liability	76,648,317	289,658,143
Deferred revenue	4,528,288	(43,356,319)
Payable to health networks	17,562,786	24,972,279
Accounts payable	(79,832,038)	184,485,452
Accrued payroll	202,907	(972,708)
Other accrued liabilities	(55,246)	815,772
Net cash provided by/(used in) operating activities	49,473,679	522,607,732
GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	-	(49,999,717)
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	(64,175,481)	(229,147,631)
Change in Property and Equipment	(1,312,235)	(20,607,259)
Change in Restricted Deposit & Other	-	-
Change in Board designated reserves	2,637,576	(53,265,349)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(62,850,140)	(303,020,239)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(13,376,462)	169,587,776
CASH AND CASH EQUIVALENTS, beginning of period	$954,540,198	771,575,961
CASH AND CASH EQUIVALENTS, end of period	**941,163,737**	**941,163,737**

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CalOptima Health
Spending Plan
For the Ten Months Ending April 30, 2024

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 4/30/2024	**$1,943.8**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$629.8**			**32.4%**
	Capital Assets, net of Depreciation[2]	**$96.1**			**4.9%**
Resources Allocated[3]	Homeless Health Initiative[4]	$19.2	$61.7	$42.5	1.0%
	Housing and Homelessness Incentive Program[4]	26.5	87.4	60.8	1.4%
	Intergovernmental Transfers (IGT)	58.4	111.7	53.3	3.0%
	Digital Transformation and Workplace Modernization	54.9	100.0	45.1	2.8%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	CalFresh Outreach Strategy	0.8	2.0	1.2	0.0%
	CalFresh and Redetermination Outreach Strategy	3.0	6.0	3.0	0.2%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.5%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.3	0.5	0.2	0.0%
	General Awareness Campaign	2.2	4.7	2.5	0.1%
	Member Health Needs Assessment	1.1	1.3	0.2	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	139.7	153.5	13.8	7.2%
	Medi-Cal Annual Wellness Initiative	2.1	3.8	1.7	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.5%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.0	5.0	1.0	0.2%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	0.9%
	Stipend Program for Master of Social Work Students	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	2.6%
	Distribution Event- Naloxone	2.5	15.0	12.5	0.1%
	Garden Grove Bldg. Improvement	10.2	10.5	0.3	0.5%
	Post-Pandemic Supplemental	32.1	107.5	75.4	1.6%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	2.0%
	Outreach Strategy for newly eligible Adult Expansion members	4.7	5.0	0.3	0.2%
	Quality Initiatives from unearned Pay for Value Program	23.3	23.3	0.0	1.2%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	1.0	1.0	0.0	0.1%
	Subtotal:	**$535.6**	**$891.6**	**$356.0**	**27.6%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$682.3**			**35.1%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 112 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated
[4] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives. Amount reported includes only portion funded by reserves

CalOptima Health
Key Financial Indicators
As of April 30, 2024

Income Statement

Item Name	April 2024 Actual	April 2024 Budget	April 2024 Variance	April 2024 %		July 2023 - April 2024 Actual	July 2023 - April 2024 Budget	July 2023 - April 2024 Variance	July 2023 - April 2024 %	
Member Months	928,430	839,769	88,661	10.6%		9,566,496	9,158,645	407,851	4.5%	
Operating Revenue	415,369,157	318,100,461	97,268,696	30.6%		4,048,391,120	3,394,943,442	653,447,678	19.2%	
Medical Expenses	322,594,697	301,986,763	(20,607,934)	(6.8%)		3,699,385,794	3,187,898,080	(511,487,714)	(16.0%)	
General and Administrative Expense	19,592,925	23,225,850	3,632,925	15.6%		185,721,701	213,035,296	27,313,595	12.8%	
Non-Operating Income/(Loss)	8,707,160	990,731	7,716,429	778.9%		110,548,164	(9,922,693)	120,470,857	1,214.1%	
Summary of Income & Expenses	81,888,695	(6,121,421)	88,010,116	1,437.7%		273,831,790	(15,912,627)	289,744,417	1,820.8%	

Ratios

Medical Loss Ratio (MLR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	77.7%	94.9%	(17.3%)		91.4%	93.9%	(2.5%)	

Administrative Loss Ratio (ALR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	4.7%	7.3%	2.6%		4.6%	6.3%	1.7%	

Key:

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

Investment

Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
@4/30/2024	2,508,317,343	2,447,558,338	60,759,005	2.5%

Unallocated/Unassigned Reserve Balance	Current Month @ April 2024	Fiscal Year Ending June 2022	Change	%
Consolidated	682,279,181	354,771,258	327,507,922	92.3%
*Days Cash On Hand**	112			

*Total of Board Designated reserve and unallocated reserve amount can support approximatley 112 days of CalOptima Health's current operations.

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

	April 2024				July 2023 - April 2024				All Time to Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):												
Total Capital Assets	**75,713**	**1,450,664**	**1,374,951**	**94.8%**	**18,700,891**	**17,242,640**	**(1,458,251)**	**(8.5%)**	**22,298,942**	**54,088,640**	**31,789,698**	**58.8%**
Operating Expenses:												
Salaries, Wages & Benefits	640,002	609,649	(30,353)	(5.0%)	6,273,153	6,096,490	(176,663)	(2.9%)	9,691,729	11,388,723	1,696,994	14.9%
Professional Fees	5,000	192,916	187,916	97.4%	1,196,733	1,859,160	662,427	35.6%	1,462,926	4,091,660	2,628,734	64.2%
Purchased Services	(69,041)	155,000	224,041	144.5%	-	1,550,000	1,550,000	100.0%	-	1,860,000	1,860,000	100.0%
Other Expenses	1,324,401	1,996,009	671,608	33.6%	8,644,566	14,590,090	5,945,524	40.8%	11,659,342	17,882,470	6,223,128	34.8%
Total Operating Expenses	**1,900,362**	**2,953,574**	**1,053,212**	**35.7%**	**16,114,452**	**24,095,740**	**7,981,288**	**33.1%**	**22,813,998**	**35,222,853**	**12,408,855**	**35.2%**

Funding Balance Tracking:	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	56,990,000	22,298,942	34,691,058
FY2023 Operating Budget[2]	11,127,113	6,699,546	4,427,567
FY2024 Operating Budget	30,002,899	16,114,452	13,888,447
FY2025 Operating Budget			
Ending Funding Balance	**1,879,988**	**54,887,061**	
Add: Prior year unspent Operating Budget	**4,427,567**		
Total Available Funding	**6,307,555**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets
[2] Unspent budget from this period is added back to available DTS funding

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

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

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	767,174	196,087
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,421,240	6,467,674
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	4,689,347	5,387,305
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$42,536,714**	**$59,263,286**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$42,536,714**	**$19,163,286**

Notes:

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

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

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of April 30, 2024

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	34,850,994	23,592,387	11,258,607	38,080,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	60,838,915	26,545,615	-
Total	**160,315,719**	**122,235,524**	**84,431,302**	**37,804,222**	**38,080,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	800,000	411,350	388,650	HHI
Consultant	600,000	-	600,000	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	2,922,299	1,099,013	HHI & DHCS
Infrastructure Projects	5,832,314	5,321,731	510,583	HHI
Capital Projects	98,247,369	73,300,000	24,947,369	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	-	10,184,530	DHCS
Non-Profit Healthcare Academy	350,000	275,923	74,077	DHCS
Total of Approved Initiatives	**$122,235,524[2]**	**$84,431,302**	**$37,804,222**	

Notes:
[1]CalOptima Health received the last payment of $38.1 million from DHCS in April, 2024 after the acceptance of the Medicaid Managed Care Plan (MCP) submission 2 and the MCP's performance on applicable measures

CalOptima Health
Budget Allocation Changes
Reporting Changes as of April 30, 2024

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Purchased Services - TB Shots, Flu Shots, COVID Related Services & COVID Cleaning/Building Sanitization	Moving Services	$40,000	To repurpose from TB/Flu Shots and COVID Cleaning to provide more funding for Moving Services ($16,000 from TB Shots, Flu Shots, COVID related services, $24,000 from COVID Cleaning/Building Sanitization)	2023-24
July	Medi-Cal	DTS Capital: I&O Internet Bandwidth	DTS Capital: I&O Network Bandwidth	$36,000	To reallocate funds from I&O Internet Bandwidth to I&O Network Bandwidth to cover shortage of fund for RFP	2023-24
July	OneCare	Communication - Professional Fees Marketing/Advertising Agency Consulting	Community Relations - Membership Fees	$60,000	To reallocate funds from Communication – Professional Fees Marketing/Advertising Agency Consulting to Community Relations – Membership Fees to help fund E-Indicator Sponsorship bi-weekly newsletter	2023-24
July	Medi-Cal	Corporate Application HR - Dayforce In-View	Corporate Application HR - SilkRoad OpenHire and Wingspan	$23,000	To reallocate funds from Corporate Application HR - Dayforce iView to Corporate Application HR-SilkRoad OpenHire and Wingspan due to short of funds for renewal of contract	2023-24
August	Medi-Cal	Quality Analytics – Other Operating Expenses - Incentives	Case Management – Other Operating Expenses - WPATH – Health Plan Provider Training	$24,500	To reallocate funding from Quality Analytics – Incentives to Case Management – WPATH – Health Plan Provider Training to provide funding for Blue Peak training	2023-24
August	Medi-Cal	Quality Analytics - Other Operating Expenses - Incentives	Utilization Management – Purchased Services	$74,000	To reallocate funds from Quality Analytics – Incentives(MC) and Pharmacy Management – Professional Fees (OC) to Utilization Management – Purchased Services to provide funding for the Periscope Implementation	2023-24
August	One Care	Pharmacy Management – Professional Fees	Utilization Management – Purchased Services	$15,000	To reallocate funds from Quality Analytics – Incentives(MC) and Pharmacy Management – Professional Fees (OC) to Utilization Management – Purchased Services to provide funding for the Periscope Implementation	2023-24
August	Medi-Cal	Strategic Development - Professional Fees - DC Equity Consultant & Equity Initiative Activities	Strategic Development - Other Operating Expenses - Incentives	$67,000	To reallocate funds from Professional Fees – Equity Consultant, and Equity Initiative Activities to Purchased Services – Gift Cards to provide funding to purchase member incentive gift cards	2023-24
September	One Care	Office of Compliance - Professional Fees - CPE Audit	Office of Compliance - Professional Fees - Blue Peak Services	$20,000	To reallocate funds from Professional Fees – CPE Audit to Professional Fees – Blue Peak Services to provide funding for Blue Peak Services	2023-24
September	Medi-Cal	Customer Service - Member Communication – Maintenance of Business, Ad-Hoc/New Projects	Provider Data Mgmt. Svcs – Purchased Services	$60,000	To reallocate funds from Customer Service – Member Communication Maintenance of Business and Ad-Hoc/New Projects to Provider Data Management Services – Purchased Services to provide funding for provider directory PDF Remediation services	2023-24
September	Medi-Cal	Facilities - Audio Visual Enhancements	Facilities - CalOptima Health New Vehicle	$13,135	To reallocate funds from Facilities – Audio Visual Enhancements to Facilities – CalOptima Health New Vehicle for a new company vehicle	2023-24
September	Medi-Cal	Medical Management – Other Operating Expenses – Training & Seminar	Behavioral Health Integration – Professional Fees	$16,000	To reallocate funds from Medical Management – Other Operating Expenses – Training & Seminar to Behavioral Health Integration – Professional Fees to provide funding for Autism Spectrum Therapies	2023-24
September	Medi-Cal	Population Health Management – Purchased Services – Capacity Building Vendor	Population Health Management – Purchased Services – Capacity Building	$150,000	To repurpose funds from Purchased Services – Capacity Building Vendor to support the new Medi-Cal benefit, including incentives for contracting with CCN and delegated Health Networks, doula training, and technical assistance	2023-24
September	Medi-Cal	IS – Enterprise Data & Sys Integration – Professional Fees	Enterprise Project Management Office – Professional Fees	$75,000	To reallocate funds from Enterprise Project Management Office – Training & Seminar, IS – Enterprise Data & Sys Integration – Professional Fees and IS – Application Development – Maintenance HW/SW to provide funding for the BCP consultation project	2023-24
September	Medi-Cal	IS – Application Development – Maintenance HW/SW	Enterprise Project Management Office – Professional Fees	$55,000	To reallocate funds from Enterprise Project Management Office – Training & Seminar, IS – Enterprise Data & Sys Integration – Professional Fees and IS – Application Development – Maintenance HW/SW to provide funding for the BCP consultation project	2023-24
October	Medi-Cal	DTS Capital: Migrate Data Warehouse / Analytics to the Cloud	DTS Capital: Enterprise Data Quality Enhancement	$140,000	To reallocate funds from AppDev – Migrate Data Warehouse Analytics to AppDev – Enterprise Data Quality Enhancement to help with Collibra Data Governance invoice	2023-24
October	Medi-Cal	Medi-Cal/Claim - Other Operating Expenses - Food Service Supply	Medi-Cal/Claim - Other Operating Expenses - Travel	$16,000	To reallocate funds from Medi-Cal/Claim – Food Service Supply to Medi-Cal/Claim – Travel to provide funding for Center for Care Innovations	2023-24
October	Medi-Cal	Is – Infrastructure – Other Operating Expenses – Maintenance HW/SW	Provider Data Management Services – Purchased Services	$54,000	To reallocate funds from IS – Infrastructure – Microsoft Enterprise License Agreement, Sales & Marketing – FMO OneCare Marketing Partnership and IS – Application Management – Enthrive to Provider Data Management Services to provide funding for the provider directory PDF remediation service	2023-24
October	One Care	IS – Application Management – Maintenance HW/SW	Provider Data Management Services - Purchased Services	$24,000	To reallocate funds from IS – Infrastructure – Microsoft Enterprise License Agreement, Sales & Marketing – FMO OneCare Marketing Partnership and IS – Application Management – Enthrive to Provider Data Management Services to provide funding for the provider directory PDF remediation service	2023-24
November	Medi-Cal	IS - Application Management - Maintenance HW/SW	Medical Management - Professional Fees	$100,000	To reallocate funds from IS-Applications Management - Maintenance HW/SW IBM WebSphere to Medical Management - Professional Fees to fund a consulting project	2023-24
November	Medi-Cal	Executive Office - Professional Fees	Executive Office - Other Operating Expenses - Professional Dues	$28,000	To reallocate funds from Professional Fees to Professional Dues to pay for CCI Membership	2023-24
November	Medi-Cal	Infrastructure - Misc. HW/SW Technology Equipment (New Hire Equip)	Infrastructure - HW/SW Maintenance (Palo Alto Firewall)	$84,000	To reallocate funds from Infrastructure Misc. HW/SW Technology Equipment (New Hire Equipment) to HW/SW Maintenance (Palo Alto Firewall) to help with shortage of funds due to contract is co-termed	2023-24
December	Medi-Cal	505 Building - Repair & Maintenance	505 Building - Purchased Services	$228,798	To reallocate funds from Repair & Maintenance to Purchased Services to move security contracts to the appropriate account	2023-24
December	Medi-Cal	500 Building - Repair & Maintenance	500 Building - Purchased Services	$192,120	To reallocate funds from Repair & Maintenance to Purchased Services to move security contracts to the appropriate account	2023-24
December	Medi-Cal	Infrastructure - Misc HW/SW Equip Sup	Infrastructure - Maintenance HW/SW - F5 Network	$47,000	To reallocate funds from Infrastructure - Misc HW/SW Equip Supplies to Infrastructure - Maintenance HW/SW - F5 Network and Infrastructure - Maintenance HW/SW - Calabrio to help with the annual renewal invoice	2023-24
December	Medi-Cal	Infrastructure - Misc HW/SW Equip Sup	Infrastructure - Maintenance HW/SW - Calabrio	$29,000	To reallocate funds from Infrastructure - Misc HW/SW Equip Supplies to Infrastructure - Maintenance HW/SW - F5 Network and Infrastructure - Maintenance HW/SW - Calabrio to help with the annual renewal invoice	2023-24
December	Medi-Cal	Application Mgmt. - Maintenance HW/SW (IBM WebSphere)	Enterprise Data & Sys Integration - Maintenance HW/SW (Tableau)	$249,990	To reallocate funds from Application Mgmt. - Maintenance HW/SW (IBM WebSphere) to Enterprise Data & Sys Integration - Maintenance HW/SW (Tableau) to help with Tableau invoice.	2023-24
December	Medi-Cal	Facilities - Comp supply/Minor Equipment	Facilities - R&M - Building	$100,000	To reallocate fund from Comp Supply/Minor Equipment to R&M - Building to address unanticipated repair costs	2023-24
December	Medi-Cal	Professional Fees - Altruista	Purchased Services - MCG	$40,000	To reallocate funds from Professional Fees - Altruista to Purchased Services - MCG to help with CMS requirement to add a link in CalOptima Health's website for Medicare members	2023-24
January	Medi-Cal	IS - Infrastructure - Other Operating Expenses - Misc HW/SW Equipment	Delegation Oversight - Professional Fees	$96,000	To reallocate funds from IS - Infrastructure - Misc HW/SW Equipment to Delegation Oversight - Professional Fees to provide funding for a consultant services	2023-24
January	Medi-Cal	IS - Application Development - Professional Fees	Operations Management - Professional Fees	$150,000	To reallocate funds from Application Development – Professional Fees to Operations Management - Professional Fees to help with additional services	2023-24
January	Medi-Cal	Integrated Provider Data Management System	New Ticketing Tool for CalOptima Staff	$50,000	To reallocate funds from Integrated Provider Data Management System to New Ticketing Tool for CalOptima Staff due to shortfall of funds in Phase II	2023-24
February	Medi-Cal	IS - Infrastructure - New Hire Equipment	Executive Office - Public Activities	$17,000	To reallocate funds from Infrastructure - New Hire Equipment to Executive Office - Public Activities to provide funding to support events	2023-24
February	One Care	Customer Service - Printing and Postage - Communications	Cultural & Linguistics - Purchased Services	$50,000	To reallocate funds from Customer Service - Printing and Postage to Cultural & Linguistics - Purchased Services to supplement the anticipated gap	2023-24
February	Medi-Cal	IS - Enterprise Data & Sys Integration - Professional Fees	Grievance & Appeals - Purchased Services	$20,000	To reallocate funds from Enterprise Data & Sys Integration - Professional Fees to Grievance & Appeals - Purchased Services to provide additional funding for data scanning and storage	2023-24
February	Medi-Cal	IS-Infrastructure - Other Operating Expenses - Misc HW/SW Equipment Supplies	Provider Data Management Services - Purchased Services	$71,000	To reallocate funds from IS - Infrastructure - Misc HW/SW Equipment Supplies to Provider Data Management Services - Professional Fees to provide funding for provider directory PDF Remediation Services	2023-24
February	One Care	Communications - Professional Fees	Communications - Printing and Postage - Member Communication	$150,000	To reallocate funds from Communications - Professional Fees to Member Communication to provide funding needed for OneCare marketing and advertising program	2023-24
February	Medi-Cal	Infrastructure - New Hire Equipment	IS - Infrastructure - Cisco	$18,000	To reallocate funds from Infrastructure - New Hire Equipment to Infrastructure - Cisco due to shortfall of funds	2023-24
March	One Care	Quality Analytics - Professional Fees	Quality Analytics - Other Operating Expenses - Incentives	$120,000	To reallocate funds from Quality Analytics - Professional Fees and Stars Initiatives to Incentives to provide funding for OC Health Reward Program	2023-24
March	One Care	Quality Analytics - Purchased Services - Stars Initiatives	Quality Analytics - Other Operating Expenses - Incentives	$120,000	To reallocate funds from Quality Analytics - Professional Fees and Stars Initiatives to Incentives to provide funding for OC Health Reward Program	2023-24
March	Medi-Cal	Facilities - Other Operating Expenses - Office Supplies	Facilities - Other Operating Expenses - R&M - Building	$100,000	To reallocate funds from Facilities - Office Supplies to R&M to provide funding needed for building maintenance	2023-24
March	Medi-Cal	IS - Infrastructure - Technology Equipment	IS - Infrastructure - UGovernIT	$40,000	To reallocate funds from IS - Infrastructure Technology to UGovernIT and Telco Misc HW/SW to Palo Alto Firewall due to shortfall of funds	2023-24
March	Medi-Cal	IS - Infrastructure - Telco Misc HW/SW	IS - Infrastructure - Palo Alto Firewall	$118,000	To reallocate funds from IS - Infrastructure Technology to UGovernIT and Telco Misc HW/SW to Palo Alto Firewall due to shortfall of funds	2023-24
March	Medi-Cal	IS - App Development - Provider Virtual Agent Support	IS - App Development - Migrate Website Content Management System to the	$67,100	To reallocate funds from Provider Virtual Agent Support to Migrate Website Content Management System to the Cloud due to shortfall of funds	2023-24
March	Medi-Cal	IS - Enterprise Data & Sys Integration - Professional Fees	Executive Office - Professional Fees	$28,000	To reallocate funds from IS - Enterprise & System Integration - Professional Fees to Executive Office - Professional Fees to provide funding for communications consultant	2023-24
March	Medi-Cal	IS - Cyber Security - Data Loss Prevention Suite	IS - Cyber Security - Tipping Point Intrusion Preon System	$32,000	To reallocate funds from IS - Cyber Security - Data Loss Prevention Suite to IS - Cyber Security - Tipping Point Intrusion Prevention System due to shortage of funds	2023-24
March	Medi-Cal	IS - Infrastructure - Computer Equipment Refresh	IS - App Development - Secure Auth Web Access Management	$220,000	To reallocate funds from IS - Infrastructure - Computer Equipment Refresh to IS - App Development - Secure Auth Web Access Management due to shortage of funds	2023-24
April	Medi-Cal	IS - Applications Management - Other Operating Expenses - Maint HW/SW - Vendor Selection TBD	IS - Applications Management - Other Operating Expenses - Maint HW/SW - MCG Integrated Criteria	$20,000	To reallocate funds from IS - Applications Management - Maint HW/SW - Vendor Selection TBD to Maint HW/SW - MCG Integrated Criteria due to shortage of funds	2023-24
April	Medi-Cal	Communications - Printing and Postage - Member Communications	Communications- Purchased Services - Advertising	$25,000	To reallocate funds from Communications - Printing and Postage - Member Communications to Purchased Services - Advertising to provide additional funding for the remainder of the fiscal	2023-24
April	PACE	PACE Marketing - Printing and Postage - Member Communication	PACE Marketing - Purchased Services - Advertising	$34,000	To reallocate funds from PACE Marketing - Printing and Postage - Member Communication to Purchased Services - Advertising and Public Activities to provide additional funding for the remainder of the fiscal year	2023-24
April	OneCare	Sales & Marketing - Purchased Services - FMO and or Broker Agency Commissions and Override Fees	IS - Applications Management - Other Operating Expenses - HealthEdge Burgess Group	$150,000	To reallocate funds from the Sales & Marketing - FMO and or Broker Agency Commissions and Override Fees to IS - Applications Management - HealthEdge Burgess Group due to shortage of funds	2023-24
April	Medi-Cal	IS - Infrastructure - Other Operating Expenses - Misc HW/SW Technology Equipment	IS - Application Development - Other Operating Expenses - Ceridian	$161,000	To reallocate funds from IS - Infrastructure - Misc HW/SW Technology Equipment to IS - Application Development - Ceridian due to shortage of funds	2023-24

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

Board of Directors Meeting
June 6, 2024

Monthly Compliance Report

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

A. Updates on Regulatory Audits

1. Medicare

- **CY2022 Centers for Medicare & Medicaid Services (CMS) 1/3 Financial Audit *(applicable to OneCare)*:**

***Update*:**

- Entrance Conference January 22, 2024.
- CalOptima Health has provided the auditor with documentation as requested.
- The pre-exit conference was held on March 27, 2024, and the exit conference was held on March 28, 2024.
- The Agree/Disagree Letter was shared with CalOptima Health, which includes two findings and two observations. CalOptima Health has reviewed the letter and provided a response back to the auditor on April 3, 2024.
- The auditor completed Pharmacy Benefit Manager (PBM) testing and there were no exceptions noted after all supporting documentation was received.
- CalOptima Health is pending the Draft Report from the auditor.

***Background*:**

- At least one-third of Medicare Advantage Organizations (MAOs) are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CMS will audit and inspect any books and records of the MAO that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract. The Pharmacy Benefit Management (PBM) company will also be required to provide CMS with all requested supporting documentation for this audit.
- CMS notified CalOptima Health that its OneCare plan has been selected for the CY2022 CMS Financial Audit and Davis Farr LLP will conduct the audit. Davis Farr LLP will act in the capacity of CMS agents and request records and supporting documentation for, but not limited to, the following items:
  - Claims data
  - Solvency

Back to Agenda

- Enrollment
- Base year entries on the bids
- Medical and/or drug expenses
- Related party transactions
- General administrative expenses
- Direct and Indirect Remuneration (DIR)

- **2024 Medicare Part C and Part D Data Validation Audit (MDVA) (*applicable to OneCare*):**

Update:
- CalOptima Health has contracted with an independent consulting firm to conduct its annual MDVA audit as required by Medicare Advantage and Part D (MAPD) regulations.
- The audit is proceeding according to schedule with all data files and source documentation submitted timely.
- Review of submitted items by the auditor is underway.

- **2024 CMS Program/Focused Audit Readiness *(applicable to OneCare):***

Update:
- CalOptima Health engaged an external auditor to conduct a mock audit for readiness for a CMS UM Focused audit.
- The mock audit was kicked off on April 8, 2024.
- Submission of the audit deliverables was completed on May 1, 2024.
- Upcoming Key Dates:
  - May 28, 2024 – May 30, 2024: Audit Webinar Week

Background:
- On October 24, 2023, CMS announced it is adding a new focused audit, which is limited to ODAG (Organization Determinations Appeals and Grievances) and CPE (Compliance Program Effectiveness) for Plans who do not have 2024 routine scheduled program audits.
- This new focused audit is designed to specifically target compliance with the coverage and Utilization Management (UM) policies finalized in CMS-4201-F, which is effective January 1, 2024.
- CalOptima Health Compliance has confirmed implementation of new requirements from CMS-4201-F.
- CalOptima Health anticipates receiving a targeted audit engagement letter between January through July 2024.

2. Medi-Cal

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

Update:
- March 29, 2024, DHCS held its close-out meeting with the Office of Compliance

- Close-out meeting marked the conclusion of the 2-week interview period (March 18, 2024, through March 29, 2024).
- DHCS clarified that it continued to review and assess CalOptima Health; no findings or observations were formally shared with CalOptima Health.

➢ *CalOptima Health is awaiting its draft audit report.*

Background:

➢ January 25, 2024, CalOptima Health formally engaged by DHCS for its annual medical audit.
➢ Audit covers the review period of February 1, 2023, through February 29, 2024.
➢ Audit evaluates CalOptima Health's compliance with its Medi-Cal contract and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, and member's rights.
- This year is considered a **limited-scope audit**, as such, not all audit categories will be reviewed.

➢ Below is the anticipated timeline provided by DHCS; please be advised these timeframes are subject to change.
- March 29, 2024, audit close-out meeting
- 6-8 weeks post audit close-out DHCS will provide its Draft Findings & host an Exit Conference (via webinar)
  - 3 business days prior to Exit Conference: Draft findings will be provided to CalOptima Health for review.
  - Post Exit Conference:
    - ❖ CalOptima Health will have 15 calendar days from the Exit Conference to review Draft Findings and provide comments/rebuttal.
    - ❖ DHCS will then have an additional 15 calendar days to review CalOptima Health's comments/rebuttals.
- 30 calendar days post the Exit Conference, CalOptima Health will receive the final audit report and its formal request for corrective action.
- CalOptima Health must submit its response to the corrective action, 30 calendar days from receipt of the request.
- CalOptima Health must ensure that all corrective actions are complete and effectuated within 180 calendar days of the formal corrective action plan (CAP) response.

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

Update:

➢ On May 2, 2024, CalOptima Health submitted its required 1-year update to the CSA.
➢ CalOptima Health provided narrative responses and supporting documentation on the remaining four of the seven initial recommendations.
- CalOptima Health sent a follow-up communication to CSA subsequent to the May 2, 2024, CalOptima Health Board of Directors meeting indicating all four remaining items were "Fully Implemented".

➢ CalOptima Health awaits CSA's feedback and will continue to track this audit to closure.

Background:

- As directed by the Joint Legislative Audit Committee, the California State Auditor (CSA) conducted an audit of certain aspects of CalOptima Health's budget, services and programs, and organizational changes.
- On May 2, 2023, the CSA released a report following a comprehensive nine-month audit of CalOptima Health that covered an eight-year period from January 2014 through June 2022.
- In response to the seven (7) recommendations made by CSA, CalOptima Health is required to submit 60-day, 6-month and 1-year status update regarding the implementation of each recommendation.
  - CalOptima Health's 60-day update to CSA was submitted June 30, 2023
  - CalOptima Health's 6-month update was submitted on November 2, 2023
  - CalOptima Health's 1-year update was submitted to CSA on May 2, 2024
- CSA will use the information provided by CalOptima Health to determine whether a follow-up audit is necessary.
  - CSA may also use the information to update policy and fiscal committees and subcommittees about the implementation status of all State Auditor recommendations to facilitate legislative oversight of audited agencies.

B. Regulatory Notices of Non-Compliance

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

C. Updates on Health Network Monitoring and Audits

- **Health Network Audits:**

  - No updates for this month.

D. Internal Audit Updates

- **Internal Audits:**

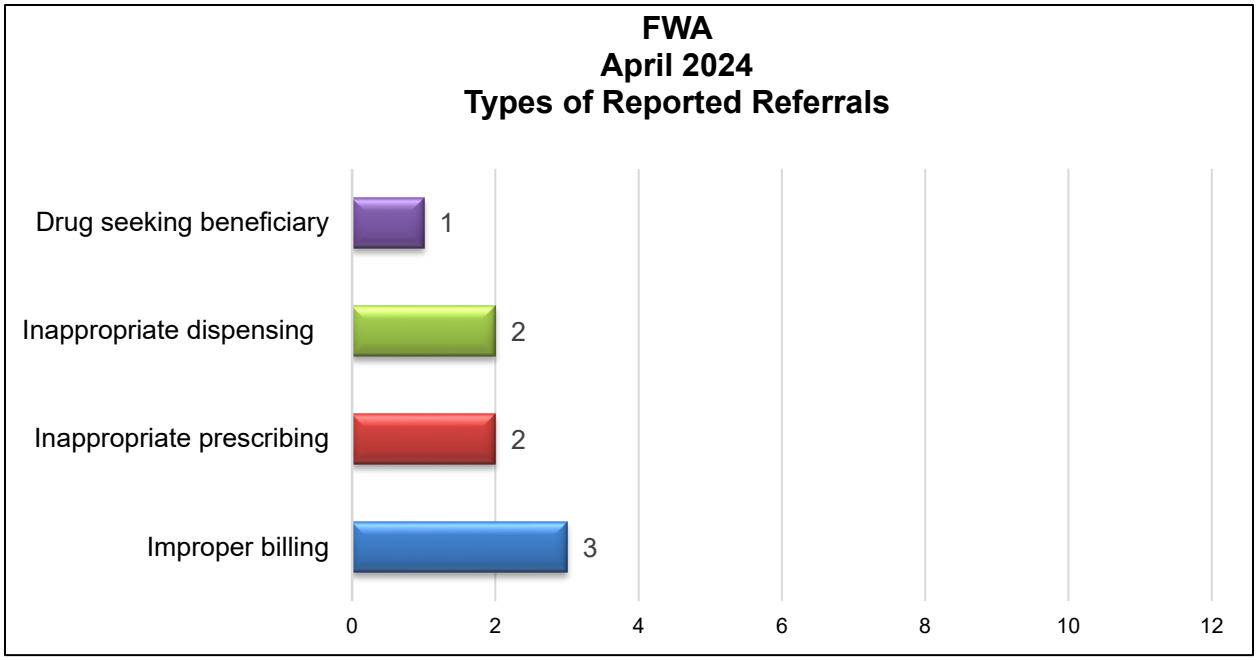
  - CalOptima Health's Internal Audit department is currently conducting six (6) internal annual audits to assess regulatory compliance with universe, timeliness, accuracy, clinical decision-making, and processing requirements in accordance with CMS and DHCS regulatory standards.
  - The following annual audits are currently in progress by Line of Business:
    - Utilization Management (Medi-Cal) Annual Audit
      - Lookback Period: January 1, 2023, to May 31, 2023
      - Status: CAPs issued and in-process of remediation
    - Utilization Management (OneCare) Annual Audit
      - Lookback Period: January 1, 2023, to June 30, 2023
      - Status: CAPs issued and in-process of remediation
    - Grievance and Appeals (Medi-Cal) Annual Audit
      - Lookback Period: January 1, 2023, to October 31, 2023

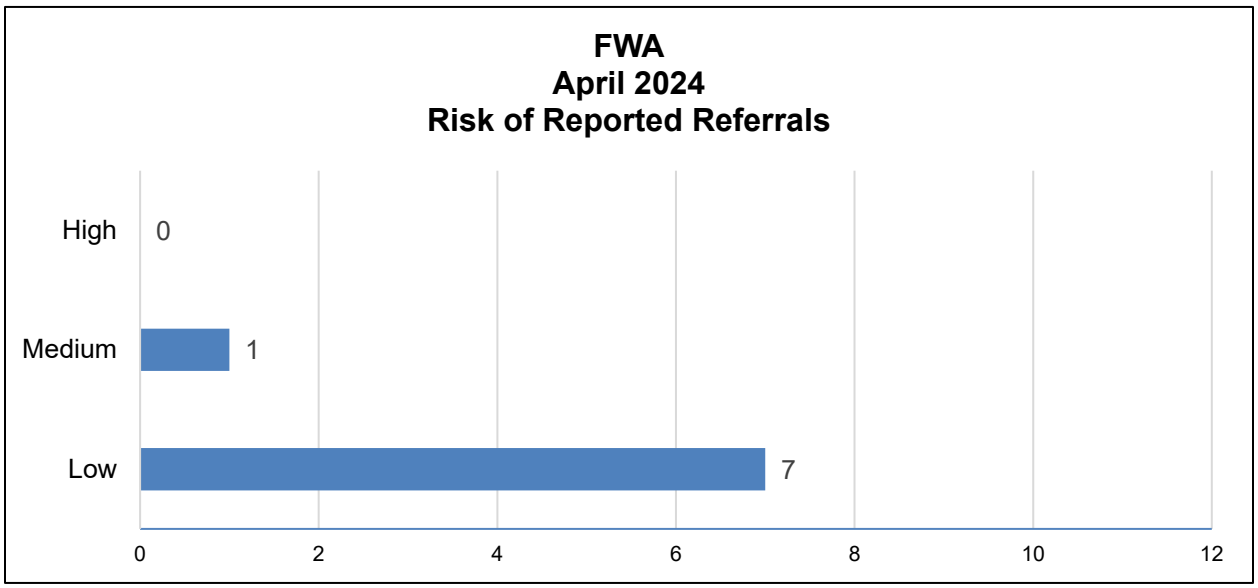
    - Status: CAPs issued and in-process of remediation
  - CDAG Pharmacy and GARS Grievance Part D (OneCare) Annual Audit
    - Lookback Period: January 1, 2023, to November 30, 2023
    - Status: Initial CAP issued on April 24, 2024. Department CAP responses due on May 8, 2024.
  - PACE (OneCare) Annual Audit
    - Lookback Period: July 1, 2023, to January 31, 2024
    - Status: Webinar commenced on April 30, 2024 and concluded on May 2, 2024
  - Customer Service (OneCare) Annual Audit
    - Lookback Period: January 1, 2024, to March 31, 2024
    - Status: Engaged on April 29, 2024

- **Board-Approved Initiatives Review:**

  - CalOptima Health's Internal Audit department is currently in the process of reviewing CalOptima Health's Board-approved initiatives. Internal Audit's goal is to identify opportunities to strengthen the oversight of the fund's surplus expenditure management process, including the structure for reviewing and signing off on grant programs and initiatives.
  - There are 26 Board-approved initiatives with total funding allocations of approximately $922 million. Initiatives are classified into the following program types:
    - Grant programs
    - Quality/Population Health Management programs
    - Strategic Initiatives
  - CalOptima Health's Internal Audit department engaged a consultant in October 2023 to review the Board-approved initiatives with the objective of identifying opportunities to strengthen and improve processes.
  - Consultant presented preliminary observations and opportunities for improvement to executive leadership on March 26.
  - Development and implementation of consultant's recommendations scheduled to begin in May.

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

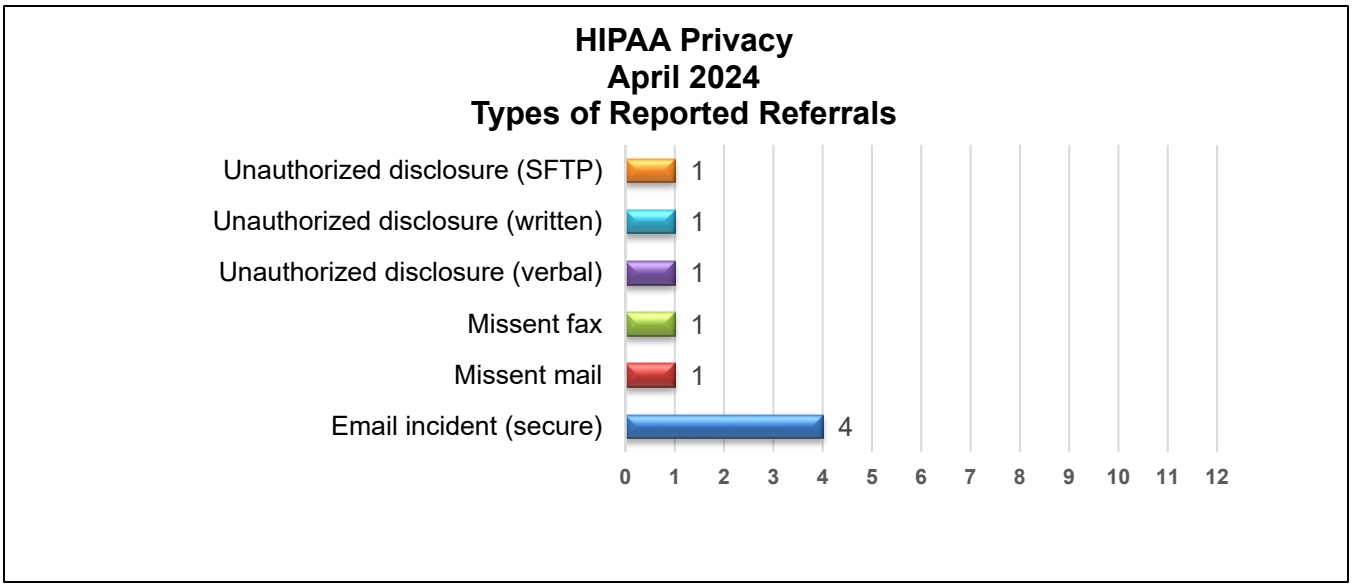


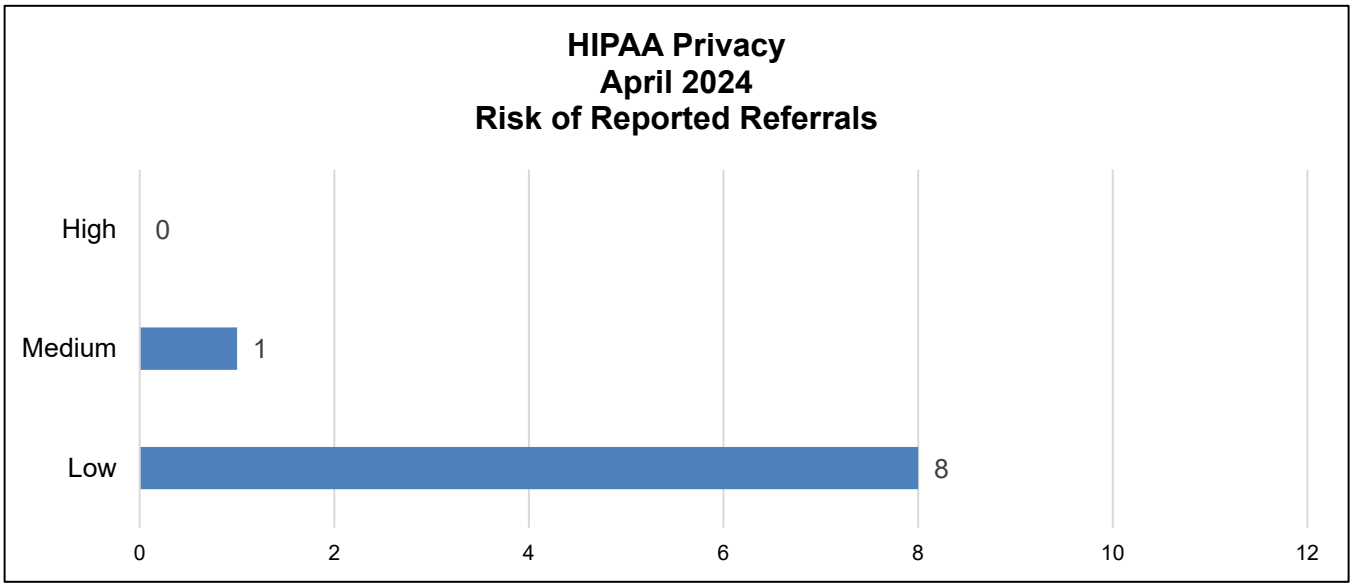


Total Number of New Cases Referred to DHCS (State)	8
Total Number of New Cases Referred to DHCS and CMS*	2
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**8**

* Any potential FWA *with impact to Medicare* is reported to CMS within 30 days of the start of an investigation.

F. Privacy Update (April 2024)





Total Number of Referrals Reported to DHCS (State)	9
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

May 10, 2024

To: CalOptima Health

From: Potomac Partners DC & Strategic Health Care

Re: May Board of Directors Report

FISCAL YEAR 2024 APPROPRIATIONS

At the end of April, the House Appropriations Committee released their Fiscal Year 2025 (FY25) Community Project Funding (CPF) earmark guidance. Despite support from new Appropriations Committee Chairman Cole (R-OK) for reopening the Labor-Health and Human Services-Education (LHHSE) bill to earmarks, the new guidance did not make substantial changes to FY24 guidance. While the LHHSE bill is not an eligible earmark account this year, it is promising to know that Chairman Cole would like to reopen the bill to earmarks, a position that Democrats also support, which could mean that regardless of election outcomes, the LHHSE bill could be reopened to earmarking in FY26. The House is expected to begin marking up the FY25 appropriations bills by the end of May.

MOTION TO VACATE

On May 8th, U.S. Representative Marjorie Taylor Greene (R-GA) followed through on her threat to introduce a "Motion to Vacate" (MTV) in an effort to remove House Speaker Mike Johnson (R-LA) from the Speaker's post. The MTV was summarily rejected by the majority of the House, with 359 Members voting to table the motion (i.e., keep Speaker Johnson), 43 Members voting against the motion to table (i.e., remove Speaker Johnson), seven Members voting 'Present,' and 21 Members not voting. The list of recorded votes is available here. No Members of the Orange County delegation voted to remove Speaker Johnson.

HOUSE HEARING ON MEDICAID ACCESS AND INTEGRITY

On April 30th, the House Energy and Commerce Committee held a hearing entitled "*Legislative Proposals to Increase Medicaid Access and Improve Program Integrity.*" The sole witness was CMS Deputy Administrator / Director of the Center for Medicaid & CHIP Services, Daniel Tsai. The primary topic for Members during the hearing was Medicaid affordability, including costs to individuals and the States. Republicans also focused on improper payments and asked what the Administration is doing to detect and stop improper payments. Another topic of concern among Members of the Committee was the health care workforce. The full hearing is available for viewing here. A list of discussed proposals and the written witness testimony is available here.

Back to Agenda

House Hearing on Cyber Attacks in Health Care

In another Energy and Commerce hearing, UnitedHealth (owner of Change Healthcare) declined to send a witness to discuss the massive attack on their system. Members of the Committee were not pleased. Witnesses that were present, including the American Hospital Association (AHA), cybersecurity experts, and a physician in private practice, described the massive disruption to health care providers caused by cybersecurity attacks. Witnesses and Members discussed interrupted cash flows, high-interest loans, substantial administrative burden, and fragmented care coordination. Republicans and Democrats both questioned how consolidation in the insurance and health technology industries is impacting provider abilities. The full hearing and written witness testimony are available here.

Telehealth Legislation

A new pair of telehealth bills have been introduced in the House of Representatives. A bill introduced by Reps. Michael C. Burgess, M.D. (R-TX), Greg Murphy, M.D. (R-NC), Derrick Van Orden (R-WI), and Troy Nehls (R-TX) would permanently extend telehealth services for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics. Furthermore, a bipartisan bill introduced by Reps. Mike Kelly (R-PA), Mike Thompson (D-CA), and Adrian Smith (R-NE) would permanently expand the list of practitioners eligible for Medicare payments for telehealth services to include qualified physical therapists, occupational therapists, speech-language pathologists, and audiologists. Rep. Burgess' bill is available here. Rep. Kelly's bill is available here.

HHS Behavioral Health Funding Opportunities

On May 8th, the U.S. Department of Health and Human Services (HHS) announced $46.8 million in grant funding availability to promote youth mental health, grow the behavioral health workforce, improve access to culturally competent behavioral care across the country, and strengthen peer recovery and recovery support. For example, $15.4 million is available through the Minority Fellowship Program, which aims to reduce health disparities and improve behavioral health care outcomes for racial and ethnic populations. The program also seeks to train and better prepare behavioral health practitioners to more effectively treat and serve people of different cultural and ethnic backgrounds. The full press release and a list of highlighted funding opportunities are available here.

Final Rule on DACA Recipients

On May 3rd, HHS issued a Final Rule expanding Affordable Care Act (ACA) access to undocumented immigrants brought to the US as children under the Deferred Action for Childhood Arrivals (DACA) program. The final rule updates the definition of "lawfully present," ensuring DACA recipients are eligible to purchase qualified health plans through federal and state marketplaces as well as receive premium tax credits and cost-sharing reductions. With estimates suggesting up to 100,000 previously uninsured DACA recipients could enroll in ACA or basic health plans, the rule will provide healthcare access for immigrant communities unable to receive it before. The Final Rule is available here. A press release from HHS is available here.

Final Rule on Medicaid and CHIP Managed Care Access

Private health insurance companies operating Medicaid managed care plans are preparing to face heightened scrutiny due to a new final rule released by CMS. The rule, aimed at increasing transparency and accountability within the Medicaid managed care system, mandates standards for appointment wait times, requires disclosure of provider payment rates, and establishes a comprehensive platform on states' websites for Medicaid beneficiaries to compare services offered by different managed care plans. The final rule is available here. The CMS factsheet is available here.

Final Rule on Nursing Home Staffing Requirement

CMS released a pair of controversial final rules that set staffing levels for nursing homes and compensation requirements for home care agencies, much to the ire of the health care industry. Under the rule, nursing homes must deliver 3.48 hours of daily direct care per patient under a final staffing mandate. According to industry estimates, roughly 80% of nursing homes would need to hire more nurses to comply with the requirement, which also requires a registered nurse on site 24/7 at most facilities (*This was also a topic for Republicans during the hearing with Deputy Administrator Tsai previously mentioned*). Additionally, the rule will require at least 80% of Medicaid payments for home care services to go toward wages, and states will be required to declare how much they pay for home care services and how they set rates. The CMS factsheet is available here. The final rule is available here.

Health Disparities

The Commonwealth Fund's 2024 State Health Disparities Report highlights the persistent racial and ethnic disparities within the U.S. health care system. By examining 25 indicators of health system performance, encompassing health outcomes, access to health care, and quality of services, the report underscores the urgent need for targeted interventions to rectify the systemic disparities plaguing the U.S. health care landscape. The full report is available here.

Additionally, a new CMS report examining disparities in Medicare Advantage (MA) care based on race, ethnicity, and sex shows that in 2023, clinical care disparities were most common for Native American and African American enrollees. Native American and African American enrollees both scored below average on measures of diabetes care. African Americans also scored below average on measures of behavioral health, cardiovascular care, and care coordination. Results for Asian American, Hispanic, Native Hawaiian, and Pacific Islander enrollees were mixed, while scores for male and female enrollees on patient experience and clinical care measures were similar. The full April 2024 report is available here.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
May 27, 2024

General Update

May 24 was the "house of origin" deadline where each chamber had to pass any active bills approved by their own policy committees. When bills get to their own floors, the collegial relationship among colleagues tends to lead to passage (historically, less than 1% of bills have failed on the floor). The Assembly passed 931 bills while the Senate passed 479 (1,410 bills total) by the house of origin deadline.

The earlier May 17 fiscal bill deadline was the more dramatic milestone. All bills with any fiscal impact were placed on each house's Appropriations Committees' "suspense file." Suspense file hearings were held in both houses on May 16, where some bills were quietly discarded without a roll call vote. The Senate dispensed about 25% of their bills; approximately 33% were stymied in the Assembly. These are well above historic averages, but not surprising due to the looming massive budget deficit.

The next key bill deadline will take place on August 15, when the Appropriations Committees will release the "suspense file" on bills sent to them by the other house (which tends not to be as accommodating as the legislators' own house).

Budget Update

The May revised budget deficit has now grown by $7 billion since the Administration's January budget, with a total deficit plug of $27.6 billion now needed. This is in addition to already addressing $17.3 billion through early action solutions in April.

January's proposed budget focused on the substantial use of the "rainy day fund" reserves to close the deficit, which may have also required declaring a "State of Emergency" by the Governor. Legislators expressed concern about using too much of the reserves too soon, and the Governor's May Revision responded by substantially reducing the reliance on rainy day reserves by decreasing their usage from $12 billion to $3 billion. However, other funding sources must now fill the gap.

While the Governor still insists that core services are remaining intact, education and healthcare stakeholders strongly disagree. Legislators are getting a front-row seat in choosing among core service priorities. The Administration budget targets have proven to be schools, community colleges and the healthcare industry through shifts of Proposition 98 school funding and MCO tax revenues. Negotiations and difficult decisions will continue until the June 15 legislative deadline to pass the budget.

Managed Care Organization (MCO) Tax - In a complete surprise, the May revision proposes a sweep of the MCO tax revenue to the General Fund. This includes $881 million in FY 2024-25 augmentations for healthcare providers, $841 million in reserves anticipated at the end of 2026, and $3.4 billion in additional net revenue anticipated by a recently learned calculation increase. Healthcare plans and providers had only recently concluded hard-fought negotiations with the legislature and administration for much needed support of the healthcare system, so this sweep has not been well-received. This also creates a strong argument to support the MCO Tax Initiative on the November 2024 ballot to secure funding for future years.

Health Care Worker $25/Hour Minimum Wage Amendments - SB 828 (Durazo). The Governor has for months asked the legislature to amend this law in light of the enormous budget deficit and the estimated $4 billion state cost in the next fiscal year. The Administration has proposed an annual "trigger" making wage increases subject to General Fund revenue availability. Amendment language was excluded in the May revise as negotiations continue. Newsom has stated, "This budget will not be signed without that deal (i.e., trigger language) we committed to being addressed."

On May 20, Senator Durazo moved to "gut and amend" SB 828 to replace it with an urgency bill (which allows immediate effect upon the Governor's signature) that pushes the law's implementation date from June 1 to July 1, giving the parties more time for discussion as part of the budget. SB 828 passed the Assembly on May 23 and is now back in the Senate for concurrence. It will be heard in the Senate Labor, Public Employment and Retirement Committee on May 29. Negotiations with the Governor continue.

Key Legislation Update

Single-Payer Healthcare - AB 2200 (Kalra). The latest version of the long-pursued single-payer healthcare system for all Californians (CalCare) died in the Assembly Appropriations Committee on May 16. The bill had faced an uphill battle because of the current fiscal deficit.

Prior Authorization - SB 516 (Skinner). Last year, Senator Nancy Skinner (D-Oakland) pursued this legislation through the "gut and amend" process. This bill seeks to control health insurance plans' use of prior authorization, by waiving it for clinicians who have 90% of their prior authorizations approved. The bill remains alive but has had no action or hearings so far this year.

Utilization Review for Health Care - SB 1120 (Becker). Sponsored by the doctors, this bill mandates that health plans using AI for utilization review have a licensed physician supervise all AI decision-making tools. Since AI has helped expedite approvals for authorizations, some health plans are concerned the language could slow the authorization process. On May 23, it was unanimously approved by the Senate.

Propositions and Initiatives

Proposition 1 – Approved by voters in March, this is an overhaul of California's mental health funding system and a $6.4 billion bond for facilities. The Governor announced that the first round of bond funding ($3.3 billion) will be available through project solicitations in July. Counties, cities, tribes, non-profits, and for-profits are eligible to apply. County mental health departments must support the proposed projects, and matching funds or collateral are required.

"Protect Access to Health Care Act of 2024" Ballot Initiative - MCO Tax. Funded by hospitals, doctors, and dentists, the coalition's submitted signatures are currently being verified and expected to be sufficient to qualify for the November 2024 ballot. Passage of this initiative would be the first time this tax, which leverages federal reimbursement dollars, is made a permanent tax on health plans. This has proven particularly important given the recent proposed sweep of the MCO tax revenues by the Administration to help solve the current budget deficit. The campaign in support has raised over $8 million.

2023–24 Legislative Tracking Matrix

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

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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 492 Pellerin	**Reproductive and Behavioral Health Integration Pilot Programs:** Would provide grants, incentive payments or other financial support to Medi-Cal managed care plans (MCPs) to partner with providers for the development and implementation of behavioral health integration pilot programs to improve access to services. Partnering providers must be enrolled in the Family Planning, Access, Care, and Treatment (Family PACT) program and provide reproductive health services. ***Potential CalOptima Health Impact*:** Increased funding and access to reproductive and behavioral health services.	**06/14/2023** Referred to Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 512 Waldron	**Behavioral Health Facilities Database:** Would require the California Health and Human Services Agency (CalHHS) to create a committee to study how to develop a real-time, internet-based system, usable by hospitals, clinics, law enforcement, paramedics and emergency medical technicians, and other health care providers to display information about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities and residential alcoholism or substance abuse treatment facilities in order to identify available facilities for the temporary treatment of individuals experiencing a mental health or SUD crisis. ***Potential CalOptima Health Impact*:** Increased efficiency and timeliness of facility referrals; decreased visits to the emergency department.	**01/19/2024** Died in Assembly Appropriations Committee **03/14/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 940 Villapudua	**Eating Disorder Treatment:** Would expand the approved facilities for inpatient treatment of eating disorders to include psychiatric health facilities. ***Potential CalOptima Health Impact*:** Increased access to treatment for eating disorders.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1316 Irwin	**Psychiatric Emergency Medical Conditions:** Would require the Medi-Cal program to cover emergency services and care necessary to treat a psychiatric emergency medical condition, including screening examinations necessary to determine the presence or absence of an emergency medical condition — regardless of duration and whether the beneficiary was voluntarily or involuntarily admitted. ***Potential CalOptima Health Impact*:** Increased scope of behavioral health services for CalOptima Health Medi-Cal members.	**01/25/2024** Passed Assembly floor; referred to Senate Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1470 Quirk-Silva	**Behavioral Health Documentation Standards:** Would require DHCS to standardize data elements relating to documentation requirements, including medically necessary criteria and develop standard forms containing information necessary to properly adjudicate claims. No later than July 1, 2025, regional personnel training on documentation should be completed along with the exclusive use of the standard forms. ***Potential CalOptima Health Impact*:** New data requirements; additional training for CalOptima Health behavioral health staff on new documentation.	**09/12/2023** Passed Senate floor; referred to Assembly for concurrence in amendments **06/01/2023** Passed Assembly floor	CalOptima Health: Watch
AB 1936 Cervantes	**Maternal Mental Health Screenings:** Would require a health plan's maternal mental health program to consist of at least one maternal mental health screening during pregnancy and at least one additional screening during the first six months of the postpartum period, if determined medically necessary and clinically appropriate, to improve treatment and referrals to other maternal mental health services, including coverage for doulas. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal benefit for CalOptima Health Medi-Cal members.	**05/09/2024** Passed Assembly floor; referred to Senate Health Committee	CalOptima Health: Watch
AB 2556 Jackson	**Behavioral Health and Wellness Screenings Notice:** Would require a health plan, on an annual basis, to provide each legal guardian of an enrollee ages 10 to 18 a written or electronic notice regarding the benefits of a behavioral health and wellness screening. ***Potential CalOptima Health Impact***: Increased resources and access to behavioral health services for CalOptima Health Medi-Cal members.	**05/02/2024** Passed Assembly floor; referred to Senate Health Committee	CalOptima Health: Watch CAHP: Oppose
Budget			
H.R. 2872 Graves (LA)	**Further Additional Continuing Appropriations and Other Extensions Act, 2024:** Enacts a third Continuing Resolution (CR) to further extend Fiscal Year (FY) 2023 federal spending levels from January 19, 2024, through March 1, 2024, for certain agencies, and from February 2, 2024, through March 8, 2024, for other agencies. ***Potential CalOptima Health Impact:*** Continuation of current federal spending on programs impacting CalOptima Health members.	**01/19/2024** Signed into law	CalOptima Health: Watch

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

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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
California Advancing and Innovating Medi-Cal (CalAIM)			
AB 586 Calderon	**Community Support: Climate Change or Environmental Remediation Devices:** Would add "climate change or environmental remediation devices" as a Medi-Cal Community Support option, defined as the coverage and installation of devices to address health-related complications, barriers or other factors linked to extreme weather, poor air quality or other climate events, including air conditioners, electric heaters, air filters and backup power sources. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address social determinants of health (SDOH).	**01/19/2024** Died in Assembly Appropriations Committee **04/11/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 1338 Petrie-Norris	**Community Support: Fitness**: Would add fitness, physical activity, or recreational sports programs, activities, or memberships as a Medi-Cal Community Support option. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address SDOH.	**01/19/2024** Died in Assembly Appropriations Committee **04/18/2023** Passed Assembly Health Committee	CalOptima Health: Watch
Covered Benefits			
SB 324 Limón	**Endometriosis:** Would add any clinically indicated treatment for endometriosis as a covered benefit without prior authorization or other utilization review. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**06/27/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 339 Wiener	**Human Immunodeficiency Virus (HIV) Preexposure Prophylaxis (PrEP) and Postexposure Prophylaxis (PEP):** Increases Medi-Cal coverage of PrEP and PEP furnished by a *pharmacist* from a 60-day maximum course to a 90-day maximum course, which could be further extended under certain conditions. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**02/06/2024** Signed into law	CalOptima Health: Watch CAHP: Oppose
SB 953 Menjivar	**Menstrual Products:** Would add menstrual products as covered Medi-Cal benefits. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**03/20/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 1180 Ashby	**Emergency Medical Services:** Would require health plans to cover services provided by a community paramedicine program, triage to alternate destination program and mobile integrated health program. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**05/21/2024** Passed Senate floor; referred to Assembly	CalOptima Health: Watch CAHP: Oppose
AB 47 Boerner	**Pelvic Floor Physical Therapy**: Beginning January 1, 2024, would require health plans to provide coverage for pelvic floor physical therapy after pregnancy. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 365 Aguiar-Curry	**Continuous Glucose Monitors (CGMs):** Would add CGMs and related supplies as a covered Medi-Cal benefit for the treatment of diabetes when medically necessary, subject to utilization controls. Would also allow DHCS to require a manufacturer of CGMs to enter into a rebate agreement with DHCS. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**08/21/2023** Re-referred to Senate floor **06/21/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CalPACE: Support
AB 1036 Bryan	**Emergency Medical Transportation:** Would require a physician to certify upon patient arrival at an emergency room via emergency medical transportation whether an emergency medical condition existed and required emergency medical transportation. If certified, would require a health plan to provide coverage for emergency medical transportation. ***Potential CalOptima Health Impact:*** Increased CalOptima Health costs for reimbursement of emergency transportation services.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1975 (AB 1644) Bonta	**Medically Supportive Food**: Would add medically supportive food and nutrition intervention plans as covered Medi-Cal benefits, when determined to be medically necessary to a patient's medical condition by a provider or plan. The benefit would be based in part on the following Community Support offered through CalAIM: Medically Tailored Meals. ***Potential CalOptima Health Impact:*** Formalization and expansion of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**05/21/2024** Passed Assembly floor; referred to Senate Rules Committee **01/30/2024** Re-introduced as AB 1975 **01/19/2024** Died in Assembly Appropriations Committee as AB 1644	CalOptima Health: Watch LHPC: Support CAHP: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2105 (AB 907) Lowenthal	**PANDAS and PANS**: Beginning January 1, 2025, would require a health plan to provide coverage for prophylaxis, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS), prescribed or ordered by a provider as medically necessary. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**05/21/2024** Passed Assembly floor; referred to Senate Rules Committee **02/05/2024** Re-introduced as AB 2105 **10/07/2023** Vetoed as AB 907 *(see veto message)*	CalOptima Health: Watch CAHP: Oppose
AB 2446 Ortega	**Diapers:** Would add diapers as a covered Medi-Cal benefit for the following individuals: • Infants or toddlers with certain conditions such as urinary tract infection and diseases of the skin. • Children greater than three years of age diagnosed with a condition that contributes to incontinence • Other individuals under 21 years of age to address a condition pursuant to EPSDT standards ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**05/21/2024** Passed Assembly floor; referred to Senate Rules Committee	CalOptima Health: Watch
AB 2668 Berman	**Cranial Prostheses:** Beginning January 1, 2025, would add cranial prostheses as a covered Medi-Cal benefit as part of a prescribed course of treatment for individuals experiencing permanent or temporary medical hair loss. Coverage would be limited to a maximum of $750 for each instance, no more than once per year. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**04/23/2024** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
AB 2843 Petrie-Norris	**Rape and Sexual Assault Care:** Would require a health plan to provide coverage without cost-sharing for emergency room medical care and follow-up treatment following a rape or sexual assault. Would also prohibit a health plan from requiring members to provide a police report or press charges for rape or sexual assault in order to receive care. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**05/16/2024** Passed Assembly floor; referred to Senate Rules Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Eligibility and Enrollment			
S. 423 Van Hollen (MD) **H.R. 1113** Bera (CA)	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, the Children's Health Insurance Program (CHIP) or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they were subject to a zero net premium. Would also make individuals eligible for Medicaid or CHIP based on a prior finding of eligibility for the Temporary Assistance for Needy Families program or the Supplemental Nutrition Assistance Program. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment of CalOptima Health members.	**02/14/2023** Introduced; referred to committees	CalOptima Health: Watch
SB 1112 Menjivar	**Families with Subsidized Childcare:** Would require DHCS and the California Department of Social Services (CDSS) to inform and direct families receiving subsidized childcare on how to enroll an eligible child into Medi-Cal. Additionally, the child would be referred to developmental screenings that are available under EPSDT services. ***Potential CalOptima Health Impact*:** Expanded procedures for enrollment of pediatric CalOptima Health members.	**05/16/2024** Passed Senate Appropriations Committee; referred to Senate floor **04/15/2024** Passed Senate Human Services Committee **03/20/2024** Passed Senate Health Committee	CalOptima Health: Watch
SB 1289 Roth	**Medi-Cal Call Center Standards and Data:** Would require DHCS to establish, with stakeholder input, statewide minimum standards for assistance provided by a county's call centers to individuals applying for, renewing, or requesting help in obtaining or maintaining Medi-Cal coverage ***Potential CalOptima Health Impact:*** Increased resources for CalOptima Health members; increased number of CalOptima Health members as a result of additional new enrollments and fewer disenrollments.	**05/21/2024** Passed Senate floor; referred to Assembly	CalOptima Health: Watch
AB 1608 Patterson	**Regional Center Clients:** Would exempt from mandatory Medi-Cal MCP enrollment any dual-eligible and non-dual-eligible Medi-Cal beneficiaries who receive services from a regional center and use the Medi-Cal fee-for-service (FFS) delivery system as secondary form of health coverage. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1783 Essayli	**Unsatisfactory Immigration Status:** States the intent of the Legislature to enact legislation to prohibit state funding of health care benefits for individuals with unsatisfactory immigration status. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members	**01/04/2024** Introduced	CalOptima Health: Watch
AB 2956 Boerner	**Adult Continuous Eligibility and Redetermination:** Would require DHCS to seek federal approval to extend continuous Medi-Cal eligibility to individuals over 19 years of age. Would also require a county to attempt communication through all additional available channels before completing a redetermination and to conduct an additional review of information in an attempt to renew eligibility without needing a response., Would require counties to accept self-attested information from beneficiary for the purpose of income verification during a redetermination. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment and re-enrollment of CalOptima Health members.	**04/16/2024** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch LHPC: Support
Medi-Cal Operations and Administration			
H.R. 2811 Arrington (TX)	**Limit, Save, Grow Act of 2023:** Would require Medicaid beneficiaries ages 19–55 without dependents to work, complete community service and/or participate in a work training program for at least 80 hours per month for at least three months per year. Exemptions would be provided for those who are pregnant, physically or mentally unfit for employment, complying with work requirements under a different federal program, participating in a drug or alcohol treatment program, or enrolled in school at least half-time. HHS estimates that 294,981 Medi-Cal beneficiaries in Orange County would be subject to the proposed work requirements without an exemption. ***Potential CalOptima Health Impact:*** Disenrollment of certain CalOptima Health Medi-Cal members, especially those who experience homelessness, who are not exempt from work requirements.	**04/26/2023** Passed House floor; referred to Senate Budget Committee	CalOptima Health: Concerns ACAP: Oppose
SB 1120 Becker	**Artificial Intelligence (AI) in Utilization Review:** Would require a health plan's use of algorithms, AI, and other software tools for utilization management purposes to comply with specified fairness and equity requirements. ***Potential CalOptima Health Impact:*** Implementation of new utilization management (UM) procedures	**05/23/2024** Passed Senate floor; referred to Assembly	CalOptima Health: Watch CAHP: Oppose unless amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1690 Kalra	**Universal Health Care Coverage**: States the intent of the Legislature to guarantee accessible, affordable, equitable and high-quality health care for all Californians through a comprehensive universal single-payer health care program. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal and commercial health care delivery systems, including changes to administration, covered benefits, financing and organization.	**01/19/2024** Died without referral to committee	CalOptima Health: Watch
AB 2200 Kalra	**Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of California. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal and commercial health care delivery systems, including changes to administration, covered benefits, financing and organization.	**04/23/2024** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
AB 2340 Bonta	**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Informational Materials:** Would require DHCS to standardize informational materials that effectively explain and clarify the scope and nature of EPSDT services that are available under the Medi-Cal program, including content designed for youth. Would require a Medi-Cal MCP to provide the informational materials to EPSDT-eligible beneficiaries and their parents within 60 days of initial Medi-Cal eligibility determination and annually thereafter. ***Potential CalOptima Health Impact:*** Standardization and increased number of mailings to certain CalOptima Health Medi-Cal members.	**05/16/2024** Passed Assembly floor; referred to Senate Rules Committee	CalOptima Health: Watch
AB 2466 Carrillo	**Network Adequacy Standards:** Would deem a Medi-Cal MCP out of compliance with appointment time standards if either of the following are true: • Fewer than 85% of network providers had an appointment available within the standards • DHCS receives information establishing that the plan was unable to deliver timely, available or accessible health care services Would also require health plans to submit an annual renewal request for alternative access standards, describing the efforts made in the previous 12 months to mitigate or eliminate circumstances that justify the use of an alternative access standard. ***Potential CalOptima Health Impact:*** Increased network analysis and reporting to DHCS.	**04/16/2024** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 3260 Pellerin	**Utilization Reviews and Grievances:** Would require health plans to complete utilization review decisions within 72 hours. If a plan fails to meet such deadline, the plan must automatically open a grievance on behalf of the affected beneficiary. Additionally, would require plans to review urgent grievances, as determined by the provider, within 72 hours. ***Potential CalOptima Health Impact***: Expedited and modified UM and Grievance procedures for covered Medi-Cal benefits.	**05/21/2024** Passed Assembly floor; referred to Senate Rules Committee	CalOptima Health: Watch CAHP: Oppose
Older Adult Services			
S. 1002 Cassidy (LA)	**No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act:** Would modify the MA risk adjustment model to prevent overpayment to MA plans, as follows: • Utilization of two years instead of one of diagnostic data • Exclusion of outdated diagnoses solely included on health risk assessments • Coding adjustment to account for other payment differences between MA and Medicare FFS ***Potential CalOptima Health Impact:*** Decreased reimbursement rates from the CMS for CalOptima Health OneCare members.	**03/28/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1703 Carper (DE) **H.R. 3549** Wenstrup (OH)	**Program of All-Inclusive Care for the Elderly (PACE) Part D Choice Act of 2023:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Health Impact:*** Increased enrollment into CalOptima Health PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.	**05/18/2023** Introduced; referred to committees	**08/30/2023** CalOptima Health: SUPPORT NPA: Support
S. 3950 Cassidy (LA)	**Delivering Unified Access to Lifesaving Services (DUALS) Act of 2024:** Would require each state to develop and implement a comprehensive, integrated health plan for beneficiaries dually eligible for Medicaid and Medicare. Would also expand PACE coverage nationwide to individuals under the age of 55 as well as allow PACE enrollment at any time of the month. ***Potential CalOptima Health Impact:*** Increased coordination and benefits for dually eligible CalOptima Health members; increased enrollment into CalOptima Health PACE.	**03/14/2024** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1022 Mathis	**PACE Rates and Assessments**: Would require PACE capitation rates to also reflect the frailty level and risk associated with participants. In addition, would expand a PACE organization's authority to use video telehealth to conduct all assessments. ***Potential CalOptima Health Impact:*** Increased capitation rates for CalOptima Health PACE participants; expanded use of video telehealth assessments.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1223 Hoover	**PACE Audits:** Would require DHCS to perform program audits of PACE organizations and to develop and maintain standards, rules and auditing protocols, including related to data collection, technical assistance, formal decisions and enforcement of non-compliance. ***Potential CalOptima Health Impact:*** Modified audit protocols for CalOptima Health PACE.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1230 Valencia	**Special Needs Plans (SNPs)**: No later than January 1, 2025, would require DHCS to offer contracts to health plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to provide care to dual eligible beneficiaries. ***Potential CalOptima Health Impact:*** Increased number of SNPs in Orange County; decreased number of CalOptima Health OneCare members.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch LHPC: Oppose
Providers			
S. 3059 Bennet (CO)	**Requiring Enhanced & Accurate Lists of (REAL) Health Providers Act:** Effective plan year 2026, would require MA plans to update and ensure accurate provider directory information at least once every 90 days. If a plan is unable to verify such information for a specific provider, a disclaimer indicating that the information may not be up to date is required. Would also require the removal of a provider from a directory within five business days if the plan determines they are no longer participating in the network. ***Potential CalOptima Health Impact:*** Increased staff oversight of CalOptima Health's OneCare provider directory.	**10/17/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 497 Duncan (SC)	**Freedom for Health Care Workers Act:** would repeal the rule issued by CMS on November 5, 2021, that requires health care providers participating in the Medicare and Medicaid programs to ensure staff are fully vaccinated against COVID-19**.** ***Potential CalOptima Health Impact:*** Elimination of COVID-19 vaccination mandate for CalOptima Health PACE staff and contracted providers.	**01/31/2023** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 7149 Steel (CA)	**Equal Access to Specialty Care Everywhere (EASE) Act of 2024:** Would use existing Center for Medicare and Medicaid Innovation funds to test a virtual specialty network dedicated to providing a range of virtual modalities in partnership with primary care providers in underserved and rural communities, including Federally Qualified Health Centers (FQHCs). ***Potential CalOptima Health Impact:*** Expanded telehealth access for CalOptima Health members.	**01/30/2024** Introduced; referred to House Energy and Commerce Committee	CalOptima Health: Watch
SB 516 **(SB 598)** Skinner	**Prior Authorization "Gold Carding"**: Beginning January 1, 2026, would prohibit a health plan from requiring a contracted provider to obtain a prior authorization for any services if the plan approved or would have approved no less than 90% of the prior authorization requests submitted by the provider in the most recent one-year contracted period. Would also broadly prohibit prior authorization requirements for any services approved by a health plan at least 95% of the time. ***Potential CalOptima Health Impact:*** Implementation of new UM procedures to assess provider approval rates; decreased number of prior authorizations.	**09/14/2023** SB 516 gutted and amended as new vehicle for SB 598; re-referred to Assembly Appropriations Committee **07/11/2023** Passed Assembly Health Committee **05/25/2023** Passed Senate floor	**08/30/2023** CalOptima Health: OPPOSE LHPC: Oppose CAHP: Oppose
SB 819 Eggman	**Medi-Cal Mobile Health Care Site Enrollment:** Would exempt intermittent or mobile health care sites from enrolling in Medi-Cal as a separate provider if operated by a government-operated primary care clinic that is exempt from licensure by the California Department of Public Health (CDPH). ***Potential CalOptima Health Impact:*** Expansion of intermittent and mobile health care sites; increased access to care for CalOptima Health members.	**08/16/2023** Passed Assembly Appropriations Committee; referred to Assembly floor **07/11/2023** Passed Assembly Health Committee **05/04/2023** Passed Senate floor	CalOptima Health: Watch
SB 1268 Nguyen, J.	**Medi-Cal Safety Net Provider Contracts:** Would require a Medi-Cal MCP to offer and maintain a network provider contract with each safety net provider operating within the MCP's geographic service areas unless the safety net provider cannot provide necessary scope of services due to specified, covered reasons. Would prohibit a Medi-Cal MCP from initiating a contract termination for any reason. ***Potential CalOptima Health Impact*:** Revision of current provider contract language; decreased oversight and accountability of contracted providers.	**04/03/2024** Referred to Senate Health Committee **02/15/2024** Introduced	**04/15/2024** CalOptima Health: OPPOSE LHPC: Oppose CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 236 Holden	**Provider Directory Audits:** Would require health plans to annually verify and delete inaccurate listings from its provider directories. Would also require a provider directory to be 60% accurate by July 1, 2025, with increasing percentage accuracy each year until the directories are 95% accurate by July 1, 2028. In addition, plans would be subject to penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. Further, beginning July 1, 2025, would require plans to delete a provider from its directory if a plan has not reimbursed the provider in the prior year. Would also require a plan to arrange care for all covered health services provided to a beneficiary who reasonably relied on inaccurate, incomplete or misleading information contained in a plan's provider directory as well as require the plan reimburse the provider the contracted amount for those services. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**01/30/2024** Passed Assembly floor; referred to Senate Health Committee	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 564 Villapudua	**Medi-Cal Claim Signatures**: Would allow Medi-Cal providers to submit electronic signatures for claims and remittance forms. ***Potential CalOptima Health Impact:*** Reduced administrative burden for CalOptima Health contracted providers.	**06/14/2023** Referred to Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 815 Wood	**Provider Credentialing**: Would require CalHHS to create a provider credentialing board that certifies entities to credential providers in lieu of a health plan's credentialing process, effective July 1, 2025. Would require a health plan to accept a credential from such entities without imposing additional criteria and to pay a fee to such entities based on the number of contracted providers credentialed. Health plans could use their own credentialing processes for any providers who are not credentialed by certified entities. ***Potential CalOptima Health Impact***: Reduced credentialing application workload for CalOptima Health staff; reduced quality oversight of contracted providers.	**06/07/2023** Referred to Senate Health Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch LHPC: Oppose Unless Amended CAHP: Concerns

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1842 (AB 1288) Reyes	**Medication-Assisted Treatment Prior Authorization**: Would prohibit health plans from requiring prior authorization for a naloxone product, buprenorphine product, methadone or long-acting injectable naltrexone for detoxification or maintenance treatment of an SUD, when prescribed according to generally accepted national professional guidelines. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**04/29/2024** Passed Assembly floor; referred to Senate Health Committee **01/16/2024** Re-introduced as AB 1842 **10/08/2023** Vetoed as AB 1288 *(see veto message)*	CalOptima Health: Watch CAHP: Oppose
AB 2110 Arambula	**Adverse Childhood Experiences (ACEs) Trauma Screenings:** Would include Medi-Cal enrolled community-based organizations and local health jurisdictions that provide health services through community health workers and doulas as providers qualified to provide and eligible to receive payments for ACEs trauma screenings. **Potential CalOptima Health Impact:** Increased access to care for eligible CalOptima Health Medi-Cal members; additional provider contracting and credentialing.	**04/09/2024** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch LHPC: Support
AB 2129 Petrie-Norris	**Immediate Postpartum Contraception:** No later than January 1, 2025, would authorize a provider to separately bill for devices, implants or professional services, or a combination of both, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or accredited birthing center. ***Potential CalOptima Health Impact:*** Modified Claims procedures for a covered Medi-Cal benefit.	**05/02/2024** Passed Assembly floor; referred to Senate Health Committee	CalOptima Health: Watch
AB 2339 Aguiar-Curry	**Medi-Cal Asynchronous Telehealth:** Would expand telehealth capabilities to include asynchronous electronic transmission initiated directly by patients, including through mobile telephone applications. Would also authorize a health care provider to establish a new patient relationship using asynchronous store and forward when requested by the patient. ***Potential CalOptima Health Impact:*** Expanded telehealth capabilities for CalOptima Health Medi-Cal members.	**05/21/2024** Passed Assembly floor; referred to Senate Rules Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2726 Flora	**Telehealth and Specialty Care Networks:** Would require CalHHS to establish a demonstration project for a grant program aimed at facilitating telehealth and other virtual services specialty care network for patients of certain safety-net providers, including community health centers and critical access hospitals. The project would focus on increasing access to behavioral and maternal health services as well as other specialties prioritized by CalHHS. ***Potential CalOptima Health Impact:*** Expanded telehealth capabilities and virtual specialty networks.	**04/23/2024** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
Rates & Financing			
S. 570 Cardin (MD) **H.R. 1342** Barragan (CA)	**Medicaid Dental Benefit Act of 2023:** Would require state Medicaid programs to cover dental and oral health services for adults. Would also increase the Federal Medical Assistance Percentage (FMAP) (i.e., federal matching rate) for such services. CMS would be required to develop oral health quality and equity measures and conduct outreach relating to dental and oral health coverage. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health and contracted providers; additional quality metrics.	**02/28/2023** Introduced; referred to committees	CalOptima Health: Watch
S. 1038 Welch (VT) **H.R. 1613** Carter (GA)	**Drug Price Transparency in Medicaid Act of 2023:** Would prohibit "spread pricing" for payment arrangements with PBMs under Medicaid. Would also require a pass-through pricing model that focuses on cost-based pharmacy reimbursement and dispensing fees. ***Potential CalOptima Health Impact*:** Lower costs and increased transparency in drug prices under the Medi-Cal Rx program,	**03/29/2023** Introduced; referred to committees	CalOptima Health: Watch
S. 3578 Cassidy (LA)	**Protect Medicaid Act:** Would prohibit federal funding for the administrative costs of providing Medicaid benefits to individuals with unsatisfactory immigration status. If states choose to self-fund such costs, this bill would require states to submit a report describing its funding methods as well as the process utilized to bifurcate its expenditures on administrative costs. ***Potential CalOptima Health Impact:*** New financial reporting requirements.	**01/11/2024** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 485 McMorris (WA)	**Protecting Health Care for All Patients Act of 2023:** Would prohibit all federally funded health care programs from using quality-adjusted life years (i.e., measures that discount the value of a life based on disability) to determine coverage and payment determinations for treatments and prescription drugs. ***Potential CalOptima Health Impact:*** Modified authorization limits for certain CalOptima Health members.	**02/07/2024** Passed House; referred to Senate Finance Committee **03/24/2023** Passed House Energy and Commerce Committee; referred to House floor	CalOptima Health: Watch
SB 282 Eggman	**FQHCs and Rural Health Clinic (RHC) Same-Day Visits**: Would authorize reimbursement for a maximum of two separate visits that take place on the same day at a single FQHC or RHC site, whether through a face-to-face or telehealth-based encounter (e.g., a medical visit and dental visit on the same day). In addition, would add a licensed acupuncturist within those health care professionals covered under the definition of a "visit." ***Potential CalOptima Health Impact:*** Timelier access to services at CalOptima Health's contracted FQHCs.	**07/11/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch LHPC: Support
SB 340 Eggman	**Eyeglasses Reimbursement**: Would authorize a provider to purchase eyeglasses from a private entity instead of from the Prison Industry Authority for the purpose of Medi-Cal reimbursement for covered optometric services. ***Potential CalOptima Health Impact:*** Timelier access to prescription eyeglasses for CalOptima Health Medi-Cal members.	**06/15/2023** Referred to Assembly Health Committee and Assembly Public Safety Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch
SB 828 Durazo	**Health Care Workers Minimum Wage Delay:** Would delay the minimum wage adjustments enacted pursuant to SB 525 (2023) by one month from June 1, 2024, to July 1, 2024, effective immediately as an urgency statute. ***Potential CalOptima Health Impact:*** No expected impact since CalOptima Health previously increased its minimum wage.	**05/23/2024** Passed Assembly floor; referred to Senate **05/22/2024** Passed Assembly Labor and Employment Committee **05/20/2024** SB 828 gutted and amended	CalOptima Health: Watch
SB 870 Caballero	**MCO Tax:** Would renew the MCO tax on health plans, which expired on January 1, 2023, to an unspecified future date. Would also modify the tax rates to unspecified percentages that are based on the Medi-Cal membership of the health plan. ***Potential CalOptima Health Impact:*** Increased tax liability on CalOptima Health.	**01/19/2024** Died in Senate Appropriations Committee **04/26/2023** Passed Senate Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 1423 Dahle	**Critical Access Hospital Payment Structure:** Effective January 1, 2026, subject to federal approvals and a state appropriation, would require each critical access hospital that elects to participate in the Medicare rural hospital flexibility program to be reimbursed at 100% of the hospital's projected allowable costs for covered Medi-Cal services, based on one or more approved reimbursement methodologies. ***Potential CalOptima Health Impact:*** Modified payments to CalOptima Health contracted critical access hospitals.	**05/22/2024** Passed Senate floor; referred to Assembly	CalOptima Health: Watch
SB 1492 Menjivar	**Private Duty Nursing Rate Increases:** Would add private duty services, which are provided to a child under 21 years of age by a home health agency, as an eligible category for the purpose of Medi-Cal rate increases from MCO tax revenue. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health contracted home health agencies.	**04/24/2024** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch
AB 55 Rodriguez	**Ground Ambulance Transportation**: Effective January 1, 2024, would require Medi-Cal MCPs to implement a value-based purchasing model that increases reimbursement to ground ambulance transportation providers who meet certain workforce standards. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted transportation providers; increased costs for CalOptima Health.	**01/19/2024** Died in Assembly Appropriations Committee **04/25/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 488 Nguyen, S.	**Vision Loss:** Would modify the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program measures and milestones to include program access, staff training and capital improvement measures aimed at addressing the needs of SNF residents with vision loss. ***Potential CalOptima Health Impact:*** Modified payments to CalOptima Health contracted SNFs; increased data collection, tracking and reporting requirements; improved quality of life for certain members with vision loss.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1549 Carrillo	**FQHC and RHC Rates:** Would require that DHCS's per-visit rates to FQHCs and RHCs account for costs that are reasonable and related to the provision of covered services, including staffing, the intensity of activities taking place in an average visit, the length or duration of a visit, and the number of activities provided during a visit. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted FQHCs.	**01/19/2024** Died in Assembly Appropriations Committee **04/25/2023** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1698 Wood	**Medi-Cal Funding**: States the intent of the Legislature to enact future legislation to increase overall funding and reimbursement for the Medi-Cal program. ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health and its contracted providers.	**01/19/2024** Died without referral to committee	CalOptima Health: Watch
AB 2043 (AB 719) Boerner	**Public Transit Contracts**: Would require Medi-Cal MCPs to reimburse public paratransit service operators who are enrolled as Medi-Cal providers at the Medi-Cal FFS rates for nonmedical transportation (NMT) and nonemergency medical transportation (NEMT) services that are not on fixed routes. Would also direct DHCS to issue updated guidance by June 1, 2026, to ensure that the financial burden of these services is not unfairly placed on such operators. ***Potential CalOptima Health Impact:*** Increased payments to public paratransit operations for NMT and NEMT services.	**05/21/2024** Passed Assembly floor; referred to Senate Rules Committee **02/01/2024** Re-introduced as AB 2043 **10/07/2023** Vetoed as AB 719 *(see **veto message**)*	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 2303 Carrillo	**Minimum Wage Add-On Payment:** Would require DHCS to develop a minimum wage add-on as an alternative payment methodology to increase rates of payment to community health centers, in order to accommodate increased labor costs resulting from recently enacted minimum wage increases pursuant to SB 525 (2023). ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health contracted community health centers.	**02/12/2024** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
AB 2342 Lowenthal	**Island-Based Critical Access Hospitals:** Would require DHCS to provide an annual supplemental payment for covered Medi-Cal services to each critical access hospital that operates on an island that is located more than 10 miles offshore of the mainland coasts of the state but is still within the jurisdiction of the state. ***Potential CalOptima Health Impact:*** Increased payments to certain critical access facilities for Medi-Cal services.	**02/12/2024** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
AB 2428 Calderon	**Community-Based Adult Services (CBAS) Rates:** Would require Medi-Cal MCPs to reimburse contracted CBAS provider at an amount equal to or greater than the Medi-Cal FFS rate. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health contracted CBAS providers.	**05/21/2024** Passed Assembly floor; referred to Senate Rules Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 3275 Soria	**Claim Reimbursement:** Would require health plans to reimburse a claim, with interest accrued, within 15 working days after receipt of the claim, unless contested by the plan within 15 working days. **Potential CalOptima Health Impact:** Decreased claim review time for CalOptima Health staff; increased interested payments to CalOptima Health contracted providers.	**05/21/2024** Passed Assembly floor; referred to Senate Rules Committee	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
Social Determinants of Health			
H.R. 1066 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2023:** Would require CMS to update guidance at least once every three years to help states address SDOH under Medicaid and CHIP. ***Potential CalOptima Health Impact:*** Increased opportunities for CalOptima Health to address SDOH.	**02/17/2023** Introduced; referred to House Energy and Commerce Committee	CalOptima Health: Watch
AB 257 Hoover	**Encampment Restrictions:** Would prohibit a person from sitting, lying, sleeping or placing personal property in any street, sidewalk or other public property within 500 feet of a school, daycare center, park or library. ***Potential CalOptima Health Impact:*** Increased outreach and support services for unsheltered CalOptima Health Medi-Cal members.	**01/19/2024** Died in Assembly Public Safety Committee **03/07/2023** Failed passage in Assembly Public Safety Committee	CalOptima Health: Watch
AB 2250 (AB 85) Weber	**SDOH Screenings:** Would add SDOH screenings as a covered Medi-Cal benefit on or after January 1, 2027. Would also require health plans to provide primary care providers with adequate access to community health workers, social workers and peer support specialists. In addition, would require FQHCs and RHCs to be reimbursed for these services at the Med-Cal FFS rate. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**04/02/2024** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **02/08/2024** Re-introduced as AB 2250 **10/07/2023** Vetoed as AB 85 *(see **veto message**)*	CalOptima Health: Watch LHPC: Support

2023 Signed Bills

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

2023 Vetoed Bills

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

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association
SNP Alliance: Special Needs Plan Alliance

Last Updated: May 23, 2024

2024 Federal Legislative Dates

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

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

2024 State Legislative Dates

January 3	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
January 12	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2023
January 19	Last day for any committee to hear and report to the floor any bill introduced in that house in 2023
January 31	Last day for each house to pass bills introduced in that house in 2023
February 16	Last day for legislation to be introduced in 2024
March 21–March 30	Spring recess
April 26	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2024
May 3	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house in 2024
May 17	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house in 2024
May 20–24	Floor session only
May 24	Last day for each house to pass bills introduced in that house in 2024
June 15	Budget bill must be passed by midnight
July 3	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 3–August 4	Summer recess
August 16	Last day for fiscal committees to report bills in their second house to the Floor
August 19–31	Floor session only
August 23	Last day to amend bills on the Floor
August 31	Last day for each house to pass bills; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2024 Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through three major programs: Medi-Cal, OneCare (HMO D-SNP) and the Program of All-Inclusive Care for the Elderly (PACE).

CalOptima Health Community Outreach Summary — May and June 2024

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups as well as supports our community partners' public activities. Participation includes providing Medi-Cal educational materials and, if criteria is met, financial support and/or CalOptima Health-branded items.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

Community Outreach Highlight

On January 1, 2024, a new law in California went into effect to allow adults ages 26 through 49 to qualify for full Medi-Cal regardless of immigration status. In response, CalOptima Health in collaboration with the County of Orange Social Services Agency (SSA), the Orange County Board of Supervisors, government officials and community-based organizations initiated a concerted effort to raise awareness of the latest expansion of Medi-Cal and ensure eligible and newly eligible populations in Orange County are able to enroll.

Between January and June, a series of seven community events were held across Orange County to increase awareness and enrollment in Medi-Cal. The strategy was to reach locations across the county, with events taking place in the cities of Anaheim, Orange, Buena Park, Santa Ana and Costa Mesa. The primary objective was to disseminate information and facilitate enrollment for those eligible for the expanded Medi-Cal coverage.

In addition, CalOptima Health launched the Medi-Cal Expansion Community Event Sponsorship Opportunity in May to foster collaboration with local community-based organizations. The opportunity encourages community partners to host community events aimed at increasing awareness and enrollment in Medi-Cal and CalFresh, especially for newly eligible individuals and hard-to-reach communities.

Summary of Public Activities

As of May 10, CalOptima Health plans to participate in, organize or convene 68 public activities in May and June. In May, there were 43 public activities, including 19 virtual community/collaborative meetings, six community-based presentations, 17 community events and one Health Network Forum. In June, there will be 25 public activities, including 17 virtual community/collaborative meetings, six community events, one Cafecito and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided three endorsements since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Letter of support for Delhi's Youth Program Shirts for their Teens Engaged in Leadership and Learning program.
2. Letter of support for Orange County United Way's application for the People with Lived Experience of Homelessness Financial Compensation Coordination Program.
3. Letter of support for the University of California, Irvine's submission to the National Institute of Mental Health "UC Irvine ALACRITY Center: Advancing Youth Mental Health Service Delivery with Social Technology-Focused Interventions in a Community Mental Health Partnership."

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

CalOptima Health

Attachment to the June 6, 2024 CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in May and June 2024:

May 2024

May 3, 6–9 p.m., Alcohol and Other Drugs Prevention Conference, hosted by the Orange County Department of Education (OCDE)

Boys and Girls Club of Santa Ana, 950 W. Highland St., Santa Ana

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 4, 11:30 a.m.–2 p.m., Mental Health Awareness Event, hosted by Olive Crest

Santa Ana Zoo, 1801 E. Chestnut Ave., Santa Ana

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 5, 10:30 a.m.–12:30 p.m., Health Fair, hosted by Christ Our Redeemer Church

Christ Our Redeemer Church, 45 Tesla, Irvine

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 7, 10–11 a.m., CalOptima Health Medi-Cal Overview in Spanish

Delhi Community Center, 505 E. Center Ave., Santa Ana

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

May 7, 5:30–7 p.m., CalOptima Health Medi-Cal Overview in Spanish

Shanti Orange County, 23461 S. Pointe Dr., Suite 100, Laguna Hills

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

May 8, 8 a.m.–4 p.m., FaCT Annual Conference, hosted by Families and Communities Together

Hyatt Regency Orange County, 11999 Harbor Blvd., Garden Grove

- Sponsorship fee: $2,500; included a resource table at event, logo on event materials and conference landing page, logo recognition video at the conference, and four event tickets.
- At least seven staff members attended (in person).
- Health/resource fair, open to the public.

May 9, 10 a.m.–1 p.m., Senior Get Together, hosted by OC Public Libraries

OC Library Seal Beach Branch, 707 Electric Ave., Seal Beach

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

May 11, 9 a.m.–Noon., Super Kids Event, hosted by University of California, Irvine (UCI) and Children's Hospital of Orange County (CHOC) Pediatric Residency Program

Boys and Girls Club of Santa Ana, 950 W. Highland St., Santa Ana

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 11, 10 a.m.–1 p.m., 2nd Annual Multilingual Family Education Resource and Literacy Fair, hosted by Saddleback Valley Unified School District (SVUSD)

SVUSD, 25631 Peter A. Hartman Way, Mission Viejo

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 14, 9 a.m.–Noon, Senior Resource Fair, hosted by City of Stanton

Stanton Civic Center Banquet Hall, 7800 Katella Ave., Stanton

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 14, 11:45 a.m.–12:15 p.m., CalOptima Health Medi-Cal Overview in English

Living Independent Fair and Equal, virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

May 14, 9 a.m.–Noon, Senior Resource Fair, hosted by City of Stanton

Stanton Civic Center Banquet Hall, 7800 Katella Ave., Stanton

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 15, 2:30 –3:30 p.m., CalOptima Health Medi-Cal Overview in English

Guadalupe Manor, 17103 Magnolia St., Fountain Valley

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community

May 16, 9 a.m.–2 p.m., Ma(n)y Celebration Event, hosted by the Asian American Senior Citizens Service Center

Heritage Museum of Orange County, 3101 W. Harvard St., Santa Ana

- Sponsorship fee: $500; included a resource table at event, company name and logo on event flyer and website, and social media mention of company name.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 16, 10 a.m.–1 p.m., Senior Get Together, hosted by OC Public Libraries

OC Library San Clemente Branch, 242 Avenida Del Mar, San Clemente

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 17, 4–5 p.m., Family Night, hosted by Martin Elementary School

Martin Elementary School, 939 W. Wilshire Ave., Santa Ana

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

May 18, 9 a.m.–1 p.m., 14th Annual Caregiver Recognition Day, hosted by Alzheimer's Orange County

Northgate Corporate Offices, 1201 N. Magnolia Ave., Anaheim

- Sponsorship fee: $300; included a welcome presentation to attendees, resource table at event, company logo placed around event and on the agenda.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 18, 9 a.m.–1 p.m., Children and Families Health Fair, hosted by OC Supervisor Doug Chaffee and the County of Orange Social Services Agency (SSA)

Orangethorpe Elementary School, 1400 S. Brookhurst Rd., Fullerton

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 18, 9 a.m.–2 p.m., Enrollment and Resource Fair, hosted by Community Health Initiative of Orange County (CHIOC)

CHIOC, 1505 E. 17th St. Suite 108, Santa Ana

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 22, 11:30 a.m.–1 p.m., State of the 5th District, hosted by the South Orange County Economic Coalition and South County Chambers of Commerce in collaboration with OC Supervisor Katrina Foley

The Hills Hotel, 25205 La Paz Rd., Laguna Hills

- Sponsorship fee: $1,000; included a resource table, eight guests seated together, name printed on table and name in State of the 5th program.
- At least four staff members attended (in person).
- Health/resource fair, open to the public.

May 23, 10 a.m.–1 p.m., Senior Get Together, hosted by OC Public Libraries

OC Library Tustin Branch, 345 E. Main St., Tustin

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

May 24, 11 a.m.–Noon, CalOptima Health Medi-Cal Overview in English

211OC, virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

May 29, Noon– 1 p.m., CalOptima Health Medi-Cal Overview in English

Tustin Non-Profit Connect, virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

June 2024

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

June 8, 9 a.m.–1 p.m., Community Resource Fair (Medi-Cal Expansion, Renewal, CalFresh), hosted by CalOptima Health

Lions Park, 570 W. 18th St., Costa Mesa

- At least twenty staff members attended (in person).
- Health/resource fair, open to the public.

June 15, Noon–7 p.m., Juneteenth Festival, hosted by the Orange County Heritage Council

Pearson Park, 400 N. Harbor Blvd., Anaheim

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

June 16, 1–5 p.m., Summerfest, hosted by City of Fountain Valley

Fountain Valley Sports Park, 16400 Brookhurst St., Fountain Valley

- Sponsorship fee: $3,000; includes a resource table, brand placement in event materials, and English and Vietnamese media pitching.
- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

June 19, 6–9 p.m., Juneteenth Celebration, hosted by City of Buena Park

Boisseranc Park, 7520 Dale St., Buena Park

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

June 20, 4–7 p.m., Third Annual Youth and Resource Fair, hosted by Project Youth Orange County

Project Youth OC, 1650 E. 17th St., Santa Ana

- At least one staff member to attend (in person).
- Health/resource fair, open to the public.

June 25, 9–10:30 a.m., Cafecito Meeting, hosted by CalOptima Health

Virtual

- At least eight staff members to attend.
- Steering committee meeting, open to collaborative members.

June 29, TBD, Emotional Wellness Fiesta, hosted by Orange County Hispanic Chamber of Commerce

Santa Ana College, 1530 W. 17th St., Santa Ana

- Sponsorship fee: $2,500; includes a seat on the behavioral health panel, logo featured on event marketing through social media, verbal acknowledgement during event and five VIP seats to the networking event.
- At least one staff member to attend (in person).

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
18. Approve the CalOptima Health Fiscal Year 2024-25 Operating Budget

Contact
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions
1. Approve the CalOptima Health Fiscal Year 2024-25 Budget, as reflected in Attachment A: Fiscal Year 2024-25 Operating Budget for All Lines of Business and Non-Operating Items; and
2. Authorize the expenditures and appropriate the funds for the items listed in Attachment B: Administrative Budget Details and Attachment B1: Digital Transformation Administrative Budget Details, which shall be procured in accordance with CalOptima Health Policy GA.5002: Purchasing.

Background
The CalOptima Health Fiscal Year (FY) 2024-25 Budget provides revenues and appropriations for the period of July 1, 2024, through June 30, 2025, and includes the following budget categories:

- Lines of Business:
  - Medi-Cal
  - OneCare
  - Program for All-Inclusive Care for the Elderly (PACE)
  - Multipurpose Senior Services Program (MSSP)
  - Facilities (505 Building)
- Digital Transformation Strategy
- Non-Operating Items:
  - Net Investment Income
  - 500 Building
  - Street Medicine Support Center

Staff is submitting a comprehensive budget for all lines of business for approval, using assumptions based on the best information available to date. Pursuant to CalOptima Health Policies GA.3202: CalOptima Health Signature Authority, GA.5002: Purchasing, and GA.5003: Budget Approval and Budget Reallocation, the Board of Directors' (Board) approval of the budget authorizes the expenditure for the item and appropriates the funds requested without further Board action to the extent the Board has or is, as indicated in the budget attachments, delegating authority to staff.

CalOptima Health's primary revenue source is the State of California. On May 10, 2024, the Governor released his May Revision to the State Budget (May Revise). The May Revise includes additional budget solutions to address a forecasted deficit of $27.6 billion. The following provides a summary of

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FY 2024-25 state budget proposals that, if enacted, will directly or indirectly impact CalOptima Health's programs:

- Amend the managed care organization tax effective April 1, 2023, through December 31, 2026, to increase funding to support the Medi-Cal program, including targeted rate increases (TRI). The May Revise proposes to include health plan Medicare revenue in the total revenue limit calculation to increase funding to the State; and
- Eliminate planned Medi-Cal TRI and investments scheduled to begin January 1, 2025. Some of these domains include specialty mental health services, specialty care services, community or hospital outpatient procedures and services, family planning and women's health services, emergency services, ground emergency transport services, designated public hospitals, and institutional behavioral health care.

The following items are approved state budget actions that will impact the Medi-Cal program in FY 2024-25:

- Maintain full-scope Medi-Cal eligibility expansion to all income-eligible adults aged 26 through 49, regardless of immigration status (referred to as Unsatisfactory Immigration Status (UIS) members);
- Eliminate the asset test to determine Medi-Cal eligibility beginning January 1, 2024;
- Continue CalAIM implementation; and
- Implement TRI to defined provider types that render primary care or general care services effective January 1, 2024.

Staff will continue to monitor budget actions and return to the Board with further recommendations if additional resources are necessary beyond what was incorporated in this budget.

Discussion

Operating Budget: Staff proposes an Operating Budget with an operating surplus of $240,079 for FY 2024-25 as summarized in the following table and detailed below:

FY 2024-25 Operating Budget

	Medi-Cal	OneCare	PACE	MSSP*	FY 2024-25 Budget
Average Monthly Enrollment	883,231	17,451	481	568	901,163
Revenue	$3,814,724,802	$426,644,977	$48,208,554	$3,042,208	$4,292,620,541
Medical Costs excluding Provider Rate Increases	$3,593,379,309	$400,482,809	$45,583,384	$2,888,898	$4,042,334,401
Administrative Expenses	$207,055,690	$37,913,789	$3,564,726	$1,511,856	$250,046,061
Operating Income/Loss excluding Provider Rate Increases	**$14,289,803**	**($11,751,621)**	**($939,556)**	**($1,358,546)**	**$240,079**
Medical Loss Ratio (MLR)	94.2%	93.9%	94.6%	95.0%	94.2%
Administrative Loss Ratio (ALR)	5.4%	8.9%	7.4%	49.7%	5.8%

* MSSP enrollment included in Medi-Cal total.
Note: Totals may not add evenly due to rounding.

Based on a separate Board action approved at the May 2, 2024, meeting, the FY 2024-25 Operating Budget includes medical costs of approximately $210.5 million for provider rate increases to hospitals, community clinics, behavioral health/applied behavior analysis providers, physicians, health networks, and other ancillary providers. These provider rate increases will be funded by unallocated reserves.

Adjusted Budget Including Provider Rate Increases	Medi-Cal	FY 2024-25 Budget
Revenue	$3,814,724,802	$4,292,620,541
Medical Costs including Provider Rate Increases	$3,803,871,558	$4,252,826,650
Administrative Expenses	$207,055,690	$250,046,061
Operating Income/Loss including Provider Rate Increases	**($196,202,447)**	**($210,252,170)**
MLR including Provider Rate Increases	99.7%	99.1%
ALR	5.4%	5.8%

For more information, please refer to Attachment A: Fiscal Year 2024-25 Operating Budget for All Lines of Business and Non-Operating Items. Including the provider rate increases, the adjusted aggregate MLR is 99.1%. Staff will bring the related contract amendments for eligible provider groups as separate Board actions to the June 6, 2024, meeting.

Operating Budget Analysis

Enrollment: The budget includes the ongoing effects from four (4) significant changes in enrollment: (1) an increase in Medi-Cal enrollment effective January 1, 2024, from coverage expansion for adults aged 26 through 49, regardless of immigration status; (2) a decrease in Medi-Cal enrollment that began July 2023 related to the resumption of normal Medi-Cal eligibility redetermination activities (staff anticipates seeing the full effects of these activities by August 2024); (3) a decrease in Medi-Cal enrollment from the implementation of a statewide Medi-Cal direct contract with Kaiser Permanente that began January 1, 2024; and (4) the elimination of the asset test effective January 1, 2024, to determine Medi-Cal eligibility.

Revenue: The budget projects revenue for each line of business based on the most recent capitation rates available from the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS). Staff made additional adjustments based on member acuity and federal and state program and policy changes and included trend assumptions based on CalOptima Health's Rate Development Template submission to DHCS. The FY 2024-25 Operating Budget revenue on a per member per month (PMPM) basis is approximately 6.7% higher than the prior year's budget. This increase is primarily driven by funding for the TRI, higher average acuity of UIS members, and increasing trends observed within categories of service.

Medical Costs: The budget proposes a 94.2% MLR excluding the provider rate increase (99.1% MLR including the provider rate increase). The budget accounted for forecasted claims payments, provider capitation payments, managed long-term services and supports, prescription drugs, medical management, and CalAIM and other medical costs. The budget includes the following:

- TRI for provider types that render primary care or general care to align with DHCS guidance, effective January 2024. The TRI will be applied to specified procedure codes as defined by DHCS to all contracted provider types who bill on a CMS 1500 claim form;

- Incorporation of risk arrangement changes for certain health networks;
- Continuation of CalAIM Community Support services; and
- Provider rate increases committed by the Board on May 2, 2024.

Several methods were utilized to develop the medical cost forecasts. Predominantly, projections were based on trends calculated from historical experience. Historical experience included several years' worth of data to incorporate trends from before, during, and after the COVID-19 Public Health Emergency. Staff assigned various credibility to the different time periods depending on how representative they were of expected future utilization. In addition, adjustments were applied to account for known changes to operations, program structure, benefits, and regulatory policies. For newly implemented programs, staff used historical data, proxy data, and industry benchmarks, where available, and checked the results for reasonability.

Administrative Expenses: The budget proposes a 5.8% ALR, which is higher than the prior year adjusted Board-approved ALR of 5.4%. The primary drivers for the higher administrative expenses in the budget are:

- Personnel costs, including an annual merit increase of 4%, anticipation of higher costs due to a decrease in the vacancy factor from 7.5% in FY 2023-24 to 5% for FY 2024-25, recent Board-approved actions to update the salary schedule, employee benefit premium increases, and continuation of certain employee supplemental benefits. The budget does not add any new positions.
- Non-salary expenses, including expenses to comply with mandated program requirements and technology updates to support business changes.

Staff prepared the general and administrative budget using a "zero-based" budgeting methodology, which required departments to justify each expense before adding it to the budget. Attachment B: Administrative Budget Details provides additional information regarding all administrative expenses included in the FY 2024-25 Operating Budget.

Digital Transformation Strategy
On March 17, 2022, the Board authorized a three-year Digital Transformation and Workplace Modernization Strategy and created a $100 million restricted reserve to fund digital transformation efforts. The budget includes $27.6 million in operating costs for the third year of implementation, including $7.1 million in salaries, wages & employee benefits and $20.5 million in other administrative expenses. The capital projects have been included in the proposed FY 2024-25 Digital Transformation Capital Budget. Attachment B1: Digital Transformation Administrative Budget Details provides additional information regarding operating expenses to implement initiatives in year three.

Non-Operating
Net Investment Income: The budget projects $80.0 million in net investment income, which is based on projected market conditions and returns on investments in FY 2024-25.

500 Building: Based on the projected revenue and estimated depreciation costs, the budget projects an estimated net deficit of approximately $645,348.

Street Medicine Support Center: The budget includes $762,000 to support preparation activities for preconstruction services and other building related costs.

Status of Total Assets and Board-Designated Reserve Levels
As of March 31, 2024, CalOptima Health's total net assets are $1.9 billion. Of this amount, $632.5 million is in Board-designated reserves, $95.8 million in capital assets, $545.4 million in unspent resources committed by the Board, and $588.3 million is unallocated resources.

Through previous actions, the Board has committed $889.1 million to community outreach and investments, quality incentive programs, and infrastructure and capacity building. Many of these initiatives are multi-year commitments. As of March 31, 2024, $343.7 million has been spent, with $545.4 million left in unspent resources committed by the Board. At the May 2, 2024, meeting, the Board approved a total commitment of up to $526.2 million from unallocated reserves to support contracted provider rate increases for a 30-month period. Staff will monitor and report these initiatives separately through the monthly financial package and the quarterly net asset analysis.

Fiscal Impact

Consolidated: As outlined above and described in Attachment A: Fiscal Year 2024-25 Operating Budget for All Lines of Business and Non-Operating Items, the FY 2024-25 Operating Income (Excluding Provider Rate Increases) shows a projected surplus of $240,079.

Provider Rate Increases: A previous Board action on May 2, 2024, committed $210.5 million from unallocated reserves to support contracted provider rate increases in FY 2024-25.

Digital Transformation: A previous Board action on March 17, 2022, established a restricted Digital Transformation and Workplace Modernization Reserve in the amount of $100 million. An appropriation of $27,552,334 from the restricted reserve will fund the operating expenses for Year Three of the Digital Transformation Strategy in FY 2024-25.

Non-Operating Items: The fiscal impact for non-operating items results in a net income of $78,592,652.

Rationale for Recommendation

Staff submits the FY 2024-25 Operating Budget for all lines of business areas and non-operating items using the best information available to provide covered services to CalOptima Health's forecasted enrollment.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Finance and Audit Committee

Attachments

1. Fiscal Year 2024-25 Operating Budget Presentation
2. Attachment A: Fiscal Year 2024-25 Operating Budget for All Lines of Business and Non-Operating Items
3. Attachment B: Administrative Budget Details
4. Attachment B1: Digital Transformation Administrative Budget Details

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

Fiscal Year 2024-25 Operating Budget

Board of Directors Meeting

June 6, 2024

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

Agenda

- Executive Summary
- FY 2024-25 Budget Overview
  - Operating Budget
    - Enrollment
    - Revenue
    - Medical Costs
    - Administrative Expenses
  - Digital Transformation Strategy
  - Non-Operating Items
- Recommended Actions
- Appendix
  - FY 2024-25 Operating Budget by Lines of Business
  - Net Asset and Reserve Policy Update

Executive Summary

Budget Objectives

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CalOptima Health

FY 2024-25 Operating Budget:
REVENUE

$4,292,620,541

FY 2024-25 Operating Budget:
EXPENSES

$4,292,380,462

Note: Excludes $210.5 million for contracted provider rate increases

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CalOptima Health

FY 2024-25 Operating Budget:
OPERATING MARGIN

$240,079

Note: Excludes $210.5 million for contracted provider rate increases

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CalOptima Health

FY 2024-25 Operating Budget:
Provider Rate Increases (Funded by reserves)

$210,492,249

Note: Board approved commitment at the May 2, 2024, meeting

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CalOptima Health

Operating Budget Highlights

FY 2024-25 Operating Budget	
Average Enrollment	901,163
Revenue	$4,292,620,541
Medical Costs	$4,042,334,401
Medical Loss Ratio (MLR)	*94.2%*
Administrative Expenses	$250,046,061
Admin Loss Ratio (ALR)	*5.8%*
Operating Income/Loss	**$240,079 or 0.01%**
Provider Rate Increases (Funded by reserves)	$210,492,249
Operating Income/Loss including Provider Rate Increases	($210,252,170)

CalOptima Health spends 94 cents of every dollar received on member care

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CalOptima Health

FY 2024-25 Operating Budget Overview

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CalOptima Health

FY 2023-24 Budget vs. FY 2024-25 Budget

	FY 2023-24 Budget *	FY 2024-25 Budget	FY 2024-25 vs. FY 2023-24 Budget
Average Monthly Enrollment	899,462	901,163	1,701
Revenue	$4,014,893,012	$4,292,620,541	$277,727,529
Medical Costs (excluding Provider Rate Increases)	$3,783,144,348	$4,042,334,401	$259,190,053
Administrative Expenses	$216,173,509	$250,046,061	$33,872,552
Operating Income/Loss (excluding Provider Rate Increases)	**$15,575,155**	**$240,079**	**($15,335,076)**
MLR	*94.2%*	*94.2%*	*0.0%*
ALR	*5.4%*	*5.8%*	*0.4%*
Operating Income/Loss including Provider Rate Increases	*$15,575,155*	*($210,252,170)*	*($225,827,325)*

* Includes Board actions and budget adjustments as of March 2024

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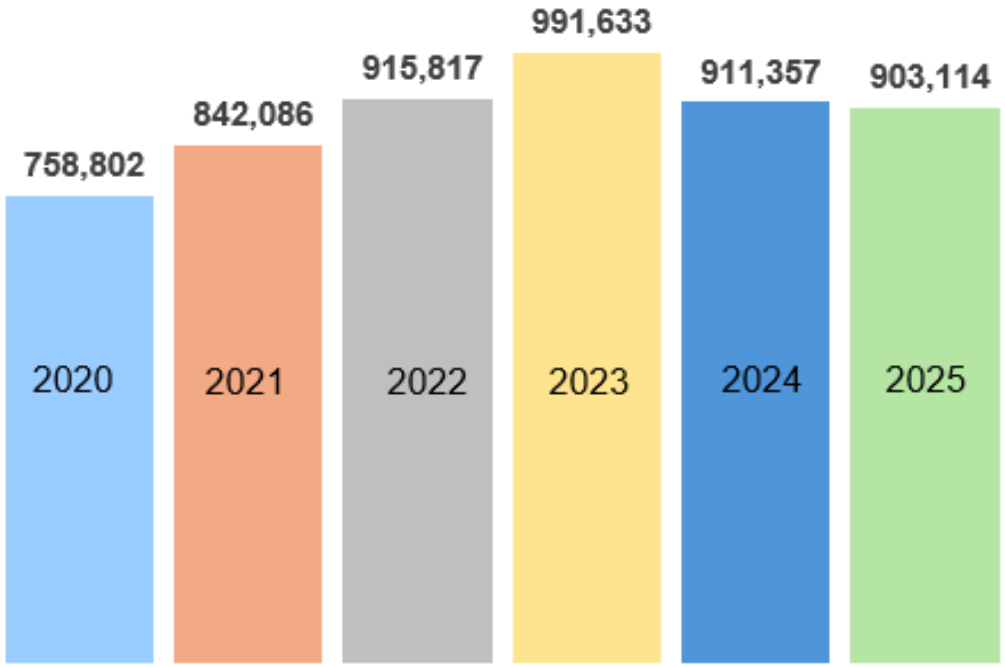
CalOptima Health

Enrollment

Consolidated June Enrollment: Actuals to Forecast



- Forecasted enrollment decrease of about 8,200 or (0.9%) from June 2024 to June 2025

Enrollment Projections: Average Member Months

LOB	FY 2021-22	FY 2022-23	FY 2023-24*	FY 2024-25 Budget	Change FY 2023-24 to FY 2024-25
Medi-Cal	859,242	940,326	930,015	**883,231**	(46,784)
OneCare Connect	14,671	7,159	0	**0**	0
OneCare	2,337	10,190	17,528	**17,451**	(77)
PACE	417	435	449	**481**	32
Total:	**876,667**	**958,109**	**947,992**	**901,163**	**(46,829)**

- Ongoing drivers include:
  - Effects of Medi-Cal eligibility redetermination activities
  - Coverage expansion for income-eligible adults aged 26-49, regardless of immigration status
  - Kaiser membership carved-out to statewide Medi-Cal direct contract
  - Beginning January 2024, elimination of asset test to determine Medi-Cal eligibility

* Forecast based on actuals through February 2024

Note: Rounding may impact calculations

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CalOptima Health

Revenue

Revenue: Key Assumptions

LOB	July – Dec 2024	Jan – June 2025
Medi-Cal	Calendar Year (CY) 2024 Draft Rates	Draft CY 2025 rates expected October 2024 • 1.2% increase to Medi-Cal Classic • 0.0% for Expansion and Whole Child Model • Forecasted trends informed by Rate Development Template submission
OneCare	Jan 2024: Part C base rates increased 4.35%	• Jan 2025: Projected Part C base rates to increase another 1.98% • RAF score relatively flat at 1.35
PACE	• Medi-Cal revenue: -2.9% (credibility and blend modified CY 2024) • CMS revenue +7.2% (Base rate and RAF score)	

Medical and Administrative Costs:
Budget to Budget Comparison

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CalOptima Health

Medical Costs:
FY 2023-24 Budget vs. FY 2024-25 Budget

	FY 2023-24 Budget *	FY 2024-25 Budget (excluding Provider Rate Increases)	FY 2024-25 vs. FY 2023-24 Budget	FY 2024-25 Budget (including Provider Rate Increases)
Revenue	**$4,014,893,012**	**$4,292,620,541**	**$277,727,529**	**$4,292,620,541**
Provider Capitation	$1,381,174,895	$1,416,937,629	$35,762,734	$1,531,451,705
Claims Payments	$1,357,035,143	$1,493,685,605	$136,650,462	$1,583,797,111
Managed Long-Term Services and Supports (MLTSS)	$610,195,749	$582,217,847	($27,977,902)	$588,084,514
Prescription Drugs	$124,146,899	$113,972,885	($10,174,014)	$113,972,885
CalAIM & Other Medical	$189,081,617	$292,197,263	$103,115,646	$292,197,263
Medical Management	$121,510,045	$143,323,172	$21,813,127	$143,323,172
Total Medical Costs	**$3,783,144,348**	**$4,042,334,401**	**$259,190,053**	**$4,252,826,650**
MLR	**94.2%**	**94.2%**	**(0.1%)**	**99.1%**

* Includes Board actions and budget adjustments as of March 2024

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CalOptima Health

Medical Costs: Assumptions

- Calculates trends based on historical experience
  - Incorporates trends before, during and after the COVID-19 Public Health Emergency
- Applies targeted rate increases (TRI) for contracted providers who render primary care or general care as defined in DHCS guidance
- Incorporates risk arrangement changes for certain health networks
- Makes adjustments for any known changes to operations, program structure, benefits and regulatory policies
- Continues CalAIM Community Support services
- Includes provider rate increases committed by the Board on May 2, 2024

Medical Costs: Provider Rate Increases by Category

Category	Estimated Annual Amount (in millions)		
	Health Networks	Fee-for-Service	Total
Hospital	$49.3	$50.9	$100.2
Professional	$9.0	$3.6	$12.6
Behavioral Health	$0.0	$25.2	$25.2
Ancillary	$4.3	$15.5	$19.8
Other Contract Changes	$51.9	$0.8	$52.7
Total	**$114.5**	**$96.0**	**$210.5**

Note: Board approved commitment at the May 2, 2024, meeting

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CalOptima Health

Administrative Expenses: FY 2023-24 Budget vs. FY 2024-25 Budget

	FY 2023-24 Budget *	FY 2024-25 Budget	FY 2024-25 Budget vs. FY 2023-24 Budget
Revenue	$4,014,893,012	$4,292,620,541	$277,727,529
Salaries, Wages & Benefits	**$143,514,313**	**$154,862,084**	**$11,347,771**
Non-Salary Expenses: Operating	**$65,882,243**	**$84,495,372**	**$18,613,129**
Professional Fees	$10,457,180	$11,356,790	$899,610
Purchased Services	$17,630,310	$23,944,982	$6,314,672
Printing & Postage	$6,863,500	$9,195,365	$2,331,865
Other Operating Expenses	$30,931,253	$39,998,235	$9,066,982
Non-Salary Expenses: Other	**$6,776,953**	**$10,688,605**	**$3,911,652**
Depreciation & Amortization	$7,342,800	$11,154,505	$3,811,705
Indirect Cost Allocation, Occupancy	($565,847)	(465,900)	$99,947
Total Administrative Expenses	**$216,173,509**	**$250,046,061**	**$33,872,552**
ALR	**5.4%**	**5.8%**	**0.4%**

* Includes Board actions and budget adjustments as of March 2024

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CalOptima Health

Administrative Expenses:
Forecast to Budget Comparison

Administrative Expenses: FY 2023-24 Forecast vs. FY 2024-25 Budget

	FY 2023-24 Forecast *	FY 2024-25 Budget	FY 2024-25 Budget vs. FY 2023-24 Forecast
Revenue	$4,424,931,273	$4,292,620,541	($132,310,732)
Salaries, Wages & Benefits	**$137,924,688**	**$154,862,084**	**$16,937,396**
Non-Salary Expenses: Operating	**$49,268,774**	**$84,495,372**	**$35,226,598**
Professional Fees	$7,439,529	$11,356,790	$3,917,261
Purchased Services	$14,107,961	$23,944,982	$9,837,021
Printing & Postage	$6,321,955	$9,195,365	$2,873,410
Other Operating Expenses	$21,399,329	$39,998,235	$18,598,906
Non-Salary Expenses: Other	**$8,799,949**	**$10,688,605**	**$1,888,656**
Depreciation & Amortization	$9,546,919	$11,154,505	$1,607,586
Indirect Cost Allocation, Occupancy	($746,970)	(465,900)	$281,070
Total Administrative Expenses	**$195,993,411**	**$250,046,061**	**$54,052,650**
ALR	**4.4%**	**5.8%**	**1.4%**

* Forecasted based on annualized actuals as of March 2024; Revenue excludes directed payments; Administrative Expenses exclude Board commitments and Digital Transformation Strategy

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Administrative Budget: Bridge for FY 2023-24 Forecast vs. FY 2024-25 Budget

G&A Expense	Bridge	Key Drivers
Salaries, Wages & Benefits	**$17.0M**	• FY 2024-25 does not add any new positions • Open positions: $7.1M • Annual merit increase: $4.9M • Employee benefits adjustments: $3.6M • Decrease in vacancy factor from 7.5% to 5.0%: $2.0M
Non-Salary Expenses: Operating		
Professional Fees	**$3.9M**	• Internal audit • Consulting for new initiatives and software applications • Strategic plan development and implementation
Purchased Services	**$9.8M**	• Broker agency commission for member enrollment • Member interpretation and translation • Claims prepayment editing and coordination of benefits • OneCare marketing efforts
Printing & Postage	**$2.9M**	• Mailing and processing of member packages and notices • Marketing and outreach materials for members and providers
Other Operating Expenses	**$18.6M**	• Computer equipment replacement, software licenses and maintenance agreements • Member and provider outreach and community events • Building maintenance and supplies
Non-Salary Expenses: Other		
Depreciation & Amort	**$1.9M**	• Capital items placed in service
Total G&A	**$54.1M**	

Digital Transformation Strategy

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DTS Year Three Operating Budget

	FY 2024-25 Budget
Salaries, Wages & Benefits	$7,078,172
Professional Fees	$6,313,000
Purchased Services	$1,704,000
Other Operating Expenses	$8,936,162
Depreciation & Amortization	$3,521,000
Total:	**$27,552,334**

- March 17, 2022: Board authorized a three-year strategy and created a $100 million restricted reserve to fund digital transformation efforts
- Please refer to DTS funding summary provided in the FY 2024-25 Capital Budget materials

Non-Operating Items

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Non-Operating Budget

	FY 2024-25
500 Building	
Annual Revenue	$1,630,391
Estimated Operating Expenses	$2,275,739
Net Change:	**($645,348)**
Street Medicine Support Center	
Estimated Operating Expenses	$762,000
Net Change:	**($762,000)**
Investment Income	
Total Investment Income	**$80,000,000**
Total Non-Operating	**$78,592,652**

- Building expenses are treated as non-operating for FY 2024-25

Attachment A: Consolidated Income Statement

Attachment A: Fiscal Year 2024-25 Operating Budget for All Lines of Business and Non-Operating Items
Medical Costs Include All Planned Provider Rate Increases

	Medi-Cal	OneCare	PACE	MSSP	Facilities	Consolidated
Member Months	10,598,767	209,408	5,775	6,816	-	10,813,951
Avg Members	883,231	17,451	481	568	-	901,163
Revenue						
Capitation Revenue	$ 3,814,724,802	$ 426,644,977	$ 48,208,554	$ 3,042,208	$ -	$ 4,292,620,541
Total	$ 3,814,724,802	$ 426,644,977	$ 48,208,554	$ 3,042,208	$ -	$ 4,292,620,541
Medical Costs						
Provider Capitation	$ 1,340,163,256	$ 191,288,449	$ -	$ -	$ -	$ 1,531,451,705
Claims Payments	$ 1,485,212,306	$ 79,605,441	$ 18,979,365	$ -	$ -	$ 1,583,797,111
Managed Long-Term Services and Supports (MLTSS)	$ 587,275,070	$ -	$ 413,957	$ 395,487	$ -	$ 588,084,514
Prescription Drugs	$ -	$ 107,296,577	$ 6,676,308	$ -	$ -	$ 113,972,885
CalAIM & Other Medical	$ 283,211,649	$ 5,860,253	$ 3,125,361	$ -	$ -	$ 292,197,263
Medical Management	$ 108,009,278	$ 16,432,090	$ 16,388,393	$ 2,493,411	$ -	$ 143,323,172
Total	$ 3,803,871,558	$ 400,482,809	$ 45,583,384	$ 2,888,898	$ -	$ 4,252,826,650
MLR	*99.7%*	*93.9%*	*94.6%*	*95.0%*		*99.1%*
Gross Margin	$ 10,853,244	$ 26,162,168	$ 2,625,170	$ 153,310	$ -	$ 39,793,891
Administrative Expenses						
Salaries, Wages, & Employee Benefits	$ 136,959,417	$ 14,521,947	$ 2,072,865	$ 1,307,856	$ -	$ 154,862,084
Non-Salary Operating Expenses	$ 68,578,139	$ 11,078,842	$ 1,271,562	$ 116,000	$ 3,450,830	$ 84,495,372
Depreciation & Amortization	$ 8,795,305	$ -	$ 19,200	$ -	$ 2,340,000	$ 11,154,505
Indirect Cost Allocation, Occupancy Expense	$ (7,277,170)	$ 12,313,000	$ 201,100	$ 88,000	$ (5,790,830)	$ (465,900)
Total	$ 207,055,690	$ 37,913,789	$ 3,564,726	$ 1,511,856	$ (0)	$ 250,046,061
ALR	*5.4%*	*8.9%*	*7.4%*	*49.7%*		*5.8%*
Operating Income/(Loss) Excluding Provider Rate Increases	$ (196,202,447)	$ (11,751,621)	$ (939,556)	$ (1,358,546)	$ 0	$ (210,252,170)
Provider Rate Increases (Funded by Reserves)						$ 210,492,249
Adjusted Operating Income/(Loss) Excluding Provider Rate Increases						$ 240,079
Digital Transformation Strategy						$ (27,552,334)
Non-Operating						
Net Investment Income						$ 80,000,000
500 Building						$ (645,348)
Street Medicine Support Center						$ (762,000)
Total Non-Operating Income/(Loss)						$ 78,592,652

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Recommended Actions

- Approve the CalOptima Health Fiscal Year 2024-25 Budget, as reflected in Attachment A: Fiscal Year 2024-25 Operating Budget for All Lines of Business and Non-Operating Items

- Authorize the expenditures and appropriate the funds for items listed in Attachment B: Administrative Budget Details and Attachment B1: Digital Transformation Administrative Budget Details
  - Items shall be procured in accordance with CalOptima Health Policy GA.5002: Purchasing Policy

Appendix: FY 2024-25 Operating Budget by Line of Business

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Medi-Cal

Medi-Cal Budget

	FY 2022-23 Actual	FY 2023-24 Forecast*	FY 2024-25 Budget (excluding Provider Rate Increases)	FY 2024-25 Budget (including Provider Rate Increases)
Average Monthly Enrollment	940,893	941,750	883,231	883,231
Revenue	$3,809,288,714	$3,986,841,381	$3,814,724,802	$3,814,724,802
Medical Costs	$3,456,269,901	$3,684,973,591	$3,593,379,309	$3,803,871,558
Administrative Expenses	$164,727,666	$163,689,393	$207,055,690	$207,055,690
Operating Income/Loss	**$188,291,147**	**$138,178,397**	**$14,289,803**	**($196,202,447)**
MLR	90.7%	92.4%	94.2%	99.7%
ALR	4.3%	4.1%	5.4%	5.4%

* Forecasted as of March 2024

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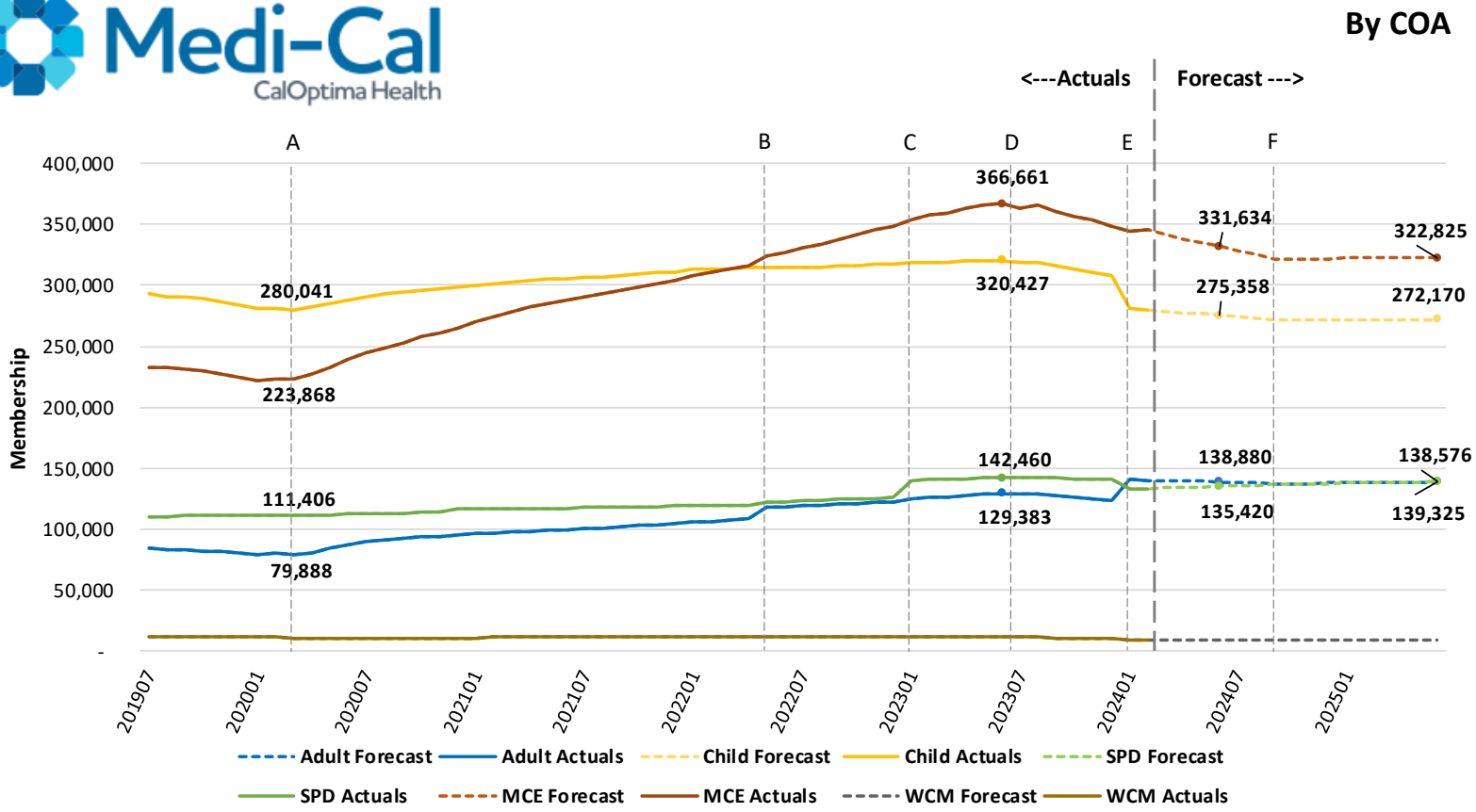
Medi-Cal Enrollment: Trend and Forecast

Medi-Cal
CalOptima Health



A. March 2020 - Beginning of PHE
B. May 2022 - Undoc. Adults Age 50+ (17K)
C. January 2023 - OCC enrollment moves to OC and MC (Duals)
D. July 2023 - Redetermination Begins
E. January 2024 - Undoc. Adults Age 26-49 (+45K) and Kaiser Transition (-55K)
Asset Test Elimination For Medi-Cal Programs
F. August 2024 - Forecasted Redetermination Catch-up Complete

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Medi-Cal Revenue

- Estimated trends are based on the DHCS Rate Development Template (RDT) submission process

	Medi-Cal Classic	Medi-Cal Expansion	Medi-Cal Whole Child Model (WCM)
Base Rates	July – December 2024: Calendar Year (CY) 2024 rates		
	January – June 2025: Draft CY 2025 rates expected October 2024		
	• Assumes 1.2% PMPM increase	• Assumes 0% PMPM increase	• Assumes 0% PMPM increase

Medi-Cal Fee-for-Service Adjustments

- Staff continuously assesses member access and provider network viability/adequacy
- Included in the provider rate increases committed by the Board on May 2, 2024

	From	To
FFS Hospitals Inpatient	112% APR-DRG for Classic and 117.3% APR-DRG for Expansion	125% APR-DRG
FFS Hospitals Outpatient	140% of the Medi-Cal fee schedule	240% of the Medi-Cal fee schedule for selected services (e.g., emergency, trauma, surgeries)
Specialist Physicians	133% of the Medi-Cal fee schedule for Classic and 140% of the Medi-Cal fee schedule for WCM	156% of the Medi-Cal fee schedule (to align payment with Expansion members)
Skilled Nursing Facilities	Fixed per diem structure for authorized short-stays	LTC plus add-on payments for (1) therapy level-of-care and (2) hard-to-place members
Other Ancillary	Updates rates to expand access to providers, such as home health, CBAS, laboratory, ambulatory surgery centers	

Medi-Cal Capitation Adjustments

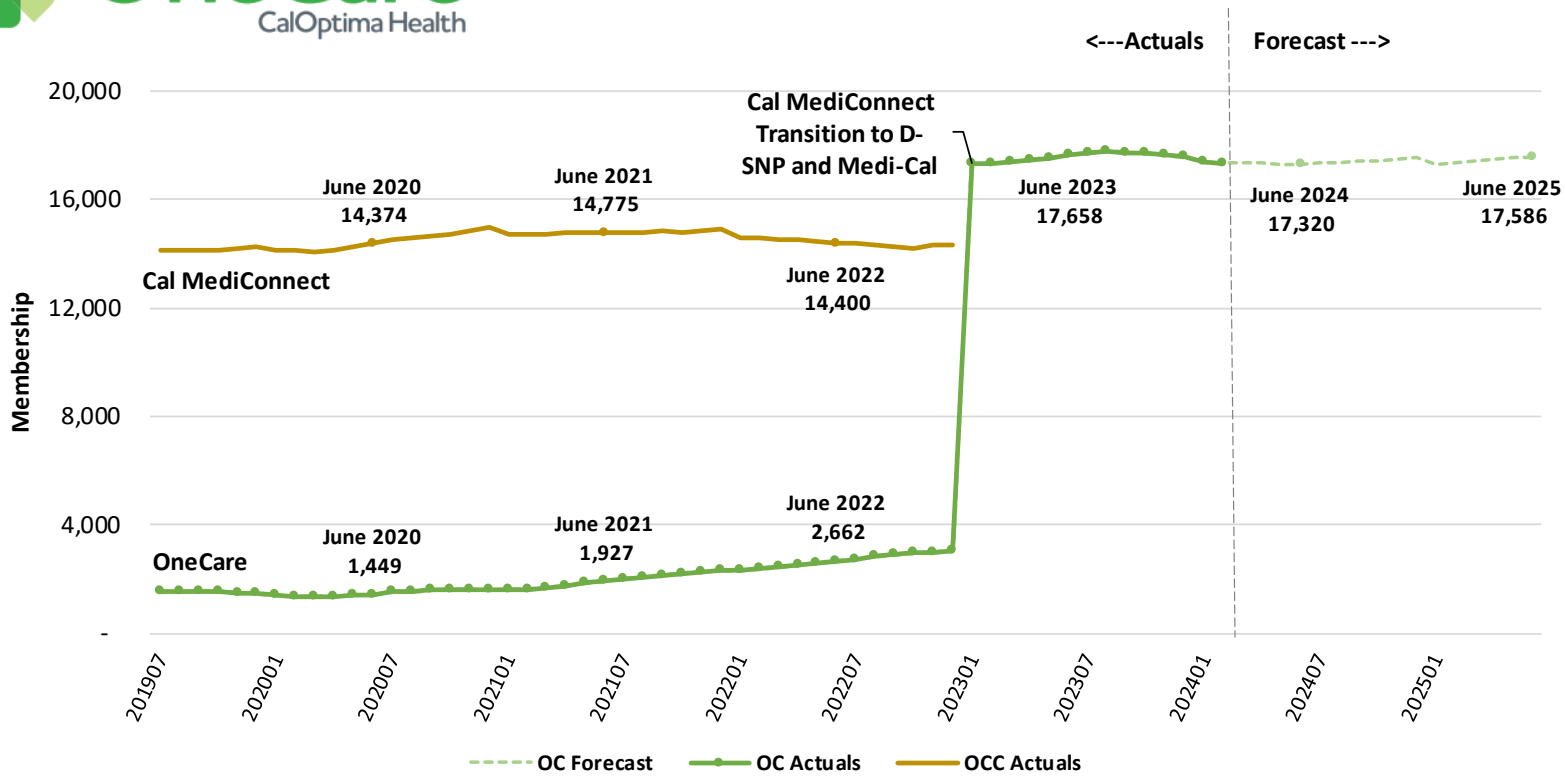
- Staff applied an actuarially reviewed process to:
  - Adjust capitation rates to account for the DHCS TRI
  - Incorporate fee-for-service contractual and programmatic changes
  - Some of these changes include:
    - Immigration Status Expansion
    - Community Health Workers
    - Hospice
    - Dyadic Screening
    - Doula
    - Genome Sequencing
    - Annual Wellness Visit Funding
    - Additional Admin, Medical Management, and Risk
    - Adjustments for Encounter Quality, Completion, and Prospective Trends

OneCare

OneCare Budget

	FY 2023-24 Forecast	FY 2024-25 Budget
Average Monthly Enrollment	17,589	17,451
Revenue	$391,361,181	$426,644,977
Medical Costs	$356,122,529	$400,482,809
Administrative Expenses	$28,267,013	$37,913,789
Operating Income/Loss	**$6,971,639**	**($11,751,621)**
MLR	91.0%	93.9%
ALR	7.2%	8.9%

OneCare Enrollment: Trend and Forecast



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OneCare Budget Assumptions

- Enrollment projected to decrease slightly by 0.4% compared to the FY 2023-24 forecast
- OneCare revenue rate assumptions*
  - CalOptima Health will continue to receive and absorb a 2% sequestration reduction

Medicare Part C	Medicare Part D
• CMS CY 2024 Monthly Membership Report (MMR) actuals • Forecasted 1.98% based on CMS growth percentage estimates for CY 2025	• CMS CY 2024 MMR actuals • Forecasted 7.8% increase from combination of base rate, RAF score and other adjustments

- Medical Costs
  - Uses current capitation percent of premium (POP) rates
  - Shift in risk arrangements for certain health networks
  - Includes expenses for approved supplemental benefits

* Used most current rates available

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OneCare Program Improvement Opportunities

- Plan Design
  - Offer a competitive benefit design that appeals to the needs of dual eligible beneficiaries in Orange County
- Marketing and Enrollment
  - Expand marketing and education to highlight the benefits of OneCare as a Medicare and Medi-Cal Exclusively Aligned Enrollment (EAE) Dual Special Needs Plan (D-SNP)
  - Promote enrollment growth through education of brokers regarding new enrollment rules applicable to EAE D-SNP plans
- Internal Operations
  - Review current operational practices to improve efficiency, accuracy and quality (Star Ratings)
  - Improve data submission processes to accurately reflect diagnoses for Risk Adjustment Factors

PACE

PACE Budget

	FY 2022-23 Actual	FY 2023-24 Forecast *	FY 2024-25 Budget
Average Monthly Enrollment	434	446	481
Revenue	$44,007,489	$45,987,795	$48,208,554
Medical Costs	$39,133,938	$38,746,953	$45,583,384
Administrative Expenses	$2,729,295	$2,750,763	$3,564,726
Operating Income/Loss	**$2,144,256**	**$4,490,079**	**($939,556)**
MLR	89.0%	84.3%	94.6%
ALR	6.2%	6.0%	7.4%

* Forecasted as of March 2024

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PACE Enrollment: Trend and Forecast

PACE
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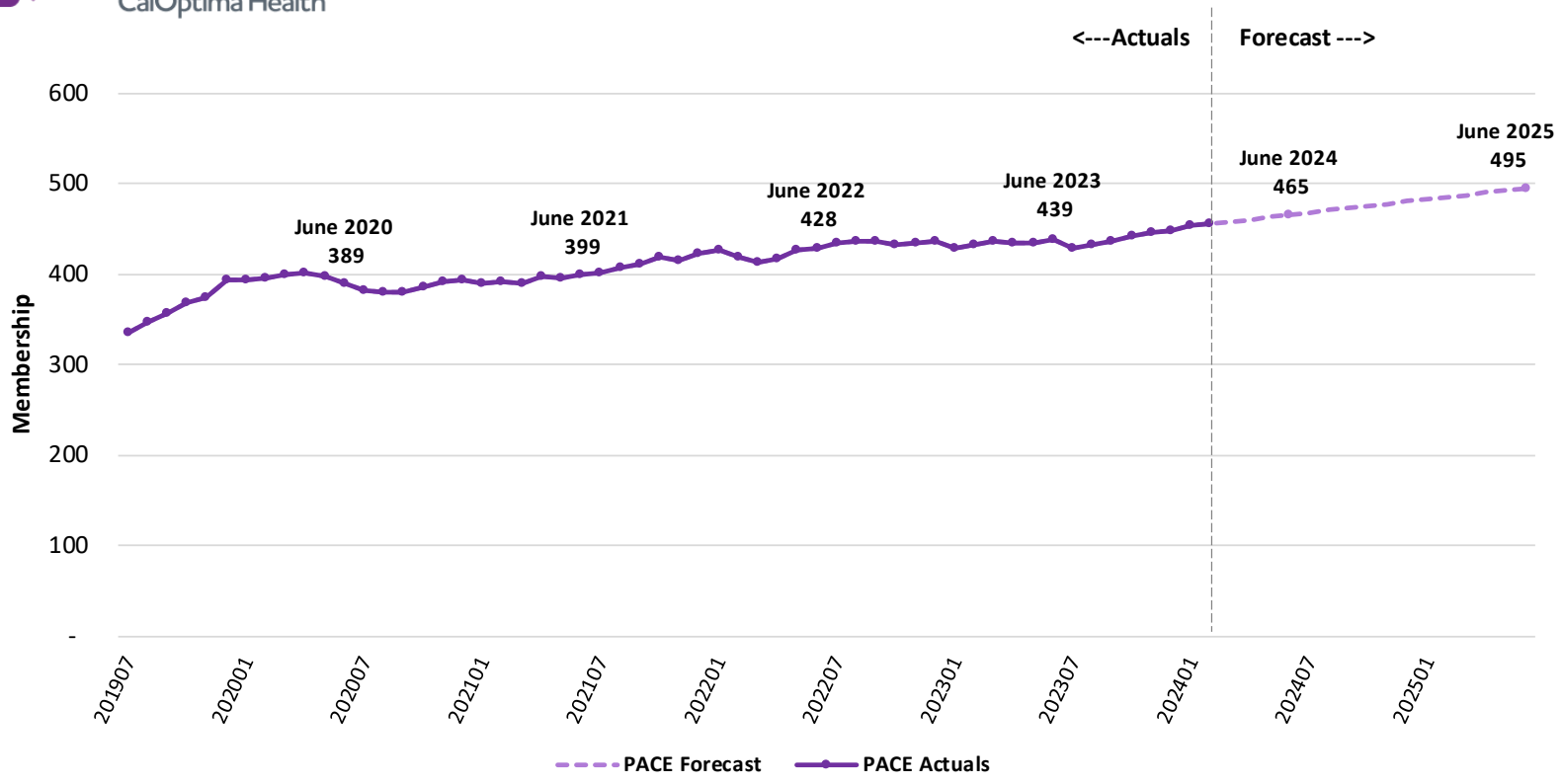

PACE Budget Assumptions

- PACE revenue rate assumptions

Medicare Part C	Medicare Part D	Medi-Cal
• CMS CY 2024 MMR actuals • Forecasted 1.98% PMPM increase based on CMS growth percentage estimates for CY 2025	• CMS CY 2024 MMR Report actuals • Forecasting flat Part D revenue PMPM for CY 2025	PMPM rates based on CY 2024 rates and reflect no trend into CY 2025 • Utilized RDT reported cost • Reduced revenue due to change in blending methodology by DHCS

- Operating costs
  - Forecasted increase due to membership and provider rate increases; medical management and admin are the main drivers of medical and operational costs
  - Assumes transition back to pre-pandemic operations at the PACE Center will increase operational and medical costs (e.g., transportation, meals)
  - Assumes growth in members who receive services at alternative care settings (ACS)

Note: Used most current rates available

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PACE Improvement Opportunities

- Improve operational efficiencies and encounter data collection and quality
- Increase enrollment through provider partnerships

Net Asset and Reserve Policy Update

Reserve Summary (as of March 2024)

	Amount (in millions)
Board Designated Reserves	$632.5
Capital Assets (Net of Depreciation)	$95.8
Resources Committed by the Board	$545.4
Resources Unallocated/Unassigned	$588.3
Total Net Assets	$1,861.9

- May 2, 2024: Board committed up to $526.2 million from unallocated reserves to support contracted provider rate increases for a 30-month period (7/1/24 – 12/31/26)

Revised Reserve Policy (GA.3001)

- Updated Policy GA.3001: Statutory and Board-Designated Reserve Funds, effective June 1, 2024

Old Policy	**New Policy**
Tangible Net Equity (TNE) Requirement included in Board-designated Reserve calculation	Create separate reserve fund for TNE Requirement
Board-designated Reserves at 1.4 to 2.0 months capitation	Board-designated Reserves at 2.5 to 3.0 months capitation

Note: Board approved the policy revisions at the May 2, 2024, meeting

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Attachment A: Fiscal Year 2024-25 Operating Budget for All Lines of Business and Non-Operating Items
Medical Costs Include All Planned Provider Rate Increases

	Medi-Cal	OneCare	PACE	MSSP	Facilities	Consolidated
Member Months	10,598,767	209,408	5,775	6,816	-	**10,813,951**
Avg Members	883,231	17,451	481	568	-	**901,163**
Revenue						
Capitation Revenue	$ 3,814,724,802	$ 426,644,977	$ 48,208,554	$ 3,042,208	$ -	**$ 4,292,620,541**
Total	$ 3,814,724,802	$ 426,644,977	$ 48,208,554	$ 3,042,208	$ -	**$ 4,292,620,541**
Medical Costs						
Provider Capitation	$ 1,340,163,256	$ 191,288,449	$ -	$ -	$ -	**$ 1,531,451,705**
Claims Payments	$ 1,485,212,306	$ 79,605,441	$ 18,979,365	$ -	$ -	**$ 1,583,797,111**
Managed Long-Term Services and Supports (MLTSS)	$ 587,275,070	$ -	$ 413,957	$ 395,487	$ -	**$ 588,084,514**
Prescription Drugs	$ -	$ 107,296,577	$ 6,676,308	$ -	$ -	**$ 113,972,885**
CalAIM & Other Medical	$ 283,211,649	$ 5,860,253	$ 3,125,361	$ -	$ -	**$ 292,197,263**
Medical Management	$ 108,009,278	$ 16,432,090	$ 16,388,393	$ 2,493,411	$ -	**$ 143,323,172**
Total	$ 3,803,871,558	$ 400,482,809	$ 45,583,384	$ 2,888,898	$ -	**$ 4,252,826,650**
MLR	***99.7%***	***93.9%***	***94.6%***	***95.0%***		***99.1%***
Gross Margin	$ 10,853,244	$ 26,162,168	$ 2,625,170	$ 153,310	$ -	**$ 39,793,891**
Administrative Expenses						
Salaries, Wages, & Employee Benefits	$ 136,959,417	$ 14,521,947	$ 2,072,865	$ 1,307,856	$ -	**$ 154,862,084**
Non-Salary Operating Expenses	$ 68,578,139	$ 11,078,842	$ 1,271,562	$ 116,000	$ 3,450,830	**$ 84,495,372**
Depreciation & Amortization	$ 8,795,305	$ -	$ 19,200	$ -	$ 2,340,000	**$ 11,154,505**
Indirect Cost Allocation, Occupancy Expense	$ (7,277,170)	$ 12,313,000	$ 201,100	$ 88,000	$ (5,790,830)	**$ (465,900)**
Total	$ 207,055,690	$ 37,913,789	$ 3,564,726	$ 1,511,856	$ (0)	**$ 250,046,061**
ALR	***5.4%***	***8.9%***	***7.4%***	***49.7%***		***5.8%***
Operating Income/(Loss) Ixcluding Provider Rate Increases	**$ (196,202,447)**	**$ (11,751,621)**	**$ (939,556)**	**$ (1,358,546)**	**$ 0**	**$ (210,252,170)**
Provider Rate Increases (Funded by Reserves)						**$ 210,492,249**
Adjusted Operating Income/(Loss) Excluding Provider Rate Increases						**$ 240,079**
Digital Transformation Strategy						**$ (27,552,334)**
Non-Operating						
Net Investment Income						**$ 80,000,000**
500 Building						**$ (645,348)**
Street Medicine Support Center						**$ (762,000)**
Total Non-Operating Income/(Loss)						**$ 78,592,652**

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Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2024-25 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Corporate Software Maintenance (Provider Sanctioning and Analytics, Data Warehouse Cleansing, Analytics, Business Application Workflow, Website Content Management, Compliance and Other Corporate Applications)	2,870,565	X	X
Other Operating Expenses	Insurance Premiums - Errors and Omissions Professional Liability - General and Property Liabilities - Excess Liabilities - Commercial Auto - Directors and Officers (D&O) - Network/Privacy (Cyber), Crime, Employment Practices Liability (EPL) - Earthquake, Pollution and Umbrella - Wage and Hour Coverage	2,861,170	X	X
Other Operating Expenses	Facets Core System (Enrollment, Claims, Authorizations and Other Modules) License Renewal and Maintenance, Facets True Up Membership	2,311,815	X	X
Other Operating Expenses	Member and Provider Engagement and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Improvement	1,827,000	X	X
Other Operating Expenses	Replacement Hardware for Operating System Upgrade, Desktop Software Licenses, and Other Minor Computer Equipment, Laptop and Desktop Replacements, Computer Equipment Refresh	1,760,100	X	X
Other Operating Expenses	Contact Center as a Service Solutions Annual Subscription	1,661,596	X	X
Other Operating Expenses	Telecommunications and Network Connectivity Expenses, Business Telephones and Accessories (Desk Phones, Headsets, Tablets and Accessories)	1,550,000	X	X
Other Operating Expenses	Enterprise Subscriptions, Information Technology Advisory, Licenses and Certifications, Support for Service Management on Foundational Modules, Project and Portfolio Management, Audio Equipment and Printing Support for Facilities	1,408,715	X	X
Other Operating Expenses	Operating Systems and Office Software Suite License Costs to Support Entire Organization	1,369,465	X	X
Other Operating Expenses	Database Monitoring, Data Loss Prevention, Email Security Anti-Phishing, Intrusion Prevention, Vulnerability Management, Digital Forensics and Incident Response, Security Incident and Event Management Software and Password Vault	1,350,000	X	X
Other Operating Expenses	Network Connectivity Maintenance and Support for CalOptima Health Sites (Network Monitoring Tools, Web Filters, All Main Distribution Frame and Intermediate Distribution Frame Batteries, Internet Optimizers, Routers, Wireless Application Protocol Devices, Other Tools)	1,216,130	X	X
Other Operating Expenses	Application Software Maintenance - IT Development Tools (Data Modeling, Architecture, Technical Libraries, Documentation, Technical Frameworks, Electronic Data Interchange, Software Development Testing)	1,142,797	X	X
Other Operating Expenses	Training & Seminar - Professional Development and Education - System and Software Update Training - Process Improvement Training - Financial and Reporting Software Upgrade and Training - Training Classes for Facility Management, Environmental and Safety Issues - Training Classes for Professional Certifications and Continuing Legal Education	1,076,862	X	X
Other Operating Expenses	User Licenses for Medicare Claims Pricing Software	1,048,526	X	X
Other Operating Expenses	Business Continuity Plan (BCP) Software	1,000,000	X	X
Other Operating Expenses	Human Resources Corporate Application Software Maintenance (Training, Recruitment, Performance Evaluation, HR Benefits, Employee Time and Attendance and Payroll)	956,583	X	X
Other Operating Expenses	Software Licenses and Subscriptions Pertaining to Capital Projects	895,000	X	X
Other Operating Expenses	Real Time Claims Adjudication Function One Time License Fee and Annual Maintenance	743,144	X	X
Other Operating Expenses	Association Membership Dues (Provide Advocacy, Program Support, Technical Support Regarding State and Federal Regulatory Issues)	701,700	X	X
Other Operating Expenses	Finance Corporate Applications Software Maintenance (Accounting, Finance and Procurement Systems)	618,602	X	X
Other Operating Expenses	Server Connectivity Maintenance and Support for Server Equipment (Servers, Storage, Virtual Machine Licenses, Backup Software)	610,000	X	X
Other Operating Expenses	Sponsorship, Registration Fees and Other Related Costs for New and Anticipated Community Events, Health Fairs, Venue Rental, Services and Supplies	540,000	X	X

Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2024-25 Input	Authorization	Appropriation
Other Operating Expenses	Cloud Access Security Broker and Data Loss Prevention Solutions	500,000	X	X
Other Operating Expenses	Endpoint Protection and Threat Intelligence Powered by Artificial Intelligence	500,000	X	X
Other Operating Expenses	Purchases and Installation of Office Furniture for Adds, Moves, Furniture, Fixture and Equipment, and Various Other Articles of Minor Equipment	432,000	X	X
Other Operating Expenses	Predictive Analytics Modeling: Quarterly Model Refresh and Deliverables Cycles	390,000	X	X
Other Operating Expenses	Information Security Data Loss Prevention Solution Annual Maintenance	350,000	X	X
Other Operating Expenses	Maintenance for Windows and Carpet Cleaning, Furniture Repair, Doors, Audio Visual Equipment, Plumbing and Other General Maintenance Needs	325,000	X	X
Other Operating Expenses	Contract Management System	315,000	X	X
Other Operating Expenses	Maintenance and Support Annual Renewal for the Telecommunications Network Systems	300,975	X	X
Other Operating Expenses	24/7 Support to Assist CalOptima Health's Operating Systems and Office Software Suite Related Questions and Issues	300,000	X	X
Other Operating Expenses	Employee Engagement Events and CalOptima Health Logo Apparel	275,475	X	X
Other Operating Expenses	Office Supplies (Paper, Toner, Batteries, Mouse Pads, Keyboards, Environmental Health and Safety, Disaster Recovery, Other Miscellaneous Items) for Company-Wide Usage	240,000	X	X
Other Operating Expenses	Tuition Reimbursement for Staff Development and Organizational Development Programs (CalOptima Health Special Speakers, Trainers, Computer Classes, Other Training Events)	223,000	X	X
Other Operating Expenses	Provider and Physician Credentialing System Maintenance and License Renewal	114,980	X	X
Other Operating Expenses	Travel - Conferences/Seminars and Meetings for Managers and Staff - State Meetings Related to Regulatory and Legislative Issues, Strategic Development - Association Meetings - Vendor Site Visits, Field Staff Visits - Mileage and Parking Reimbursement for Community Events and Presentations, Provider Offices and Member Enrollment	114,070	X	X
Other Operating Expenses	Supplies and Costs Associated with Various Outreach, Community Events, Sponsorships and Health Fairs	106,000	X	X
Other Operating Expenses	Additional Software License and Upgrade Costs for Operating Systems and Office Software Suite	100,000	X	X
Other Operating Expenses	Maintenance of Operations and Desktop Application Software and Hardware	97,520	X	X
Other Operating Expenses	Strategic Development, Orange County Indicators Report and Other Professional Membership Dues	94,000	X	X
Other Operating Expenses	Database Administrator License Renewals, Maintenance and Support	91,212	X	X
Other Operating Expenses	Office Supplies for Various Departments' Needs for Everyday Operations	90,457	X	X
Other Operating Expenses	Professional Dues and Member Fees for Various Professional Associations	85,445	X	X
Other Operating Expenses	Subscription Renewal for Standard Medical Coding Schedules and Multiple User Licenses	85,000	X	X
Other Operating Expenses	Employee Appreciation Events	84,700	X	X
Other Operating Expenses	Member and Provider Incentives	67,500	X	X
Other Operating Expenses	Food Services for Community Events and Supporting New Initiatives	50,000	X	X
Other Operating Expenses	Subscriptions for Existing Software, Databases and User Groups	43,525	X	X
Other Operating Expenses	Project Portfolio Management (PPM) Software	36,000	X	X
Other Operating Expenses	Board Member Stipends, Memberships, Conferences, Training and Travel	35,000	X	X
Other Operating Expenses	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences, Department Meetings and Other Events	34,550	X	X
Other Operating Expenses	Subscription Fees for Various Licenses, Literature and Organizations	22,224	X	X
Other Operating Expenses	Promotional Items and Outreach Activities to Help Support CalOptima Health Programs and Initiatives	20,000	X	X
Other Operating Expenses	Human Resources Program Books, Surveys, E-Learning Courses, Mentoring and Succession Planning, Video Maker, Audio Editing and Various Licenses	17,929	X	X
Other Operating Expenses	Food Services for CalOptima Health Informational Series, Legislative Luncheon Events, Member and Provider Meetings/Conferences, Board Meetings and Other Events	17,750	X	X
Other Operating Expenses	Subscription Fees for Electronic Surveys, Managing Software Licenses, Education Videos for Members and Associations, Print and Digital Content Subscriptions	16,590	X	X
Other Operating Expenses	General Supplies for CalOptima Health Staff	15,000	X	X

Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2024-25 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Food Services for Provider Advisory Committee, CalOptima Health Community Network Lunch and Learn Events and Anniversary Event	4,000	X	X
Printing & Postage	Postage for Maintenance of Business, Direct Mailer, QMB Mailings, Ad hoc and New Projects	2,132,316	X	X
Printing & Postage	Print and Fulfillment for Regular Mailings of Daily/Monthly Packets	1,641,708	X	X
Printing & Postage	General Postage for Outgoing Mail	984,000	X	X
Printing & Postage	QMB Mailings, Ad hoc and New Projects	521,873	X	X
Printing & Postage	Print and Fulfillment for Newsletters	424,160	X	X
Printing & Postage	Printing of the Annual Report to the Community, Holiday Cards, Provider Press Newsletter, Legislative Platform, Advocacy Items, Strategic Plan Booklet, Direct Mail, Marketing Material and Ad Hoc Collateral Materials	103,500	X	X
Printing & Postage	Mail Services Charges, Courier/Delivery of Print Materials	79,100	X	X
Printing & Postage	Miscellaneous Member Materials, Printing Expenses and Supplies for Various Departments	41,000	X	X
Printing & Postage	Printing Services for Facilities Projects and Events, Safety and Security, Other CalOptima Health Departments' Printing Needs	36,000	X	X
Printing & Postage	Provider Relations Provider Directory Validation Forms, Annual In-Service Letters and Attestation Forms, Access and Availability Required Mailings and Postage Required to Ensure Provider Training and Education Compliance	10,000	X	X
Professional Fees	General and Adversarial Legal Fees for Outside Legal Counsel	3,350,000	X	X
Professional Fees	Support for Assessment of Growth Opportunities and Capabilities and Implementation, Coalition Grant Contracts Monitoring, and Other Consulting Services Supporting Business Development Plans	725,000	X	X
Professional Fees	Consulting Services for Strategic Advice and Assistance Regarding Government Affairs Activities, Engagement, and Communications	600,000	X	X
Professional Fees	Government Affairs Contract and Management of State, Federal and Local Lobbyists	590,000	X	X
Professional Fees	Consulting Fees to Expand Internal Audit Work Plan, Develop a Board-Approved Initiatives Review Process, Conduct Validation Audit and Risk Assessment, and other Ad Hoc Projects	500,000	X	X
Professional Fees	Employee Engagement and Feedback, Executive Recruiter Expenses, Direct Hire Fees, Leave and Accommodation and Ad Hoc Consulting	438,400	X	X
Professional Fees	Consultant for Medi-Cal Mock Audit and Other Required Audits	400,000	X	X
Professional Fees	Consulting Fees for Organizational and Strategic Plan Support	400,000	X	X
Professional Fees	Annual IBNR Certification, Network Support and Other Related Actuarial Consulting Services	321,500	X	X
Professional Fees	Consulting Fees To Support Media Outreach and Engagement to Boost Awareness and Positive Perception of CalOptima Health	280,000	X	X
Professional Fees	Consulting Services for Health Check on Existing Cyber Security Tools, Failover and High Availability Configuration Review	270,000	X	X
Professional Fees	Medical Loss Ratio Audit	258,090	X	X
Professional Fees	Core Systems Upgrade Consultation, Technical Training and Other Core Application Support	252,000	X	X
Professional Fees	Cloud Platform Assistance, Work Station Management and Miscellaneous Consulting/Professional Services	248,000	X	X
Professional Fees	Financial Audit Annual Contract	216,000	X	X
Professional Fees	Consulting Fees To Support Campaign Development and Advertising Strategy	210,000	X	X
Professional Fees	Consulting Services to Assist with Development of a New Delegation Agreement and Restructuring of the Delegation Oversight Process	192,000	X	X
Professional Fees	Space Planning Services, Mechanical Engineering Consultant, and Broker Services	190,000	X	X
Professional Fees	Compensation and Job Classification Study	100,000	X	X
Professional Fees	Investment Advisory Support Services	100,000	X	X
Professional Fees	Fraud Consultant to Assess CalOptima Health's Program Integrity Areas and Procedures	80,000	X	X
Professional Fees	Professional Fees for Dynamic 365 and Slover Support, Other Post Employment Benefits (OPEB) and Various Accounting and Related Consulting Services	72,500	X	X
Professional Fees	Third-Party Reviewers of Medical Records to Assess for Clinical Appropriateness and Coding/Billing Accuracy	70,000	X	X
Professional Fees	Consulting Services to Support Process Enhancement and Implementation	50,000	X	X
Professional Fees	Consulting Services for Budget Support	30,000	X	X
Professional Fees	Evaluation of End to End Workflow for System/Process Improvements	30,000	X	X
Professional Fees	Professional Consultant Services for Enterprise Project Management Office	20,000	X	X
Professional Fees	Professional Fees for Procurement Support	15,000	X	X

Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2024-25 Input**	**Authorization**	**Appropriation**
Purchased Services	Claims Prepayment Editing Services	2,958,120	X	X
Purchased Services	Face to Face Interpreter Services, Telephonic and Video Interpreter Services, Translation Services for Threshold Languages, Translation Audit Review and Translation Skill Assessment and Test	2,591,300	X	X
Purchased Services	Coordination Of Benefits (COB) Project	1,716,000	X	X
Purchased Services	Overpayment Identification Services	1,680,000	X	X
Purchased Services	Electronic Data Interchange Institutional Claims	1,320,000	X	X
Purchased Services	Third Party Check Printing and Mailing Fees	750,000	X	X
Purchased Services	Managed Service Support to Provide Technical Resources for Software Development and Quality Assurance	640,000	X	X
Purchased Services	Supplemental Security Income (SSI) Conversion Services	528,000	X	X
Purchased Services	Long Term Care Rate Adjustments	480,000	X	X
Purchased Services	Claims Imaging and Indexing Services	456,000	X	X
Purchased Services	Business Bank Fees	435,000	X	X
Purchased Services	Radio, Television, Print, Outdoor, Digital Advertising Campaign to Encourage Use of CalOptima Health-Covered Preventative Services	375,000	X	X
Purchased Services	Ongoing Digital, Social Media Advertising and Partnerships to Promote Routine Annual Medi-Cal Renewal, Mailing Campaign to Promote County Community Services Center	250,000	X	X
Purchased Services	Security Operations Center to Provide Expert Monitoring, Analysis, and Response to Security Incidents Using a Centralized Platform	250,000	X	X
Purchased Services	Ongoing Design and Support for ServiceNow	204,000	X	X
Purchased Services	Health Insurance Portability and Accountability Act (HIPAA) Security Compliance, including Risk Management, Assessment and Network Penetration	195,000	X	X
Purchased Services	Provider Directory Production and Remediation, Other Miscellaneous Purchased Services	171,000	X	X
Purchased Services	Medicare Third Party Liability (TPL)	168,000	X	X
Purchased Services	Recruitment Advertisement and Sourcing	155,000	X	X
Purchased Services	Data Modeling Pricing	150,000	X	X
Purchased Services	Background Screening	150,000	X	X
Purchased Services	Grant Management Tools to Support Ongoing Management of Grants and Process Improvement	150,000	X	X
Purchased Services	Fraud, Waste and Abuse (FWA) Recovery Fees	130,000	X	X
Purchased Services	Insurance Broker Services	126,000	X	X
Purchased Services	Regulatory 508 Compliance Remediation Services for Pdf Files to Make Member, Provider, Board and Other Materials Accessible to People With Disabilities on the Website as Required by CMS, DHCS and Section 508 Regulations	125,000	X	X
Purchased Services	Technical Development for Multiple Facets Projects	125,000	X	X
Purchased Services	Telecom Expense Management System, Other Ongoing Services	120,000	X	X
Purchased Services	Benefit Broker Services	116,500	X	X
Purchased Services	Data Scanning and Storage, Other General Purchased Services	102,000	X	X
Purchased Services	Telework, Handling, Deliveries and Arm Guards	84,000	X	X
Purchased Services	Employee Assistance Program	82,000	X	X
Purchased Services	Ongoing Access to Expert Security Professionals to Quickly Respond to Emerging Threats and Offer Proactive Guidance	75,000	X	X
Purchased Services	Sponsorship of Television Network Featuring Brand Placement and Raising Awareness of Health Topics	70,000	X	X
Purchased Services	Flexible Spending Accounts (FSA)/Consolidated Omnibus Budget Reconciliation Act (COBRA)	65,000	X	X
Purchased Services	Healthcare Productivity Automation Services	60,000	X	X
Purchased Services	Funding for Photography and Video Production Services Needed to Support New CalOptima Health Initiatives	55,000	X	X
Purchased Services	Medical Records Retrieval, and Compliance and Ethics Hotline	55,000	X	X
Purchased Services	Offsite Backup Tape Storage and Services, Slotted Media Storage	52,000	X	X
Purchased Services	Retirement Funds Advisory	50,000	X	X
Purchased Services	TB Shots and Other General Purchased Services	48,000	X	X
Purchased Services	Provider Office Diversity, Equity and Inclusion Training	45,000	X	X
Purchased Services	Compensation System Subscription Fee	31,700	X	X
Purchased Services	Pre Employment Applicant Testing	25,000	X	X

Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2024-25 Input**	**Authorization**	**Appropriation**
Purchased Services	Health Screening	24,000	X	X
Purchased Services	Employee Wellness and Ad Hoc Programs	16,300	X	X
Purchased Services	Tax Form Processing Fees and Other General Purchased Services	13,500	X	X
Purchased Services	Destruction of Electronic Media	8,200	X	X
Purchased Services	Imaging Services	3,500	X	X
Purchased Services	General Services for Operations Management	1,200	X	X
	Total Non-Salary Operating Expenses	**68,578,139**		

Attachment B: Administrative Budget Details

	OneCare: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2024-25 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Vendor Application Support for Broker Agency Commission for Member Enrollment and Claims Pricing Solution	846,000	X	X
Other Operating Expenses	Predictive Analytics Modeling for Quarterly Model Refresh & Deliverables Cycles	219,000	X	X
Other Operating Expenses	Member Outreach Activities and Promotional Items for Community Events	155,000	X	X
Other Operating Expenses	Training and Seminars for Professional Development and Education	62,425	X	X
Other Operating Expenses	Incentive for CalOptima Health Staff for Enrollment Referrals	60,000	X	X
Other Operating Expenses	Promotional Items for Community Events, Sponsorships and Registration Fees and Venue Rental	40,000	X	X
Other Operating Expenses	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences, Community Events, Compliance Week, and Department Training and Meeting	22,950	X	X
Other Operating Expenses	Subscriptions, Certifications and Professional Dues	20,125	X	X
Other Operating Expenses	Travel Expenses for Visits to Provider Offices, Presentations, Health Fairs, Community Events, Annual Audits and Conferences/Seminars	18,100	X	X
Other Operating Expenses	Office Supplies Needed for Everyday Department Operations	10,330	X	X
Other Operating Expenses	Marketing and Outreach Activities and Promotional Items for Various Events	4,100	X	X
Printing & Postage	Marketing Materials, Including Sales Brochures, Posters, Handouts and Other Member and Provider Oriented Materials and Postage	2,068,750	X	X
Printing & Postage	Maintenance of Enrolled Members (Printing, Fulfillment, Postage), Member Routine Annual and Quarterly Mailings, Other Related Printing and Postage Expenses	681,208	X	X
Printing & Postage	Printing of Enrollment Materials, Retainment Materials, Broker Agency Enrollment Kits, and Other Related Printing Expenses	112,000	X	X
Printing & Postage	Member and Provider Materials, Fulfillment and Other Printing Fees for Various Departments	48,250	X	X
Printing & Postage	Provider Directory Validation Forms, Annual Education and Attestations, Access and Availability Timely Access, Network Adequacy, Letter, Envelopes and Postage	17,200	X	X
Professional Fees	Medicare Consultants and Agency Services	460,000	X	X
Professional Fees	Annual Contract Bid for OneCare and Other Financial Consulting Services	420,000	X	X
Professional Fees	Medicare Data Validation Audit and Program Audit Engagement	235,000	X	X
Professional Fees	Annual Compliance Program Effectiveness (CPE) Audit	60,000	X	X
Professional Fees	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Improvement	50,000	X	X
Purchased Services	Broker Agency Commission for Member Enrollment and Other Related Expenses	1,780,000	X	X
Purchased Services	Advertising and Media Buys (Newspapers, Magazines, Radio, Bus Shelter, Campaigns, Other Media)	1,640,000	X	X
Purchased Services	Pharmacy Benefits Management	1,153,000	X	X
Purchased Services	Language Interpretation, Face to Face Interpreter Services, Telephonic Interpreter and Video Interpreting Services, and Translation of Member Materials	426,904	X	X
Purchased Services	Member Chart Retrieval Services	202,500	X	X
Purchased Services	Claims Processing Through Automation Data Flow	126,000	X	X
Purchased Services	Platform Managed Service Support	120,000	X	X
Purchased Services	Data Scanning and Storage	20,000	X	X
	Total Non-Salary Operating Expenses	**11,078,842**		

Attachment B: Administrative Budget Details

	PACE: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2024-25 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Software License and Support, Repairs and Maintenance of Minor Equipment, Building and Unforeseen Incidentals and Building Security Services	89,000	X	X
Other Operating Expenses	Outreach Events and Promotional Marketing Items to Help Elevate PACE Center and Support Program Enrollment and Expansion	23,000	X	X
Other Operating Expenses	Electricity, Gas, Water and Other Related Expenses	12,000	X	X
Other Operating Expenses	General Liability, Property, Earthquake and Other Insurance Fees	8,842	X	X
Other Operating Expenses	New PACE Incentive Program	5,000	X	X
Other Operating Expenses	Food Services Allowances, as Needed, for Sponsoring, Enrollment and Retention Events, Member and Provider Meetings, Conferences and Trainings	4,330	X	X
Other Operating Expenses	Property Tax Assessment	2,500	X	X
Other Operating Expenses	Staff Development Training (Registration Fees, Travel, Accommodations, Incidentals)	2,400	X	X
Other Operating Expenses	Office Supplies for Staff	1,200	X	X
Other Operating Expenses	Staff Travel and Mileage for Home Visits, Marketing, Conferences and Enrollment	1,200	X	X
Other Operating Expenses	Subscriptions, Membership, Registration for Dietetic and Other Discipline Specific Memberships	590	X	X
Other Operating Expenses	Minor Equipment and Supplies (Kitchen, Rehab, Social Day, Staff Break Room, Clinic/Rehab Equipment)	500	X	X
Printing & Postage	Participant Newsletter, Typesetting for Translated Materials, Printing, Fulfillment and Postage Costs for Direct Mail Campaign, Marketing Materials and Other Printing Expenses	294,300	X	X
Professional Fees	Part D Actuarial Services and Other Financial Consulting Fees	106,300	X	X
Purchased Services	Advertising (Radio, Television, Print, Outdoor, Digital and Other Mediums) to Promote and Support Enrollment and Participation	700,000	X	X
Purchased Services	Health Outcomes and Satisfaction Surveys, Encounter Data File Formatting, Sterilization of Medical Equipment, Provider Communication, Appointment Services, Telehealth Support Services, Medical Equipment Calibration and Other Related Expenses	20,400	X	X
	Total Non-Salary Operating Expenses	**1,271,562**		

Attachment B: Administrative Budget Details

	MSSP: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2024-25 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Information Management Software for Long Term Care	52,000	X	X
Other Operating Expenses	Cell Phones and Data Plans for Field Staff and Management Team Who Complete Onsite Home Assessments	17,000	X	X
Other Operating Expenses	Regular Home Visits with Members for Field Staff and Quarterly Director Site Meeting	12,000	X	X
Other Operating Expenses	Professional Development and Education	10,500	X	X
Other Operating Expenses	Professional Certifications	7,000	X	X
Other Operating Expenses	Routine Office Supplies for Field and Office Staff	500	X	X
Professional Fees	Annual Finance Audit	17,000	X	X
	Total Non-Salary Operating Expenses	**116,000**		

Attachment B: Administrative Budget Details

	505 Building: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2024-25 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Electricity	587,142	X	X
Other Operating Expenses	Janitorial Night Contract	435,909	X	X
Other Operating Expenses	Security Contract	343,198	X	X
Other Operating Expenses	Property, Liability and Earthquake Insurance	319,849	X	X
Other Operating Expenses	Engineering Contract	222,990	X	X
Other Operating Expenses	Other Repair and Maintenance (Signage, Steam Cleaning, Roof, Locksmith, Pest Control Contract, Lobby Decor, Common Area Maintenance (CAM), Other Maintenance)	168,192	X	X
Other Operating Expenses	Janitorial Day Contract	155,978	X	X
Other Operating Expenses	Plumbing	126,540	X	X
Other Operating Expenses	HVAC Miscellaneous	121,648	X	X
Other Operating Expenses	Other Fire/Life Safety Expenses (Phone, Emergency Generator, Other Expenses)	107,381	X	X
Other Operating Expenses	Janitorial Supplies	97,200	X	X
Other Operating Expenses	Electrical Repairs and Supplies	83,750	X	X
Other Operating Expenses	Exterior Landscape Contract	52,541	X	X
Other Operating Expenses	Door Maintenance and Repair	38,800	X	X
Other Operating Expenses	Gas	33,039	X	X
Other Operating Expenses	Security Equipment and Maintenance	32,024	X	X
Other Operating Expenses	Elevator Maintenance Contract	31,320	X	X
Other Operating Expenses	Property Tax Assessments	30,267	X	X
Other Operating Expenses	Windows	30,072	X	X
Other Operating Expenses	Landscape Extras	29,580	X	X
Other Operating Expenses	HVAC Maintenance Contract	24,707	X	X
Other Operating Expenses	Painting	23,700	X	X
Other Operating Expenses	Walls/Ceilings/Floors/Sidewalks/Railings	19,380	X	X
Other Operating Expenses	Water Treatment	19,211	X	X
Other Operating Expenses	Water - Building	18,539	X	X
Other Operating Expenses	Trash	12,900	X	X
Other Operating Expenses	Parking Lot Maintenance and Sweeping	10,116	X	X
Purchased Services	Property Management, Administration Fee and Other Related Expenses	274,858	X	X
	Total Non-Salary Operating Expenses	**3,450,830**		

Attachment B: Administrative Budget Details

	500 Building: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2024-25 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Security Contract	302,853	X	X
Other Operating Expenses	Electricity	233,717	X	X
Other Operating Expenses	Other Repair and Maintenance (Signage, Steam Cleaning, Roof, Locksmith, Pest Control Contract, Lobby Decor, Common Area Maintenance (CAM), Other Maintenance)	169,776	X	X
Other Operating Expenses	Janitorial Night Contract	155,226	X	X
Other Operating Expenses	Property, Liability and Earthquake Insurance	104,947	X	X
Other Operating Expenses	Engineering Contract	73,308	X	X
Other Operating Expenses	Parking Lot Maintenance and Sweeping	69,062	X	X
Other Operating Expenses	Electrical Repairs and Supplies	44,600	X	X
Other Operating Expenses	Janitorial Day Contract	42,253	X	X
Other Operating Expenses	HVAC Miscellaneous	41,285	X	X
Other Operating Expenses	Water - Building	35,985	X	X
Other Operating Expenses	Exterior Landscape Contract	35,475	X	X
Other Operating Expenses	Property Tax Assessments	35,052	X	X
Other Operating Expenses	Plumbing	29,700	X	X
Other Operating Expenses	Walls/Ceilings/Floors/Sidewalks/Railings	22,132	X	X
Other Operating Expenses	Painting	20,475	X	X
Other Operating Expenses	Door Maintenance and Repair	20,400	X	X
Other Operating Expenses	HVAC Maintenance Contract	20,356	X	X
Other Operating Expenses	Landscape Extras	19,700	X	X
Other Operating Expenses	Windows	15,810	X	X
Other Operating Expenses	Security Equipment and Maintenance	12,460	X	X
Other Operating Expenses	Other Fire/Life Safety Expenses (Phone, Emergency Generator, Other Expenses)	11,215	X	X
Other Operating Expenses	Elevator Maintenance Contract	10,896	X	X
Other Operating Expenses	Janitorial Supplies	9,600	X	X
Other Operating Expenses	Water Treatment	8,522	X	X
Other Operating Expenses	Trash	6,660	X	X
Printing and Postage	Postage and Courier	320	X	X
Purchased Services	Property Management, Administration Fee and Other Related Expenses	111,955	X	X
	Total Non-Salary Operating Expenses	**1,663,740**		

Attachment B: Administrative Budget Details

	Street Medicine Support Center: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2024-25 Input**	**Authorization**	**Appropriation**
Purchased Services	Preparation Activities for Preconstruction and Other Related Building Costs	510,000	X	X
	Total Non-Salary Operating Expenses	**510,000**		

Attachment B1: Digital Transformation Administrative Budget Details

	Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2024-25 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Government and Commercial Subscription for Cloud Platform	4,000,000	X	X
Other Operating Expenses	Software Licenses Pertaining to Capital Projects	1,778,000	X	X
Other Operating Expenses	Data Masking and Virtual Database License and Support	960,404	X	X
Other Operating Expenses	Customer Relations Management	741,600	X	X
Other Operating Expenses	Encounter Submissions and Critical Risk Adjustment Analytics	520,000	X	X
Other Operating Expenses	Security Controls, Encrypted Systems, Firewall, Efficient Access	450,000	X	X
Other Operating Expenses	Robotic Process Automation Software	250,000	X	X
Other Operating Expenses	Website Content Management and Digital Experience Platform	131,158	X	X
Other Operating Expenses	Care Management System Software (Read Only for Transition Period)	105,000	X	X
Professional Fees	Digital Transformation Consulting Services in Various Areas	5,000,000	X	X
Professional Fees	Consulting Assistance, Support Automation, New Application Masking, Data Engine Setup and Provision, Training, Integration Systems and Platform	1,313,000	X	X
Purchased Services	Automation Process for Claims	1,500,000	X	X
Purchased Services	SOC (Security Operation Center) as a Service	204,000	X	X
	Total Non-Salary Operating Expenses	**16,953,162**		

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

19. Approve the CalOptima Health Fiscal Year 2024-25 Routine Capital and Digital Transformation Year Three Capital Budgets

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

1. Approve the CalOptima Health Fiscal Year 2024-25 Routine Capital and Digital Transformation Year Three Capital Budgets; and
2. Authorize the expenditures and appropriate the funds for the following items, which shall be procured in accordance with policies approved by the Board of Directors:
    a. Attachment A: Fiscal Year 2024-25 Routine Capital Budget by Project;
    b. Attachment A1: Fiscal Year 2024-25 Digital Transformation Year Three Capital Budget by Project; and
    c. Attachment A2: Update to the Digital Transformation Year One and Year Two Capital Budgets by Project.

Background

As of March 31, 2024, CalOptima Health recorded gross capital assets of $143.3 million in the 505 Building, 500 Building, Street Medicine Support Center in Garden Grove, building improvements, furniture, equipment, and information systems, including Digital Transformation projects. To account for these fixed assets wearing out over time, staff has charged against the costs of these assets an accumulated depreciation totaling $68.6 million. Staff will record capital assets acquired in Fiscal Year (FY) 2024-25 at acquisition cost and will depreciate the value on a straight-line basis over their estimated useful lives as follows:

- Five (5) years for office furniture and fixtures;
- Three (3) years for computer equipment and software;
- The lesser of fifteen (15) years or remaining term of lease for leasehold improvements; and
- Ten (10) to twenty (20) years, based on components, for building improvements.

The resulting net book value of these fixed assets was $74.7 million, as of March 31, 2024. Prior Routine Capital Budgets approved by the Board of Directors (Board) were $14.7 million in FY 2023-24 and $13.7 million in FY 2022-23. On June 1, 2023, the Board approved $21.0 million for the FY 2023-24 Digital Transformation Year Two Capital Budget.

Pursuant to CalOptima Health Policies GA.3202: CalOptima Health Signature Authority, GA.5002: Purchasing, and GA.5003: Budget Approval and Budget Reallocation, the Board's approval of the budget authorizes the expenditure for the item and appropriates the funds requested without further

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Board action to the extent the Board has or is, as indicated in the budget attachments, delegating authority to staff.

Discussion

A. FY 2024-25 Routine Capital Budget

Staff proposes a Routine Capital Budget of $8.3 million for FY 2024-25 in the areas of Information Technology Services (ITS) and Building and Office Improvements. More detailed information is provided in Attachment A: Fiscal Year 2024-25 Routine Capital Budget by Project.

Capital Budget Area	FY 2024-25 Budget	% of Total
1. Information Technology Services	$1,244,000	15.1%
2. Building and Office Improvements	$7,016,000	84.9%
Total:	**$8,260,000**	**100%**

FY 2024-25 Routine Capital Budget by Area

1. Information Technology Services: ITS represents $1.2 million or 15.1% of the Routine Capital Budget. This category includes funding for hardware, software, and professional fees related to the implementation of multiple systems upgrades. These upgrades are necessary to support internal operations and to ensure compliance with state and federal requirements.

Capital Budget Category	FY 2024-25 Budget	% of Total
Infrastructure	$1,219,000	98.0%
Applications Management	$25,000	2.0%
Total:	**$1,244,000**	**100%**

2. Building and Office Improvements: Building and Office Improvements represent $7.0 million or 84.9% of the Routine Capital Budget. This category includes the 505 Building, 500 Building, and PACE Center. Please refer to the attached Summary of CalOptima Health Facilities for more information.

Capital Budget Category	FY 2024-25 Budget	% of Total
505 Building Improvements	$1,485,000	21.2%
500 Building Improvements	$4,700,000	67.0%
PACE Center	$831,000	11.8%
Total:	**$7,016,000**	**100%**

B. FY 2024-25 Digital Transformation Year Three Capital Budget

On March 17, 2022, the Board authorized a three-year Digital Transformation and Workplace Modernization Strategy and created a $100 million restricted reserve to fund digital transformation efforts. The Digital Transformation Year Three Capital Budget includes new digital transformation

capital projects or requests for additional resources for capital projects approved in the prior years. The proposed budget represents the final year of this three-year, Board-approved initiative. More detailed information is provided in Attachment A1: Fiscal Year 2024-25 Digital Transformation Year Three Capital Budget by Project.

Capital Budget Category	FY 2024-25 Budget	% of Total
Infrastructure	$585,000	7.8%
Applications Management	$1,150,000	15.3%
Enterprise Data and Systems Integration	$2,700,000	35.9%
Application Development	$2,390,000	31.8%
Enterprise Architecture	$500,000	6.6%
Cyber Security	$200,000	2.7%
Total:	**$7,525,000**	**100%***

* Totals may not add evenly due to rounding.

C. Update to the Digital Transformation Year One and Year Two Capital Budgets

Since the Digital Transformation and Workplace Modernization Strategy launched in 2022, staff worked quickly to develop and implement key components of the strategy. The Board has taken specific steps to move this strategy forward, including the approval of the Digital Transformation Year One and Year Two Capital Budgets on June 2, 2022, and June 1, 2023, respectively, and separate Board actions to update and revise capital projects and funding levels within these two budgets. As of March 31, 2024, the revised Digital Transformation Year One Capital Budget was $34.6 million, and the revised Digital Transformation Year Two Capital Budget was $21.4 million.

As CalOptima Health enters the third year of the three-year strategy, staff has reassessed the previous two revised capital budgets to update the status of and determine appropriate funding levels for each capital project. The updated budget includes a consolidated list of Year One and Year Two capital projects that will continue in FY 2024-25 and has a total budgeted amount of $24.0 million. After Board approval, staff will revise the amount of capital assets based on the updated list of capital projects.

The remaining unspent funds totaling $32.0 million will return to the Digital Transformation Strategy restricted reserve pool. After accounting for actual and budgeted capital and operating costs over the three-year period, staff estimates there will be $9.7 million remaining from the $100 million pool. For more detailed information, please refer to Attachment A2: Update to the Digital Transformation Year One and Year Two Capital Budgets by Project.

Fiscal Impact

Investment in the FY 2024-25 Routine Capital and Digital Transformation Year Three Capital Budgets will reduce CalOptima Health's investment principal by $8,260,000 and $7,525,000, respectively. Depreciation expenses for Capital Budget projects are reflected in the proposed FY 2024-25 CalOptima Health Operating Budget.

Rationale for Recommendation

The FY 2024-25 Routine Capital and Digital Transformation Year Three Capital Budgets will enable necessary office improvements, system upgrades, enhance operational efficiencies, support CalOptima Health's mission and vision statements and strategic plan, and comply with federal and state requirements.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Finance and Audit Committee

Attachments

1. Attachment A: Fiscal Year 2024-25 Routine Capital Budget by Project
2. Attachment A1: Fiscal Year 2024-25 Digital Transformation Year Three Capital Budget by Project
3. Attachment A2: Update to the Digital Transformation Year One and Year Two Capital Budgets by Project
4. Summary of CalOptima Health Facilities
5. Fiscal Year 2024-25 Capital Budgets Presentation

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

Attachment A: Fiscal Year 2024-25 Routine Capital Budget by Project

INFRASTRUCTURE		TOTAL CAPITAL
Computer Network Connectivity Hardware		385,000
Technology Asset Inventory Tracking Application		362,000
Compliance and Risk Management System		125,000
Email, Text, Web SPAM Blocker System		75,000
Redundant Network Connectivity Platform		60,000
Data Warehouse Virtualization System to Scale and Improve Data Usage		55,000
Analytics and Integration Platform for Technology Issue Response and Resolution		40,000
Computer Operating System Patch and Repair Automation		40,000
Network Time Protocol System to Synchronize Network and Computer Clocks		25,000
Communication System Redundancy		17,000
Local and Wide Area Network Redundancy System Upgrade and Internet Firewall Resource Expansion		14,000
Teletypewriter (TTY) System Upgrade		13,000
Backup Data as a Service		8,000
TOTAL INFRASTRUCTURE	**$**	**1,219,000**

APPLICATIONS MANAGEMENT		TOTAL CAPITAL
Electronic Health Record Patient Continuity of Care Document Conversion System		25,000
TOTAL APPLICATIONS MANAGEMENT	**$**	**25,000**

505 BUILDING IMPROVEMENTS		TOTAL CAPITAL
Office Improvements		550,000
Office Furniture		500,000
Lobby Renovation		345,000
Intermediate Distribution Frame Room HVAC		65,000
Digital Directory in Lobby		25,000
TOTAL 505 BUILDING IMPROVEMENTS	**$**	**1,485,000**

500 BUILDING IMPROVEMENTS		TOTAL CAPITAL
Suite 300 Renovations		1,900,000
Suite 100 Renovations		1,600,000
Suite 250 Renovations		960,000
HVAC Controls Upgrade		175,000
Fire Control Panel Replacement		50,000
Touchless Faucets in Common Area Restrooms		15,000
TOTAL 500 BUILDING IMPROVEMENTS	**$**	**4,700,000**

PACE CENTER		TOTAL CAPITAL
Electronic Health Record System		500,000
Clinic Office Reconfiguration		100,000
Office Space Reconfiguration		55,000
Rooftop HVAC Unit		55,000
Touchless Fixtures		35,000
Exterior Wall Refurbishment		32,000
Waste Enclosure Expansion		28,000
Rehabilitation Equipment		13,000
Commercial Refrigerator		8,000
Patio/Lounge Furniture		5,000
TOTAL PACE CENTER	**$**	**831,000**

TOTAL FY 2024-25 ROUTINE CAPITAL BUDGET	**$**	**8,260,000**

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Attachment A1: Fiscal Year 2024-25 Digital Transformation Year Three Capital Budget by Project

INFRASTRUCTURE		TOTAL CAPITAL
Network Operations Center Monitoring and Control System		300,000
Automate Computer Provision Management Resources with New Infrastructure as a Code (IaC) Technology		185,000
Customer Service Workforce Management within the Contact Center Telephony System		100,000
TOTAL INFRASTRUCTURE	**$**	**585,000**

APPLICATIONS MANAGEMENT		TOTAL CAPITAL
Cloud Migration - Financial System		1,150,000
TOTAL APPLICATIONS MANAGEMENT	**$**	**1,150,000**

ENTERPRISE DATA AND SYSTEMS INTEGRATION		TOTAL CAPITAL
Data Warehouse Quality and Trusted Management System for Business Analytics		2,700,000
TOTAL ENTERPRISE DATA AND SYSTEMS INTEGRATION	**$**	**2,700,000**

APPLICATION DEVELOPMENT		TOTAL CAPITAL
Development Upgrade of the Portals to Improve Member and Provider Experiences		2,000,000
Governance, Risk and Compliance Solution Including Policy Management		100,000
Human Capital Management Integration		100,000
CMS Member Preference and Consent Management for Data Sharing		75,000
Member and Provider Portal Availability Monitoring System		50,000
Health Insurance Portability and Accountability Act (HIPAA) Compliant and Secure Web Forms Platform		40,000
CalOptima.org and Portal Web Site Auditing Tool		25,000
TOTAL APPLICATION DEVELOPMENT	**$**	**2,390,000**

ENTERPRISE ARCHITECTURE		TOTAL CAPITAL
Modern Application Programming Interface Architecture and Infrastructure		500,000
TOTAL ENTERPRISE ARCHITECTURE	**$**	**500,000**

CYBER SECURITY		TOTAL CAPITAL
Upgrade Secure File Encryption Software		200,000
TOTAL CYBER SECURITY	**$**	**200,000**

TOTAL FY 2024-25 DIGITAL TRANSFORMATION YEAR THREE CAPITAL BUDGET	**$**	**7,525,000**

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Attachment A2: Update to Digital Transformation Year One and Year Two Capital Budgets by Project

INFRASTRUCTURE	YEAR ONE UPDATE	YEAR TWO UPDATE	TOTAL CAPITAL
Network Bandwidth Upgrade for All Sites (Wide Area Network)	1,533,757	2,087,381	3,621,138
Modern Customer Contact Center	2,250,000		2,250,000
Internet Bandwidth Upgrade for All Sites	599,045	4,278	603,323
Data Protection and Recovery Operations Software Solution	279,263		279,263
TOTAL INFRASTRUCTURE	**$ 4,662,065**	**$ 2,091,659**	**$ 6,753,724**

APPLICATIONS MANAGEMENT	YEAR ONE UPDATE	YEAR TWO UPDATE	TOTAL CAPITAL
Care Management System	3,000,000	500,000	3,500,000
Customer Relationship Management System	231,250	2,000,000	2,231,250
Integrated Provider Data Management, Contract Management and Credentialing Systems		1,964,000	1,964,000
Enterprise Robotic Process Automation	1,500,000		1,500,000
Cloud Migration - Financial System	556,000		556,000
System Development Enhancement for CalAIM		400,000	400,000
Web Based Services for Core Administrative System		250,000	250,000
Customer Service Enhanced System Functions	150,000		150,000
Electronic Cloud Based Fax Solution	75,000	75,000	150,000
Provider Portal Integration with Clinical Guidelines	50,000	75,000	125,000
Healthcare Enterprise Management Platform		50,000	50,000
Clinical Data Sets Quality Assurance & Data Aggregator Validation		35,000	35,000
TOTAL APPLICATIONS MANAGEMENT	**$ 5,562,250**	**$ 5,349,000**	**$ 10,911,250**

ENTERPRISE DATA AND SYSTEMS INTEGRATION	YEAR ONE UPDATE	YEAR TWO UPDATE	TOTAL CAPITAL
Real-Time Data Exchange with Partners Enhancement	1,636,000		1,636,000
Digital Transformation Strategy Planning and Execution Support	1,375,635		1,375,635
Migrate Operational Reporting/Analytics to the Cloud	25,500	300,000	325,500
Enterprise Data Quality Enhancement	275,000		275,000
TOTAL ENTERPRISE DATA AND SYSTEMS INTEGRATION	**$ 3,312,135**	**$ 300,000**	**$ 3,612,135**

APPLICATION DEVELOPMENT	YEAR ONE UPDATE	YEAR TWO UPDATE	TOTAL CAPITAL
Migrate Website Content Management System to the Cloud	750,000	1,567,100	2,317,100
Human Resources Capital Management Solution Software		200,000	200,000
Human Resources Electronic Record System		150,000	150,000
Migrate User Authentication Process for Member and Provider Portal to Cloud	56,500		56,500
TOTAL APPLICATION DEVELOPMENT	**$ 806,500**	**$ 1,917,100**	**$ 2,723,600**

TOTAL UPDATE TO DIGITAL TRANSFORMATION YEAR ONE AND YEAR TWO CAPITAL BUDGETS BY PROJECT	**$ 14,342,950**	**$ 9,657,759**	**$ 24,000,709**

DIGITAL TRANSFORMATION BUDGET UPDATE	YEAR ONE	YEAR TWO	TOTAL
Digital Transformation Year One & Two Capital Budgets (Orig. with Board Adjustments)	$ 34,611,000	$ 21,422,000	$ 56,033,000
Resources Returning to Digital Transformation Restricted Reserve	$ 20,268,050	$ 11,764,241	$ 32,032,291

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Summary of CalOptima Health Facilities

CalOptima Health operations are conducted at various locations in Orange County to support the Medi-Cal, OneCare, and PACE lines of business. The summary below provides some background information on these facilities.

505 Building: This property is located at 505 City Parkway West, Orange, California. On January 6, 2011, the CalOptima Health Board of Directors (Board) approved the purchase of the property, which became the headquarters on March 5, 2012.

500 Building: This property is located at 500 City Parkway West, Orange, California. On March 17, 2022, the Board approved the purchase of the property. The property will house, among other things, CalOptima Health's member services and the Care Traffic Control Command Center in Orange County.

PACE Center: This property is located at 13300 Garden Grove Boulevard, Garden Grove, California. On February 3, 2011, the Board authorized a lease for the property to serve as the location for the PACE Center. At the June 3, 2021, meeting, the Board extended the lease agreement for ten additional years, through December 31, 2031.

Street Medicine Support Center: This property is located at 7900 Garden Grove Boulevard, Garden Grove, California. On October 5, 2023, the Board approved the purchase of the property, which is the location for the Street Medicine Support Center. The center is tentatively scheduled to open in Spring 2025.

Fiscal Year 2024-25 Capital Budgets

Board of Directors Meeting

June 6, 2024

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

Agenda

- FY 2024-25 Routine Capital Budget
  - Information Technology Services
  - Building and Office Improvements
- Digital Transformation Strategy (DTS)
  - FY 2024-25 Year Three Capital Budget
  - Update to Year One and Year Two Capital Budgets
  - DTS 3-year Resource Allocation Summary
- Recommended Actions

FY 2024-25 Budget (Capital Budget Funded)
ROUTINE CAPITAL

$8,260,000

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FY 2024-25 Budget (Reserve Funded)

DIGITAL TRANSFORMATION YEAR THREE CAPITAL

$7,525,000

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FY 2024-25 Budget
TOTAL CAPITAL

$15,785,000

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FY 2024-25
Routine Capital Budget

FY 2024-25 Routine Capital Budget

Capital Budget Area	FY 2024-25 Budget	% of Total
Information Technology Services (ITS) related capital projects	$1,244,000	15.1%
Building and Office Improvements (505 Building, 500 Building, PACE Center)	$7,016,000	84.9%
Total:	**$8,260,000**	**100.0%**

- Departments submit requests for capital projects based on strategic and operational needs
- ITS Department reviews technology requests

Information Technology Services

Capital Budget Category	FY 2024-25 Budget
Infrastructure (e.g., Computer Network Connectivity Hardware, Technology Asset Inventory Tracking Application)	$1,219,000
Applications Management (e.g., Electronic Health Record Patient Continuity of Care Document Conversion System)	$25,000
Total:	**$1,244,000**

- Represents about 15.1% of the Routine Capital Budget
- Addresses information technology infrastructure needs to support current internal operations
- Ensures compliance with state and federal requirements

Note: Capital project details can be found in Attachment A: Fiscal Year 2024-25 Routine Capital Budget by Project

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Building and Office Improvements

Capital Budget Category	FY 2024-25 Budget
505 Building Improvements	$1,485,000
500 Building Improvements	$4,700,000
PACE Center	$831,000
Total:	**$7,016,000**

- Represents nearly 84.9% of the Routine Capital Budget

Note: Capital project details can be found in Attachment A: Fiscal Year 2024-25 Routine Capital Budget by Project

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Digital Transformation Strategy

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FY 2024-25 DTS Year Three Capital Budget
($100 million restricted reserve)

Capital Budget Category	FY 2024-25 Budget
Infrastructure (e.g., Network Operations Center Monitoring and Control System)	$585,000
Applications Management (e.g., Cloud Migration – Financial System)	$1,150,000
Enterprise Data and Systems Integration (e.g., Data Warehouse Quality and Trusted Management System for Business Analytics)	$2,700,000
Application Development (e.g., Development Upgrade of the Portals to Improve Member and Provider Experiences)	$2,390,000
Enterprise Architecture (e.g., Modern Application Programming Interface Architecture and Infrastructure)	$500,000
Cyber Security (e.g., Upgrade Secure File Encryption Software)	$200,000
Total:	**$7,525,000**

Notes:

- 3/17/22: Board authorized a three-year strategy and created a $100 million restricted reserve to fund digital transformation efforts
- Capital project details can be found in Attachment A1: Fiscal Year 2024-25 Digital Transformation Year Three Capital Budget by Project

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Update to DTS Year One and Year Two Capital Budgets

	Year One	Year Two	Total Budget
DTS Year One & Two Capital Budgets *(Orig. with Board Adjustments)*	**$34,611,000**	**$21,422,000**	**$56,033,000**
Update to Capital Projects by Category	**$14,342,950**	**$9,657,759**	**$24,000,709**
Infrastructure	$4,662,065	$2,091,659	$6,753,724
Applications Management	$5,562,250	$5,349,000	$10,911,250
Enterprise Data and Systems Integration	$3,312,135	$300,000	$3,612,135
Application Development	$806,500	$1,917,100	$2,723,600
Resources Returning to DTS Restricted Reserve	**$20,268,050**	**$11,764,241**	**$32,032,291**

Note:

- Capital project details can be found in Attachment A2: Update to the Digital Transformation Year One and Year Two Capital Budgets by Project

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DTS 3-year Resource Allocation Summary

	Year One	Year Two	Year Three	Total
Capital				
Budget	$14,342,950	$9,657,759	$7,525,000	$31,525,709
Operating				
Actuals/ Budget	$8,381,011	$22,856,536	$27,552,334	$58,789,881
Grand Total:	**$22,723,961**	**$32,514,295**	**$35,077,335**	**$90,315,591**

* Totals may not add due to rounding

Total Funding $100,000,000

Remaining Balance **$9,684,409**

Notes:

Capital: Year One and Year Two amounts are from the Update to the Digital Transformation Capital Budgets; Year Three amount is from the proposed FY 2024-25 Digital Transformation Year Three Capital Budget

Operating: Year One amount reflects actual expenditures; Year Two amount is the projected expenditures based on actuals as of 3/31/24; Year Three amount is from the proposed FY 2024-25 DTS Year Three Operating Budget

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Recommended Actions

- Approve the CalOptima Health Fiscal Year 2024-25 Routine Capital and Digital Transformation Year Three Capital Budgets

- Authorize the expenditures and appropriate the funds for the following items, which shall be procured in accordance with CalOptima Health Board-approved policies:
  - Attachment A: Fiscal Year 2024-25 Routine Capital Budget by Project
  - Attachment A1: Fiscal Year 2024-25 Digital Transformation Year Three Capital Budget by Project
  - Attachment A2: Update to Digital Transformation Year One and Year Two Capital Budgets by Project

CalOptima Health

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
20. Authorize Amendments to the CalOptima Health Medi-Cal Shared-Risk Group, Physician-Hospital Consortia, and Health Maintenance Organization Health Network Contracts

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

Recommended Actions
Authorize the Chief Executive Officer to execute amendments to the CalOptima Health Medi-Cal Shared-Risk Group, Physician-Hospital Consortia, and Health Maintenance Organization Contracts to:

1. Update the Medi-Cal capitation rates for Shared-Risk Group, Physician-Hospital Consortia, and Health Maintenance Organization Health Networks, effective July 1, 2024.
2. Add language to operationalize a payment methodology to comply with the Department of Health Care Services mandatory targeted rate increases, effective January 1, 2024.

Background and Discussion
Staff requests that the CalOptima Health Board of Directors (Board) authorize amending the Medi-Cal Shared-Risk Group (SRG), Physician-Hospital Consortia (PHC), and Health Maintenance Organization Health Network (HMO) Contracts to reflect updated rates and to incorporate DHCS requirements that Managed Care Plans comply with the Department of Health Care Services (DHCS) mandatory targeted rate increase (TRI) for specific services, effective January 1, 2024. CalOptima Health's health network provider partners are a vital part of its delivery system and support CalOptima Health in providing care for its over 900,000 members. Amending the health network provider contracts is periodically necessary to remain compliant with state requirements.

The capitation rate changes to the SRG, PHC, and HMO Contracts include the following items:

Provider Rate Increase
The Board committed $210.5 million in rate increases for contracted health networks and eligible FFS providers for Fiscal Year (FY) 2024-25 at the May 2, 2024 Board meeting. This increase will ensure financial stability, network adequacy, and member access to care within the CalOptima Health delivery system over the next 30 months. The updated professional and facility capitation rates for SRG, PHC, and HMO health networks will be for the aid code categories of Child, Adult, Seniors and Persons with Disabilities, Whole Child Model, End-Stage Renal Disease, Acquired Immune Deficiency Syndrome, Enhanced Care Management, and Maternity Kick.

DHCS Targeted Rate Increase
The DHCS TRI is a set of payment increases applicable to eligible providers within the Medi-Cal FFS delivery system and Medi-Cal managed care plans for targeted services, which became effective January 2024 pursuant to the 2023 Budget Act and Assembly Bill 118 (Chapter 42, Statutes of 2023). Staff proposes amending the SRG, PHC, and HMO contracts to support TRI implementation for all future provider types that DHCS identifies as eligible. CalOptima Health shall institute a payment

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methodology to comply with requirements related to the TRI. Proposition 56 supplemental payment for physician services will be subsumed under the applicable TRI payments.

The DHCS draft All Plan Letter on TRI notes that Federally Qualified Health Centers (FQHCs) are not eligible providers for TRI payment rates. However, pursuant to the Social Security Act, §1903(m)(2)(A)(ix), CalOptima Health and its delegated health networks are required to pay rates to FQHCs at no less than other contracted providers for similar eligible services.

Staff requests the Board approve the above recommended actions, allowing for the execution of the capitated Medi-Cal health network contract amendments to comply with regulatory requirements and support member access to quality care for CalOptima Health members.

Fiscal Impact

Management has included expenses associated with the Medi-Cal SRG, PHC and HMO contracts in the proposed FY 2024-25 Operating Budget, which is pending Board approval.

For the period of July 1, 2024, through June 30, 2025:

- The aggregate annual fiscal impact of the proposed non-TRI related rate increases is approximately $114.5 million. This amount is part of the $210.5 million commitment from unallocated reserves approved by the Board on May 2, 2024. As applicable, staff will continue to include updated expenses in future operating budgets.

- The aggregate annual fiscal impact of the proposed implementation of the TRI rates for Medi-Cal SRG, PHC, and HMO is approximately $115.0 million, with $83.3 million for the conversion of the Proposition 56 physician services supplemental payments and $31.7 million in additional funding to providers. The additional funding is for added TRI procedure codes that were not formerly included under the Proposition 56 physician services supplemental payments, as well as to comply with federal requirements on compensating FQHCs with similar rates for like-services.

Period: July 1, 2024 – June 30, 2025	Provider Rate Increase (Non-TRI)	TRI: Conversion of Proposition 56 physician services supplemental payment	TRI: Additional funding to providers	Total
Professional	$50.0 million	$83.3 million	$31.7 million	$165.1 million
Facility	$64.4 million	--	--	$64.4 million
Total	$114.5 million	$83.3 million	$31.7 million	$229.5 million

Note: Totals may not add up evenly due to rounding.

Period of January 1, 2024, through June 30, 2024:

- Staff will continue making Proposition 56 physician services supplemental payments until the scheduled implementation of TRI is complete. Proposition 56 physician services supplemental payments made for Calendar Year 2024 will be subsumed under the TRI. DHCS has included TRI funding in the Calendar Year 2024 rates. The aggregate fiscal impact of the proposed rate

updates for Medi-Cal SRG, PHC, and HMO contracts is approximately $57.5 million, with $41.7 million for the conversion of the Proposition 56 physician services supplemental payments and $15.8 million in additional funding to providers.

Period: January 1, 2024 – June 30, 2024	TRI: Conversion of Proposition 56 physician services supplemental payment	TRI: Additional funding to providers	Total
Professional	$41.7 million	$15.8 million	$57.5 million

Rationale for Recommendation

The above requested rate amendments are to support CalOptima Health's delivery system, maintain compliance with the latest state requirements, and maintain a robust provider network.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. SRG Health Network Amendment
3. HMO Health Network Amendment
4. PHC-Physician (PHC-P) Health Network Amendment
5. PHC-Hospital (PHC-H) Health Network Amendment

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Health Medi-Cal Health Networks				
AltaMed Healthcare Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868
Children's Hospital of Orange County	1201 West La Veta Avenue	Orange	CA	92868
CHOC Physicians Network	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Health Services 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
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
Monarch Health Plan, Inc.	1 Technology Dr.	Irvine	CA	92618
Prospect Health Plan Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

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AMENDMENT [XX] TO

CONTRACT FOR HEALTH CARE SERVICES

This Amendment [XX] to the Contract for Health Care Services ("**Amendment**") is effective as of July 1, 2024 ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and, [health network name**]** ("**Physician**"). CalOptima and Physician may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services, originally effective [insert date], ("**Contract**"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. Department of Healthcare Services ("**DHCS**") is implementing a Targeted Rate Increase, as defined further below, and the Parties desire to outline Physician's obligation related to the Targeted Rate Increase.

C. CalOptima and Physician desire to amend the Contract on the terms and conditions set forth herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Add the following new Section 1.113, *Targeted Rate Increase*, to the Contract:

   1.113 "Targeted Rate Increase" or "TRI" means the set of provider rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) as implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. The first phase of TRIs are effective for dates of service beginning January 1, 2024. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates, including Physician and its Subcontractors, must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment previously due to provider. The TRI applies to both fee-for-service and other provider payment arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

2. Add the following new Section 2.6.1.1 to the Contract:

   2.6.1.1 Physician shall evaluate and adjust as necessary its capitation payments to Participating Providers that provide TRI-eligible services to ensure such capitation payments meet the TRI requirements. If adjustment to Participating Provider capitation payments is necessary, Physician shall adjust such capitation payments retroactive to January 1, 2024, by no later than December 1, 2024. Physician's reimbursement for TRI-eligible services shall comply with DHCS requirements, Laws, and CalOptima Policies.

3. Add the following new Section 2.7.17.3 to the Contract:

   2.7.17.3. By no later than July 31, 2024, Physician shall implement the DHCS-mandated TRI to its fee-for-service provider payments that qualify for the TRI retroactive to dates of service rendered on or after January 1, 2024. If adjustment to fee-for-service provider payments is necessary,

Physician shall adjust such fee-for-service provider payments retroactive to January 1, 2024, by no later than October 31, 2024. If a rate in an agreement between Physician and a Participating Provider for a TRI-eligible service is less than the Medi-Cal TRI fee schedule, the Medi-Cal TRI fee schedule shall control. Physician's reimbursement for TRI-eligible services shall comply with DHCS requirements, Laws, and CalOptima Policies.

4. Add the following new Section 6.4.13 to the Contract:

6.4.13 Physician agrees that CalOptima may make publicly available, as frequently as CalOptima deems necessary, reports of Physician's compliance with the Contract's requirements and performance metrics, including Members' access to care, the quality of care received by Members, and Physician's other performance trends, as applicable to Physician's obligations hereunder.

5. Add the following new Section 6.4.14 to the Contract:

6.4.14 As long as CalOptima's disclosures under this Section 6.4 otherwise comply with applicable laws, no CalOptima disclosure under this Section 6.4 shall constitute a breach of this Contract.

6. Delete Attachment E, *Capitation Rates,* in its entirety and replace it with new Attachment E, *Capitation Rates,* attached to this Amendment and incorporated into the Contract by this reference, which includes rates for Medi-Cal Members, including Medi-Cal Expansion Members.

7. Delete Attachment E-10, *Funding for Enhanced Care Management (ECM) Services*, in its entirety and replace it with new Attachment E-10, *Funding for Enhanced Care Management (ECM) Services,* attached to this Amendment and incorporated into the Contract by this reference.

8. Add to the Contract the new Attachment H, *Delegation Agreement*, which is attached hereto and incorporated into the Contract by this reference. This new Attachment H shall replace and terminate any other prior delegation agreements, including any *Delegation Acknowledgement and Acceptance Agreement*, between the Parties.

9. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

10. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern.

11. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

(signature page follows)

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PHYSICIAN:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ATTACHMENT E
CAPITATION RATES

Payments by CalOptima to Physician for Covered Services rendered to Members in accordance with the Contract shall be on a Per Member/Per Month (PMPM) basis at the rates outlined below, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child/Adult	00-00 year, Both	[redacted]	[redacted]	[redacted]
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40-64 years, Both			
	65+ years, Both			
Medi-Cal Expansion	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
SPD	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
WCM	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate

ESRD	All ages, Both	[redacted]	[redacted]	[redacted]
AIDS	All ages, Both	[redacted]	[redacted]	[redacted]

Overall Average Capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy. The Parties agree that the above rates compensate Physician for all services outlined in Attachment A, *CalOptima Medi-Cal Division of Financial Responsibility*, including ongoing compensation for COVID-19 diagnostic and screening testing services. The Parties further agree that future amendments to the Contract increasing the above rates due to a declared public health emergency shall constitute a negotiated and agreed upon new provision to the Contract delegating financial responsibility to Physician to cover the additional Medi-Cal Covered Services required by such declared public health emergency.

Supplemental OB Delivery Care Payment will be payable for all qualified deliveries based on DHCS guidance.

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment - All	[redacted]	[redacted]	[redacted]

ATTACHMENT E-10

Funding for Enhanced Care Management (ECM) Services

CalOptima shall make an ECM Supplemental Payment to Physician for ECM services provided to an ECM Member, in accordance with the terms and conditions of CalOptima Policy FF.4002 and this Attachment.

1. ECM Services Supplemental Payment

   1.1 CalOptima shall pay Physician the ECM Supplemental Payment rate of [redacted] Per Member Per Month for each Member who receives three (3) or more hours of ECM services in a given month as identified by twelve (12) or more units, subject to Physician's compliance with all of the following conditions:

   - Member is identified as an ECM-eligible Member as determined by CalOptima based on DHCS ECM eligibility criteria and in accordance with CalOptima Policy GG.1354;
   - Member is authorized to receive ECM services;
   - Member receives one of the ECM core service components (as set forth in Section 6.23.9.4 of the Contract) in the prior month;
   - Physician bills and reports ECM services to CalOptima consistent with CalOptima Policy FF.4002 and DHCS requirements; and
   - If applicable, the Physician paid the provider delegated by Physician to render ECM services; and the Physician authorized such ECM services.

   1.2 For purposes of this Attachment E-10, the term "**Per Member Per Month**" means an all-inclusive case rate that applies whenever Physician, as the ECM Provider, has provided the minimum level of service payable to an ECM-enrolled Member. This rate is paid on the basis of submitted claims and is not to be considered a capitation payment.

2. Physician shall submit ECM billing data for the ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

3. Upon validation of the ECM billing data and in accordance with CalOptima Policy FF.4002 CalOptima shall pay ninety (90) percent of all clean claims within thirty (30) calendar days of the date of receipt and ninety-nine (99) percent of all clean claims within ninety (90) calendar days of the date of receipt. The date of receipt shall be the date CalOptima receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

4. In addition to Section 9.4 of this Contract, Physician agrees to CalOptima's recovery of any overpayment of ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

ATTACHMENT H
DELEGATION AGREEMENT

For purposes of this Attachment H, [insert Provider/Physician/Physician Group/Hospital naming convention] shall be referred to as "**Delegate**". Delegate agrees to perform the delegated services in accordance with the responsibilities outlined in this Attachment H for CalOptima and its Members assigned to Delegate.

This Attachment H shall supersede all prior delegation agreements between the Parties and remain in effect for the term of the Contract.

1. **Definitions**

    a. "**Standards and Requirements**" means currently applicable NCQA accreditation standards; DHCS, DMHC, CMS requirements; state and federal statutes, regulations, and sub-regulatory requirements; and CalOptima Policies and contractual requirements, including the State Contract.

2. **Delegate Obligations**

    a. **Standards and Requirements:** Delegate agrees (either itself or through a CalOptima-approved Subcontractor or downstream entity) to provide the delegated services set forth in Schedules A, B, C, and D, as applicable, ("**Delegated Services**") in accordance with the terms of this Attachment H and Standards and Requirements. Delegate shall comply with new or revised Standards and Requirements from and after the effective date of any new or revised standard or rule. Changes necessary to comply with new/revised Standards and Requirements are not a change to a material term of this Attachment H requiring approval by either party.

    b. **Policies and Procedures:** Delegate shall comply with CalOptima's policies and procedures, including but not limited to CalOptima Policy GG.1619: Delegation Oversight. Delegate shall submit to CalOptima copies of Delegate's written policies and procedures for each delegated service as part of a readiness assessment and at least once each year during the term of the Contract. Delegate's policies and procedures are subject to annual review and/or review upon request by CalOptima.

    c. **Subdelegation:** Delegate agrees not to subdelegate any Delegated Services without prior written notice to and approval by CalOptima. Delegate shall provide CalOptima a written and complete list of subdelegates, vendors, subcontractors, and offshore entities performing services for or on behalf of Delegate at least sixty (60) days before the date Delegated Services are to begin under this Attachment H. The parties shall update the list shall no later than sixty (60) days before any changes approved by CalOptima take effect, including new subdelegates or offshore entities or the movement of Delegated Services from one subdelegate or offshore entity location to another. CalOptima may audit Delegate's subdelegates with advance notice, and Delegate will ensure its contracts with Subcontractors and subdelegates provide such an audit right for CalOptima. All Delegate contracts with subdelegated entities shall require the subdelegated entity to perform all Delegated Service(s) in compliance with the Contract, including this Attachment H and all Standards and Requirements. Delegate is responsible for ensuring each subdelegate complies with the Standards and Requirements. Subdelegation shall not relieve Delegate of its obligations or liability under the Contract, including this Attachment H and its Schedules A, B, C, and D (as applicable). Delegate represents and warrants that it shall take all steps necessary to cause subdelegates to comply with this Attachment H, including all Schedules.

    d. **Offshore Entities:** Delegate represents and warrants it does not and will not use any offshore entity to perform Delegated Services unless and until:

i. Delegate provides sixty (60) days' advance written notice to CalOptima before entering into any agreement to subcontract any Delegated Service to an offshore entity;

ii. CalOptima, in its sole discretion, agrees in writing to the subdelegation of Delegated Services to the offshore entity;

iii. Delegate and offshore entity consent to and cooperate with CalOptima's right to audit the offshore entity. Delegate shall also audit the offshore entity before the offshore entity's provision of Delegated Services and annually as long as Delegate subdelegates Delegated Services to the offshore entity; and

iv. CalOptima and Delegate file the proposed subdelegation of functions or services to the offshore entity with the appropriate regulatory authorities for approval and receive regulatory approval Delegate and the delegated offshore entity shall comply with any requirements that the applicable regulatory authority may issue at any time during the term of the Contract.

e. **Systems & System Conversions:** Delegate agrees to take all necessary steps to ensure the Delegate's systems perform in a manner that assures Delegate's compliance with all Standards and Requirements. Delegate shall provide CalOptima at least sixty (60) days' prior written notice of any systems conversions or modifications that directly impact its obligations under this Attachment H. All systems processing and/or storing of protected health information ("**PHI**") and/or personally identifiable information ("**PII**") must have at least one (1) system risk assessment/security review conducted annually that demonstrates to CalOptima that Delegate's administrative, physical, quality, and technical controls are functioning effectively in compliance with Standards and Requirements. Delegate agrees to cooperate with CalOptima and facilitate CalOptima's performance of any system risk assessment, security reviews, compliance, and/or system reviews, as required by law and its regulators.

3. **Delegate Representations and Warranties**

a. **Good Standing; Exclusion Lists:** Delegate represents and warrants to CalOptima that:

i. Delegate is, and will remain throughout the Term of the Contract, in good standing under Standards and Requirements governing its existence and operations, and it is in compliance with and shall continue to comply with all laws and regulations applicable to this Attachment H and the duties and obligations under this Attachment H, including, but not limited to, Standards and Requirements related to Delegated Services (whether or not Delegate is directly obligated under or regulated by such Standards and Requirements);

ii. Delegate is in compliance with any licensing requirements and agrees to maintain such compliance under Standards and Requirements for the express purpose of performing each delegated service; and

iii. Neither Delegate nor any of Delegate's Subcontractors, as applicable, that are or will be fully or partially responsible for Delegate's performance of its obligations under this Attachment H have (A) pled guilty or no contest to or been convicted of any felony involving dishonesty or breach of trust; (B) been excluded from participation in any federal or state-funded health program; or (C) been listed in the Department of Health and Human Services Office of Inspector ("**OIG**") exclusion list or the General Services Administrative ("**GSA**") exclusion list. If the Delegate or any of Subcontractors or downstream entities, as applicable, are listed in the OIG or GSA exclusion lists after the effective date of the Contract, CalOptima shall have the right, in its sole discretion and judgment, to disqualify

the listed person(s) from providing any part of the Delegated Services, or exercise CalOptima's rights to terminate Delegated Services under this Attachment H or to take other remedial steps.

b. **Program Representations:** Delegate warrants that each Delegated Service shall meet or exceed: (a) all CalOptima standards, policies, and procedures outlined in this Attachment H and CalOptima Policies, including the provider manual(s); (b) all Standards and Requirements applicable to Delegated Service; and (c)NCQA standards. In the event CalOptima or an accrediting organization's standards or any laws and regulations are materially changed or revised, Delegate agrees to comply with or implement, as applicable, and to the satisfaction of CalOptima, any such change or revision within the earlier of sixty (60) calendar days of receiving notice of such change or within such time frame as may be required by the accrediting organization, applicable laws and regulations, or CalOptima. The parties agree any such change or revision shall not be considered a change to a material term of this Attachment H, consistent with Section 2(a).

c. **Incentives:** Delegate further represents and warrants that as of the Effective Date and throughout the term of the Contract compensation, incentives or remuneration to persons performing such functions under this Attachment H shall not be based, directly or indirectly, on the quantity, frequency or percentage of or in any way relating to denials of Covered Services.

d. **Compliance - Government Programs:** Delegate shall (and shall cause its Subcontractors and downstream entities, as applicable) to institute, operate, and maintain an effective compliance program to detect, correct, and prevent the incidence of non-compliance with applicable state and federal regulatory requirements and the incidence of fraud, waste, and abuse. Such compliance program shall be appropriate to Delegate's, and, as applicable, Subcontractors and downstream entity organization and operations and shall include: (a) written policies, procedures, and standards of conduct articulating the entity's commitment to comply with Standards and Requirements, as well as providing mechanisms for employee/Subcontractor use in adhering to expectations regarding the reporting of potential non-compliance or fraud, waste, and abuse issues (internally and to CalOptima, as applicable); (b) for all officers, directors, employees, Subcontractors, agents, and downstream entities of Delegate, as applicable, required participation in effective compliance and anti-fraud training and education (this required training includes general compliance and fraud, waste and abuse training completion and code of conduct dissemination, initially within ninety (90) days of hire/contracting and at least annually after that; Delegate and Subcontractors and downstream entities, as applicable, may use CalOptima's code of conduct and training or an equivalent approved by CalOptima); and (c) processes to oversee and ensure compliance with these requirements.

e. **Notice of Adverse Action:** Delegate agrees to notify CalOptima promptly of: (a) any litigation brought against Delegate related to any Delegated Service or similar services provided by Delegate to other persons; (b) any actions taken or investigations initiated by any government agency involving Delegate or any entity in which Delegate holds more than a five percent (5%) interest; or (c) any legal actions or investigations, or notice thereof, initiated against Delegate by governmental agencies or individuals regarding fraud, abuse, false claim, or kickbacks. Upon CalOptima's request, Delegate agrees to provide all known details of the nature, circumstances, and disposition of any suits, claims, actions, investigations, or listings to CalOptima.

f. **Standard Operating Hours:** Delegate attests to standard operating hours for all contracted lines of business and all Delegated Services in this Attachment H.

4. **Rights and Obligations of CalOptima**

a. **Oversight:** Delegate agrees to allow and cooperate with CalOptima to maintain oversight of the Delegated Services, including, but is not limited to:

i. **Annual Audits:** Delegate shall allow CalOptima to conduct annual audits and/or review of Delegated Services upon thirty (30) calendar days' prior written notice or upon shorter notice in the event CalOptima determines a shorter period is necessary to ensure CalOptima or Delegate's compliance with Standards and Requirements. Cooperation with an annual audit shall include permitting CalOptima to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to delegated services performed by Delegate and any subdelegate, downstream or offshore entity, as applicable.

ii. **Corrective Action Plan:** If CalOptima has reason to believe Delegate failed to carry out a delegated service per the terms of this Attachment H or CalOptima's performance expectations, CalOptima will require the Delegate to submit, within a specified timeframe, a corrective action plan ("**CAP**") to address any compliance or other problems identified by CalOptima. Once the CAP is approved by CalOptima, Delegate will be required to implement, within ten (10) business days, or as designated by CalOptima, the approved CAP and permit increased audits of Delegate's performance to ensure compliance with such CAP. CalOptima may take further remediation actions as outlined in Section 14.

iii. **External Audits:** Delegate shall allow and cooperate with CalOptima or CalOptima's designated agent(s), federal, state, and local governmental authorities having jurisdiction, and any applicable accrediting organization to audit, interview staff, and access view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services during regular business hours upon at least thirty (30) calendar days' prior written notice, or upon shorter notice if CalOptima determines a shorter period is necessary to ensure CalOptima's compliance with Standards and Requirements. Any such audit shall be permitted during the term of this Attachment H and for six (6) years thereafter (or longer if required by law), with Delegate and CalOptima responsible for their own expenses incurred related to such audit. This Section 4(a)(iii) shall survive the termination of the Contract, regardless of the cause of termination.

iv. **Onsite Monitoring:** Delegate shall permit and cooperate with CalOptima or CalOptima's designated agent(s), federal, state and local governmental authorities having jurisdiction, and any applicable accrediting organization to conduct routine and non-routine on-site visits and monitoring at any site at any time where the Delegate performs Delegated Services under the terms of this Attachment H with five (5) business days' advance notice for routine monitoring and one (1) day notice for non-routine monitoring (or upon shorter notice as required by Standards and Requirements). Cooperation with on-site monitoring shall include allowing CalOptima or CalOptima's designated agent(s), federal, state and local governmental authorities having jurisdiction, and any applicable accrediting organization, to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services.

v. **Accreditation Review:** Delegate shall permit and cooperate with NCQA to conduct on-site review of any documents related to services provided by Delegate under this Attachment H during a health plan accreditation survey of CalOptima by NCQA or other accrediting organization. Cooperation with such NCQA or other accrediting organizations,

on-site review, and accreditation survey shall include permitting NCQA or other accrediting organizations to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services.

vi. **Authority over Delegated Services:** CalOptima retains discretionary authority over all Delegated Services, including final decision-making and the operation thereof.

5. **Records and Confidential Information**

   a. **Records:** Delegate agrees to retain Delegated Services records for the longer of ten (10) years following the date of service or the period required by Standards and Requirements. Delegate agrees to provide CalOptima or CalOptima's designated agent(s), federal, state, and local governmental authorities having jurisdiction, and any applicable accrediting organization, access to all delegated services records during regular business hours. This record retention provision (Section 5) shall survive the termination of the Contract regardless of the cause giving rise to the termination.

6. **Reporting:** Delegate shall provide Delegated Service reports via electronic submission to CalOptima's delegation oversight representative, as follows:

   a. As outlined in the Schedules A, B, C and D, as applicable.

   b. All other reports as required by CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting and the Report Binder.

   c. CalOptima shall provide Member experience data to Delegate on an on-going basis. Member experience data shall be provided at least annually and include complaints, results of Member satisfaction surveys (such as CAHPS), and results of focused studies.

   d. Delegate shall provide clinical performance data monthly or upon request and shall include HEDIS measure rates, HEDIS member-detail care gap reports, and other clinical data. Data shall be provided on Delegate's assigned secure file transfer protocol site.

7. **Conflicting or Overlapping Standards and Requirements:** If one or more regulatory or accreditation bodies have Standards or Requirements that create conflict or overlap, Delegate shall comply with the most stringent applicable Standards and Requirements for each Delegated Service. If Delegate is unsure of which standards may apply in a given situation, Delegate should contact healthnetworkdepartment@caloptima.org.

8. **Claims Delegation:**

   a. Timely Adjudication of Claims:

      i. Except for OneCare Member claims, Delegate will process claims from and pay Providers in compliance with timeliness requirements outlined in Standards and Requirements, including, without limitation, California Health and Safety Code Section 1371, 28 CCR Sections 1300.71 and 1300.77.4.

      ii. For Medi-Cal Members, Delegate shall also comply with DHCS standards.

      iii. For OneCare members, Delegate shall comply with federal laws and regulations applicable to Medicare organizations.

      iv. If Delegate delegates to a Subcontractor (*e.g.*, management company, claims administrator, subcontracted capitated provider) the obligation to process claims on Delegate's behalf, then Delegate shall: (A) notify CalOptima of such delegation in advance, and (B) require

the Subcontractor to comply with the claims processing procedure requirements in this Attachment H and Standards and Requirements.

b. **Claims Forwarding**: If Delegate receives a claim for services provided to a Member and the claim is the financial responsibility of CalOptima or another health plan, Health Network, or Provider, Delegate shall timely forward the claim to CalOptima or the applicable health plan, Health Network, or Provider within ten (10) working days pursuant to 28 CCR Section 1300.71(b)(3).

c. **Failure to Make Payment:** Notwithstanding anything in this Attachment H, if Delegate fails to pay a Provider for Covered Services under the delegate's financial responsibility within the time frames outlined in this Attachment H and Standards and Requirements, (allowing for permissible disputes and appeals) and CalOptima reasonably determines that such amount is due and payable by Delegate, CalOptima may, after providing no fewer than ten (10) business days' prior written notice to Delegate, pay the amount due and deduct and offset such payment from any amount then or thereafter payable by CalOptima to Delegate.

9. **Utilization Management Delegation:** Delegate will maintain a well-structured and documented utilization management ("**UM**") program and will make UM decisions in a fair, impartial, and consistent manner, consistent with all Standards and Requirements, including CalOptima's UM program, and this Contract.

a. Timely Decisions Made by Appropriately Licensed Professionals: Delegate will process UM requests in accordance with Standards and Requirements timelines for pre-service, concurrent, urgent, and post-service requests. The UM decisions will be made by appropriately licensed professionals and based upon all relevant clinical information.

b. **Member and Provider Notification:** Delegate will provide verbal, electronic and/or written UM denial notices to Members and treating Providers within Standards and Requirements timelines. Such notices will be written in using sixth (6^{th}) grade language, contain the specific protocol, benefit provision, and/or guideline that is the basis for denial, and include detailed instructions for appealing the UM decision. Further, Provider notices shall contain the name and direct telephone number, if available, or a general number and extension of the UM denial decision maker.

c. UM System Controls: At all times, Delegate shall maintain detailed policies and procedures in its UM system controls that meet all Standards and Requirements. The UM system controls will define date(s) of receipt and notification, document the process for recording dates, specify authority to modify dates, define system tracking of modifications to dates, and describe how compliance with system policies and procedures are monitored and enforced.

10. **Credentialing Delegation:** Delegate will maintain a well-structured and documented credentialing program for evaluating and selecting licensed Providers to provide care to Members that comply with all Standards and Requirements and this Contract.

a. **Credentialing Committee:** Delegate will operate a Credentialing Committee comprised of Participating Providers that makes recommendations regarding credentialing and re-credentialing Providers. Delegate will further ensure that credentialing files received from Providers that meet established credentialing or recredentialing criteria are reviewed and approved by Delegate's medical director, designated physician, or Credentialing Committee.

b. **Timely Verification and Recredentialing:** Delegate will verify information using primary sources within one hundred (180) days of credentialing, or within a shorter timeframe if required by Standards and Requirements, to ensure Providers have the legal authority and relevant training and experience to provide quality care. Delegate will recredential Participating Providers within thirty-six (36) months of their prior credentialing/re-credentialing approval date.

c. **Actions Against Providers:** Delegate will maintain policies and procedures for taking actions against Providers for violations of applicable standards and regulations that include the range of actions available to the Delegate and how Delegate makes appeal processes known to Providers.

d. **Credentialing System Controls**: At all times, Delegate will maintain detailed policies and procedures in its credentialing system controls that meet all Standards and Requirements. The system controls will define how primary source verification information is received, dated, and stored; document authority to modify information; define system tracking of modifications; and describe how compliance with system policies and procedures are monitored and enforced.

e. **Final Network Determination:** CalOptima retains the right to approve, suspend, and terminate individual Practitioners, Providers, and sites from the Delegate's network relative to CalOptima's Medi-Cal and/or OneCare program(s), even if CalOptima delegates credentialing and recredentialing decision-making to Delegate. CalOptima has the right to make the final determination of such participation in Delegate's network as it relates to CalOptima programs.

11. **Case Management Delegation:** Delegate will maintain a well-structured and documented case management program for members with multiple and/or complex health care conditions consistent with Standards and Requirements and this Contract.

    a. **Case Management Referral:** Delegate will have multiple referral avenues for Members and will accept referrals from sources including medical management, discharge planning, Member, Member's caregiver, and individual Practitioner. Delegate will begin the case management assessment process within thirty (30) days of referral to case management.

    b. **Case Management Process:** Delegate's case management process will address initial assessment of Member's health status, behavioral health status, daily living, and social determinants of health; evaluation of Member's needs, preferences, and limitations; and development of an individualized case management plan for each assigned Member, including ongoing communication strategies.

    c. **Case Management Systems:** Delegate will use a case management system that supports evidence-based, clinical guidelines to conduct assessment and management, automatic documentation of staff activity on case, and automated prompts for follow-up.

12. **Related Requirements**: Delegate will comply with all Standards and Requirements related to all Delegated Services, including, but not limited to:

    a. **New Provider Training**: Delegate will initiate training for all new Participating Providers no later than ten (10) business days from placing a Provider on active status in the network and shall complete the training within thirty (30) calendar days of placing a Provider on active status in the network. This training must include cultural and linguistic requirements, health inequities and identified cultural groups, and language and literacy needs.

13. **Regulatory Fines:** CalOptima and Delegate acknowledge that Delegated Services under this Attachment H are subject to regulation by governmental agencies with jurisdiction over the parties. If Delegate does not or is not able to fulfill any or all its obligations under this Attachment H, and if CalOptima is subject to any fines or fees from a governmental agency as a direct result thereof, Delegate agrees to pay to CalOptima the amount of such fines and any penalties incurred by CalOptima, including any applicable interest paid by CalOptima. CalOptima shall have sole discretion to pay such fees, fines, or penalties and/or to settle or compromise with such governmental agencies.

14. **Remediation for Delay or Failure to Implement CAP and/or Failures that May Cause Harm to Members:** If Delegate delays implementation of a CAP submitted and approved under Section 4(a)(ii), fails to complete a CAP within the timeframe specified in the CAP, or delegation failures that could

jeopardize the health, safety, or welfare of Members, CalOptima may take any of the following remedial measures, in general order of escalation:

a. Freeze Delegate Enrollment and/or Pause Auto-Assignment: CalOptima may freeze enrollment to the Delegate, through pausing auto-assignment of Members, or disallowing Member selection to the Delegate, or both.

b. **Withhold Quality, Shared Savings, or Incentive Payments:** CalOptima may withhold or delay any applicable quality or other incentive payments or shared savings payments until the CAP is fully implemented or Delegate's failure is fully cured, as determined by CalOptima in its sole discretion.

c. **Financial Penalties/Monetary Sanctions**: CalOptima may impose financial penalties/monetary sanctions if a Delegate fails to complete a CAP within the timeframe specified or demonstrates other failures impacting Member health, safety, or welfare:

i. Per Member sanctions of $25,000 per Member:

1. Delegate fails to provide medically necessary services that the Delegate is required to provide.
2. Delegate inappropriately delays/denies Covered Services.
3. Delegate fails to appropriately resolve a Member appeal consistent with Standards and Requirements.
4. Delegate incorrectly charges premium or unnecessary out-of-pockets costs.
5. Delegate inaccurately or untimely provides plan benefit information (*e.g.*, wrong denial notices).

ii. Aggregate sanctions for failures that impact populations of Members

1. One percent (1%) off the monthly capitation amount for a first violation.
2. Two percent (2%) off the monthly capitation amount for a second violation.
3. Three percent (3%) off the monthly capitation amount for each subsequent violation.

iii. Per determination: If CalOptima does not have the Member-specific data or the per Member impact cannot be clearly analyzed, CalOptima may calculate the penalty under the per determination basis.

iv. Delegate may appeal a financial penalty or monetary sanction through CalOptima's appeal process outlined in CalOptima Policy.

d. **Use of a Monitor at Expense of Delegate:** In cases of continued non-compliance or failures that could jeopardize the health, safety, or welfare of Members, CalOptima may require the Delegate to engage and pay for an external auditor or other consultant acceptable to and approved by CalOptima, in order to correct the identified deficiency(ies) or areas of non-compliance, to CalOptima's satisfaction.

e. Modification of Delegation: If, for any reason, CalOptima or any state or federal governmental agency with jurisdiction is dissatisfied with the performance of the Delegated Services, CalOptima may, upon written notice to Delegate, modify Delegate's status (concerning all or a particular Delegated Service) from "fully delegated" to "delegated with corrective action." Such notice shall set forth the deficiencies perceived by CalOptima and/or any state or federal governmental agency

in Delegate's performance of Delegated Services. If Delegate does not correct such deficiencies to the reasonable satisfaction of CalOptima and/or the governmental agency within ninety (90) days of such notice (or a shorter timeframe as determined by CalOptima in its reasonable discretion), CalOptima may, in its sole discretion, (a) extend the period given to Delegate to correct such deficiencies; (b) terminate all or any portion(s) of the delegation to Delegate; or (c) terminate this Attachment H.

f. **Termination of Delegation with Notice:** Notwithstanding Section 14(e), CalOptima may, upon sixty (60) days' prior written notice to Delegate, terminate all or any portion(s) of the delegation to Delegate if, after consulting with Delegate, CalOptima or any state or federal governmental agency determines that Delegate (i) no longer meets all criteria for performance of the Delegated Service(s), or (ii) is not performing, or is not reasonably likely to perform, the Delegated Service(s) in full compliance Standards and Requirements. If, within such sixty (60)-day notice period, Delegate cures such deficiencies to CalOptima's reasonable satisfaction, CalOptima may withdraw such termination.

g. **Immediate Termination of Delegation:** Notwithstanding Sections 14(e) and 14(f) of this Attachment H, CalOptima may, upon prior written notice, immediately terminate all or any portion(s) of the delegation to Delegate of the delegated service(s) if, after consulting with Delegate, CalOptima or any Government Official reasonably determines that the continued performance of the Delegated Service(s) by Group would jeopardize the health, safety, or welfare of members assigned to Delegate under this Attachment H. Such de-delegation shall terminate when Delegate demonstrates to the satisfaction of CalOptima that members' health, safety, or welfare is no longer in jeopardy.

h. **Material Breach**: Delegate agrees that Delegate's failure to agree to or begin reasonable implementation of a CAP designed to correct identified deficiencies in Delegated Services under this Attachment H shall be considered a material breach of the Contract. Additionally, Delegate agrees that Delegated Services failures that could jeopardize the health, safety, or welfare of Members shall be considered a material breach of the Contract. Any such material breach of this Attachment H shall permit CalOptima to implement or engage in any or all oversight or other CalOptima rights and obligations described in the Contract, including under Section 13.

15. **Termination of Delegation (De-Delegation):** In the event CalOptima terminates delegation, or assumes all or any portion(s) of the Delegated Service(s) under this Attachment H, the following provisions shall apply:

    a. **CalOptima's Assumption of Payment of Claims:** If Delegate's claims procedures fail to comply with the obligations outlined in Schedule A of this Attachment H, CalOptima may, as required or permitted by Standards and Requirements, assume responsibility for the processing of claims that are Delegate's financial responsibility under this Attachment H. Such assumption may be altered to the extent Delegate has established and fully implemented an approved CAP consistent with California Health and Safety Code Section 1375.4(b)(4) and 28 CCR § 1300.75.4.8.

    b. **Capitation reduction for de-delegation:** Upon termination or assumption by a CalOptima of all or any portion(s) of a Delegated Service pursuant to this Attachment H, CalOptima may, in its sole discretion, reduce the net monthly Capitation Payment otherwise payable to Delegate by the percentage set forth below. Such amounts are not intended to represent the portion of the Capitation Payment allocated to cover the cost of performance of the Delegated Service(s) by Delegate nor an estimate of the costs incurred by CalOptima as a result of the termination of the delegation; rather,

the amounts set forth below are intended as a performance fee for Delegate's failure to meet the standards established for performance of the Delegated Service.

	Medi-Cal	OneCare
Utilization Management/ Case Management	3.0%	3.0%
Credentialing	1.0%	1.0%
Claims Processing		
- non-contracted only	1.0%	1.0%
- all claims	7.0%	7.0%
- non-contracted only payment withhold *	8.5%	8.5%
- all claims payment withhold	85.0%	85.0%

* = Subject to actual claims paid experience.

c. **Obligation to Cooperate:** Upon termination of the Contract for any reason, Delegate agrees to cooperate fully with CalOptima and comply with CalOptima procedures, if any, in the transfer of Delegate's obligations under this Attachment H to CalOptima or another CalOptima delegate. Delegate agrees to promptly provide CalOptima with any and all information and documentation necessary for such transfer. This shall include copies of all Delegated Services notes and accompanying records and information submitted by Providers as requested by CalOptima.

Schedule A

Claims Payment Delegation

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Claims policies, procedures, and compliance	[insert LOB]	1. Annually submit updated, reviewed, and approved claims payment policies and procedures. 2. Provide oversight to any Subcontractors and subdelegated entities that perform claims processing or payment to ensure compliance with Standards and Requirements. 3. Submit all required reports and audit materials, as defined in Schedule A.	1. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 2. Review all required reports timely and provide substantive feedback.	Submitted to CalOptima's Delegation Oversight Committee ("Delegation Oversight") as part of the annual audit: 1. Updated, reviewed, and approved claims processing policies and procedures. 2. Evidence of oversight of Subcontractors and subdelegates	Annual audit, or more frequently as needed, using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare line of business ("LOB"). Delegate must meet at a minimum 95% compliance for each LOB.	1. CAP 2. Remediation steps outlined in Section 14
Claims processing		1. Identify and acknowledge electronic claims within two (2) working days of receipt. 2. Identify and acknowledge paper claims within fifteen (15) working days of receipt. 3. For Medi-Cal claims, process and adjudicate ninety percent (90%) of all Clean Claims for Covered Services	1. Annual claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute	Submitted via monthly XML process: 1. Claims XML Universe 2. Claims Universe Case Files	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit	1. CAP 2. Remediation steps as outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		within thirty (30) calendar days of receipt. 4. For OneCare claims, process and adjudicate ninety-five percent (95%) of Clean Claims for Covered Services within thirty (30) calendar days of receipt. a. Process and adjudicate all other Clean Claims from non-Participating Providers for Covered Services within sixty (60) calendar days from date of receipt. b. Process and adjudicate ninety-nine percent (99%) of all Clean Claims from Participating Providers for Covered Services within ninety (90) calendar days of receipt	Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	3. Claims Timeliness Report 4. DHCS Post-Payment Recovery Report (Medi-Cal Only)	Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	
Exclusion and preclusion monitoring		1. Verify Practitioner or Provider entity participation status prior to adjudicating any received claims as required by CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring 2. If Delegate pays a claim from an excluded Practitioner or Provider entity, Delegate must notify CalOptima, recover the payment, and prevent future payments to the excluded Provider.	1. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	1. Quarterly overpayment report outlined in reporting binder		1. CAP 2. Remediation steps as outlined in Section 14
Interest payment for late paid claims		Medi-Cal:			Annual audit, or more frequently as needed, using	1. Corrective Action Plan (CAP)

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		1. Pay interest and applicable penalties on all uncontested claims not paid within forty-five (45) business days. 2. For emergency services, automatically include the greater of fifteen dollars ($15) for each twelve (12)-month period (or portion thereof) on a non-prorated basis, or interest at the rate of fifteen percent (15%) per year for the period of time the payment is late. 3. For all other late payments, include interest at the rate of fifteen percent (15%) per year for the period of time the payment is late. 4. If Delegate fails to include the interest due on a late claim payment, the Delegate shall pay an additional ten-dollar ($10) penalty. OneCare: 1. Interest shall begin to accrue on the thirty-first (31st) calendar day for non-Participating Provider, non-Clean Claims, and (61st) calendar days for Participating Provider Clean Claims, calculated based on calendar days. 2. Delegate shall pay interest at the rate used for Section 3902(a) of Title 3l, U.S. Code and rounded to the nearest penny. The interest rate is determined by the applicable rate on the day of payment.			NCQA Methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum 95% compliance.	2. Remediation steps as outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		Interest shall be calculated using the following formula: a. [Payment Amount x Rate x Days] divided by [365 (366 in a leap year)] = Interest Payment				
Coordination of benefits		1. Have processes and procedures in place to identify payers that are primary and secondary to determine amounts payable and coordinate benefits for members with other health coverage ("OHC"), in accordance with Medicare and Medi-Cal crossover claims guidelines. 2. If a Member has OHC, consider the OHC plan as primary. 3. If a Member has both Medicare and OHC, both Medicare and OHC shall pay claims for services prior to Delegate. 4. Remain the secondary health plan and payer of last resort. 5. Identity and report to CalOptima any OHC or other private or public health insurance for Members 6. Identify and report to CalOptima any explanation of payment ("EOP") or explanation of medical benefits ("EOMB") received with other coverage payment	1. Annual claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	1. Monthly Post Payment Recovery Template	Policy review as part of annual audit	1. CAP 2. Remediation steps outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Third party liability		1. Notify CalOptima within five (5) calendar days of becoming aware of potential third-party liability (including casualty insurance, tort, workers compensation liability) related to Covered Services for a Member. 2. Make no claim for recovery of the value of covered services in an instance of Third Party Liability in which the DHCS has lien rights.	1. Annual claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	1. Report occurrences consistent with CalOptima Health Policy FF.2007: Reporting of Potential Third Party Liability	Policy review as part of annual audit	1. CAP 2. Remediation steps outlined in Section 14
Level 1 Provider dispute resolution		1. Acknowledge receipt of electronically submitted Level 1 disputes within two (2) working days; acknowledge receipt of hard-copy disputes within fifteen (15) working days. 2. Resolve Level 1 provider disputes or amended disputes related to claims payment decisions within forty five (45) days.			Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for	1. CAP 2. Remediation steps outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
					OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	

Schedule B

Utilization Management Delegation

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
UM Program policies, procedures, and compliance	[insert LOB]	1. Annually submit updated, reviewed, and approved written UM Program documentation outlining the structure, scope, responsible parties, criteria, timelines, policies, procedures, and processes that meet all Standards and Requirements. 2. Conduct an annual evaluation of the UM Program that verifies the program meets all Standards and Requirements, ensures all UM decisions are made by qualified professionals, evaluates the appropriateness of UM criteria, assesses the interrater reliability, ensures the criteria are consistently applied and available to Providers, and ensures all denials are reviewed by a physician or other appropriate professional. 3. Provide oversight to any Subcontractors and/or subdelegated entities that perform UM to ensure compliance with Standards and Requirements. 4. Submit all required reports and audit materials timely.	1. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 2. Review all required reports timely and provide substantive feedback.	Submitted via FTP: 1. Annual UM Program and Workplan 2. Semi-Annual Work Plan 3. Annual UM Evaluation 4. Annual UM Evaluation (Prior year) 5. All required documents for Annual Audit pursuant to the CalOptima Reporting Policy.	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB.	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
UM decision timeliness		Comply with all Standards and Requirements for notification of UM decisions, including CalOptima Health Policy GG.1508: Authorization and Processing of Referrals. Further, Delegate will make UM decisions in a timely manner and notify Providers and Members electronically or in writing: 1. Urgent concurrent and preservice decisions within seventy-two (72) hours of request 2. Medi-Cal non-urgent pre-service decisions within five (5) working days from receipt of information reasonably necessary to render a decision, but no longer than fourteen (14) calendar days of request. 3. OneCare non-urgent pre-service decisions within fourteen (14) calendar days of request 4. Post-service decisions within thirty (30) calendar days of request	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	Submitted via monthly XML process: 1. Utilization Management (UM) XML Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14
UM decision clinical information		1. Gather and use all clinical information relevant to the Member's care when making UM decisions 2. Adhere to policies set forth in CalOptima Health Policy GG.1535:	1. Annual UM Program audits, or as often as necessary, and ongoing	Submitted via XML: 1. Utilization Management (UM) XML Universe	Annual audit, or more frequently as needed using NCQA methodology	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		Utilization Review Criteria and Guidelines	performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	
Written notification of UM denials and appeal rights		Delegate shall comply with all Standards and Requirements for written notification applicable for Medi-Cal or an integrated denial notice applicable for OneCare, including CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. Delegate shall use a readability scoring tool and ensure notices for Members do not use language exceeding a sixth (6^{th})-grade level. Further, written or electronic notification of UM denials for Members and Providers must include the following:	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	Submitted via XML: 1. Utilization Management (UM) XML Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		1. The specific reason for the denial in easily understood language. 2. A reference to the benefit provision, guideline, protocol or other similar criteria upon which the denial is based. 3. A statement that the Member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criteria on which the denial decision is based, upon request. 4. The Provider notice must be addressed to the requesting Provider (not organization) and include the name and direct telephone number, if available, or general number and extension of the decision maker 5. A description of appeal rights, including the right to submit written comments, documents or other relevant information. 6. An explanation of the appeal process, including Members' rights to representation and time frames 7. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials a. Timeframe for filing b. Timeframe for decision	3. Review all required reports timely and provide substantive feedback.		ninety-five percent (95%) compliance	

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		c. Process for expedited appeal, including where to direct appeal and what information to include 8. Notice that expedited external review can occur concurrently with internal appeals process for urgent care				
UM system controls		Delegate will maintain policies and procedures in its UM system controls that meet all NCQA requirements and: 1. Define date of receipt consistent with NCQA requirements 2. Define date of notification consistent with NCQA requirements 3. Describe process for recording dates in system 4. Specify titles/roles of staff authorized to modify dates once initially recorded and circumstances when modifications are appropriate 5. Specify how the system tracks: a. Date modifications b. When the date was modified c. Who modified the date. d. Why the date was modified. 6. Describe system controls to protect data from unauthorized modification	1. Pre-delegation system review. 2. Annual review of delegate system policies and system control report. 3. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 4. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 5. Review all required reports	All required documentation for annual audit pursuant to the CalOptima Health Reporting Policy HH.2003: Health Network and Delegated Entity Reporting, including the CalOptima Timely and Appropriate Submission Grid and Supplemental Attachment	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		7. Describe how compliance with policies and procedures are monitored at least annually and how Delegate takes appropriate action when applicable 8. At least annually, monitors compliance with UM system controls by: a. Identifying and analyzing all modifications to dates that did not meet established policies and procedures. b. Acting on all findings and implementing a quarterly monitoring process until improvement is demonstrated for one finding over three (3) consecutive quarters.	timely and provide substantive feedback.			
Level 1 Provider dispute resolution		1. Process and resolve Level 1 Provider disputes related to post-service UM decisions according to Standards and Requirements, including CalOptima Policies	1. Annual audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements	Submitted via XML: 1. UM Retrospective Post-Service Decision Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
			for delegated activity. 3. Review all required reports timely and provide substantive feedback.		OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	

Schedule C Case Management Delegation

Delegated Case Management Activity	**Line of Business**	**Delegate Responsibility**	**CalOptima Responsibility**	**Reporting**	**Performance Evaluation**	**Remediation**
Case management activities		1. [List of CM activities delegated as of date of the Attachment H] 2. Changes necessary to comply with new/revised laws and regulations or new/revised accreditation standards and Requirements will not be considered a change to a material term of this Attachment H requiring approval by either party	1. [List of CM activities retained by CalOptima]	N/A	N/A	N/A
Case management policies, procedures, and compliance	[insert LOB]	1. Annually submit updated, reviewed, and approved written Case Management ("CM") program documentation outlining the structure, scope, responsible parties, criteria, timelines, policies, procedures, and processes that meet all Standards and Requirements. CM program shall include basic care management, care coordination, complex care management services, and transitional care services. The CM program shall include care management of OneCare Members, EPSDT, children with special health care needs, early intervention services, care transitions, and whole-child model. 2. Conduct an annual evaluation of the CM program that verifies the program meets all Standards and Requirements, ensures the appropriate identification,	1. Pre-delegation reviews. 2. Annual CM program audits, or as often as necessary. 3. Quarterly case file audits. 4. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 5. Review all required reports timely and provide.	All required documentation for CM program annual audit Submitted via FTP: 1. Monthly Case Management Log 2. Quarterly case files as identified by CalOptima	Annual policy review or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet ninety-five percent (95) Quarterly case file review	1. CAP 2. Remediation steps outlined in Section 14

Delegated Case Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		stratification, and management of members. 3. Provide oversight to any subdelegated entities, vendors, or consultants that perform CM to ensure compliance with Standards and Requirements. 4. Submit all required reports and audit materials timely.	substantive feedback if appropriate.		Delegate must meet minimum of 75% compliance for two consecutive quarters. Score is the combined percentage of each audited case across all applicable line of business	
Case management program referral		Delegate identifies Members with multiple or complex health care conditions, obtains access to care, and coordinates their care. Delegate has multiple referral programs (including but not limited to): 1. Medical management 2. Discharge planning 3. Member or caregiver 4. Practitioner	1. Pre-delegation reviews. 2. Conduct quarterly case file reviews or as often as necessary. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	Submitted via FTP: 1. Monthly Case Management Log 2. Quarterly case files as identified by CalOptima	Quarterly case file review, or more frequently as needed, using NCQA Methodology Delegate must meet minimum of 75% compliance for two	1. CAP 2. Remediation steps outlined in Section 14

Delegated Case Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
			4. Review all required reports timely and provide substantive feedback if appropriate.		consecutive quarters. Score is the combined percentage of each audited case across all applicable line of business.	
Case management systems		Delegate uses a CM system that supports: 1. Evidence-based clinical guidelines to conduct initial assessment and ongoing management. 2. Automatic documentation of date, time and individual who takes action on a case or interacts with a Member. 3. Automated prompts for follow-up	1. Pre-delegation reviews. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	All required documentation for CM program annual audit		1. CAP 2. Remediation steps outlined in Section 14

Schedule D Credentialing Delegation

Delegated Credentialing Activity	**LOB**	**Delegate Responsibility**	**CalOptima Responsibility**	**Reporting**	**Performance Evaluation**	**Remediation**
Credentialing policies, procedures, and compliance		Annually, Delegate will submit updated, reviewed, and approved written Credentialing Program documentation outlining the credentialing process for evaluating and selecting licensed Providers to provide care to Members that comply with all Standards and Requirements and CalOptima contract provisions. The program documentation must specify: 1. Types of Providers to credential and recredential. 2. Verification sources. 3. Criteria for credentialing and recredentialing. 4. Process for making credentialing or recredentialing decisions. 5. Process for managing credentialing files. 6. Non-discrimination policies and procedures. 7. Process for communication with Providers in the credentialing process and for notifying Providers within sixty (60) calendar days from the Credentialing Committee's decision, including informing Providers of the rights to review information about their application, correct errors, and check status of application.	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.	Submitted to Delegation Oversight annually via the audit process: 1. Credentialing program documentation	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		8. Roles and direct responsibility of Delegate's Medical Director or other designated physician in the Credentialing Program. 9. Confidentiality policies and procedures. 10. Policies and procedures designed to ensure accuracy of provider directories. 11. How Delegate considers Provider performance during recredentialing, including but not limited to, Member complaints/grievances. 12. For the Medicare LOB, ensure participating physicians haven't opted out of Medicare. 13. For the Medi-Cal LOB, ensure all Providers are confirmed as screened and enrolled for participation in Medi-Cal where there is an enrollment pathway. 14. Prevents credentialing of Providers that employ or contract with Providers, that have been excluded or sanctioned by Medicare or Medi-Cal or are excluded on any other state or federal exclusion, sanction, restriction or preclusion list. 15. Demonstrates compliance with CalOptima policies regarding credential all provider types GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment				

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		and Reassessment of Organizational Providers.				
Credentialing Committee		Delegate will operate a Credentialing Committee that makes recommendations regarding credentialing and re-credentialing decisions: 1. Committee is comprised of Participating Providers. 2. Reviews credentials for Providers who do not meet thresholds established by the Committee. 3. Ensures that files that meet Credentialing Committee-established criteria are reviewed and approved by Delegate's Medical Director, designated physician, or Credentialing Committee.	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.		Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14
Organizational Providers		The Delegate shall assess and approve, initially and in an ongoing manner, Provider organizations. Before the Delegate contracts with an organizational Provider, and for at least every thirty six (36) months thereafter, it:	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as		Annual audit, or more frequently as needed using NCQA methodology	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		1. Confirms that the Provider is in good standing with state and federal regulatory bodies. 2. Confirms that the Provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the Provider is not accredited. 4. Ensures that the Provider is Medi-Cal enrolled, if an enrollment pathway exists.	necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.		for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	
Verification of credentials		Delegate will conduct timely verification within one hundred eighty (180) days of credentialing of information (or a shorter time frame as required by Standards and Requirements) to ensure Providers have the legal authority and relevant training and experience to provide quality care to Members. Delegate will verify credentialing information through primary sources, unless otherwise indicated. 1. All National Provider Identifier (NPI) numbers, where applicable 2. A current and valid license to practice	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements	1. Credentialing Monthly Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		3. A valid DEA or CDS certificate, as applicable 4. Education and training, consistent with Standards and Regulations 5. Board certification status, as applicable 6. Work history 7. History of professional liability claims that resulted in settlements or judgements paid on behalf of practitioner 8. Sanction information: a. OIG b. System for Award Management (SAM) c. Medicare Opt-Out, if applicable d. Medi-Cal Suspended & Ineligible List e. CMS Preclusion List f. DHCS Medi-Cal Restricted Provider Database 9. For Medi-Cal LOB: For primary care Practitioners, Delegate will obtain evidence of passing the DHCS Facility Site Review 10. For Medi-Cal LOB: Delegate shall verify enrollment into the Medi-Cal program. Verification information located at	for delegated activity. 3. Review all required reports timely and provide substantive feedback.		a minimum one-hundred percent (95%) compliance	

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers				
Credentialing applications		Delegate will require Providers to submit a credentialing/re-credentialing application that includes a signed attestation that includes: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use 3. History of loss of license and felony convictions 4. History of loss or limitation of privileges or disciplinary actions 5. Current malpractice insurance coverage 6. The application's accuracy and completeness 7. Hospital admitting privileges at a CalOptima contracted Hospital or if Delegate is financially responsible for Hospital services, a Delegate-contracted Hospital 8. Practice coverage, including names of answering service and covering physicians	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	1. Credentialing Monthly Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps as outlined in Section 14
Recredentialing cycle		1. Delegate will recredential Participating Providers within thirty-six (36) months of their prior approval date.	1. Annual Credentialing Program audits, or as often as necessary, and	1. Credentialing Monthly Universe	Annual audit, or more frequently as needed using NCQA	1. CAP 2. Remediation steps as

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		2. In between recredentialing cycles, Delegate will perform ongoing monitoring and interventions between recredentialing cycles and take appropriate action against Providers when Delegate identifies occurrences of poor quality. Monitoring shall include collecting and reviewing: Medicare and Medi-Cal/Medicaid sanctions or limitations on licensure, complaints, and information of adverse events.	ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	outlined in Section 14
Actions against Providers		1. Delegate has policies and procedures for taking actions against Providers that include the range of actions available to Delegate and how it makes appeal processes known to Providers. These policies and procedures establish that the majority of the appeal panel are peers of the Provider in question, and prohibit Delegate from attorney representation at appeal hearings unless the Provider is also represented. 2. If Delegate takes action against a Provider for quality reasons, Delegate will report the action to the appropriate	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	1. Delegate must report any Business & Professions Code §§ 805 and/or 805.01 actions immediately to CalOptima Quality Improvement Department at MyCredentialingUpdates@caloptima.org	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		authorities and offers a formal appeal process. 3. Delegate will use objective evidence and patient care considerations to decide on altering a Provider's relationship with Delegate if the Provider doesn't meet Delegate's quality standards.	3. Review all required reports timely and provide substantive feedback.		one-hundred percent (95%) compliance	
Identification of HIV/AIDS Specialists		Delegate has policies and procedures for identifying HIV/AIDS Specialists: 1. Documentation describes how the Delegate identifies and annually reconfirms appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist, according to California regulations. 2. Documents that Delegate provides list of qualified Specialists to Delegate's department responsible for authorizing standing referrals	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.	1. Credentialing Monthly Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Credentialing system controls		Delegate has policies and procedures in its Credentialing Program system controls that meet all NCQA requirements and: 1. How primary source verification information is received, dated and stored. 2. How modified information is tracked and dated from its initial verification. a. When modified b. How modified c. Who modified d. Why modified 3. Identifies staff who are authorized to review, modify and delete information and circumstances when modification or deletion is appropriate. 4. Security controls in place to prevent unauthorized modification. a. Limiting physical access to location that houses credentialing information b. Preventing unauthorized access, changes to, and release of credentialing information c. Password-protecting electronic systems, including user requirements, to prevent passwords from being	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.	1. Annual report on monitoring of system controls	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one -hundred percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		compromised and policies and procedures regarding changing or withdrawing passwords if compromised passwords or individuals should no longer have electronic access to the system 5. How Delegate monitors its compliance with its Credentialing System Control policies and procedures at least annually and takes appropriate action when applicable.				
Subdelegation of credentialing		If Delegate subdelegates (subject to CalOptima's prior written approval) credentialing functions to another entity, Delegate will perform oversight of the subdelegated relationship in accordance with all Standards and Requirements, including but not limited to: 1. Using a written delegation agreement including all Standards and Requirements 2. Performing a pre-delegation review 3. Requiring at least semi-annual reporting 4. Having a described process Delegate will use to evaluate subdelegated entity's performance	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide		Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps as outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		5. Describing to subdelegate remedies available to Delegate if subdelegate does not fulfill its obligations	substantive feedback.			

AMENDMENT [XX] TO

CONTRACT FOR HEALTH CARE SERVICES

This Amendment [XX] to the Contract for Health Care Services ("**Amendment**") is effective as of July 1, 2024 ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and, [health network name**]** ("**HMO**"). CalOptima and HMO may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

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

B. The Department of Healthcare Services ("**DHCS**") is implementing a Targeted Rate Increase, as defined further below, and the Parties desire to outline HMO's obligation related to the Targeted Rate Increase.

C. CalOptima and HMO desire to amend the Contract on the terms and conditions set forth herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Add the following new Section 1.112, *Targeted Rate Increase*, to the Contract:

   1.112 "Targeted Rate Increase" or "TRI" means the set of provider rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) as implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. The first phase of TRIs are effective for dates of service beginning January 1, 2024. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates, including HMO and its Subcontractors, must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment previously due to provider. The TRI applies to both fee-for-service and other provider payment arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

2. Add the following new Section 2.7.1.1 to the Contract:

   2.7.1.1 HMO shall evaluate and adjust as necessary its capitation payments to Participating Providers that provide TRI-eligible services to ensure such capitation payments meet the TRI requirements. If adjustment to Participating Provider capitation payments is necessary, HMO shall adjust such capitation payments retroactive to January 1, 2024, no later than December 1, 2024. HMO's reimbursement for TRI-eligible services shall comply with DHCS requirements, Laws, and CalOptima Policies.

3. Add the following new Section 2.7.17.4 to the Contract:

   2.7.17.4. By no later than July 31, 2024, HMO shall implement the DHCS-mandated TRI to its fee-for-service provider payments that qualify for the TRI retroactive to dates of service

rendered on or after January 1, 2024. If adjustment to fee-for-service provider payments is necessary, HMO shall adjust such fee-for-service provider payments retroactive to January 1, 2024, by no later than October 31, 2024. If a rate in an agreement between HMO and a Participating Provider for a TRI-eligible service is less than the Medi-Cal TRI fee schedule, the Medi-Cal TRI fee schedule shall control. HMO's reimbursement for TRI-eligible services shall comply with DHCS requirements, Laws, and CalOptima Policies.

4. Add the following new Section 6.4.13 to the Contract:

6.4.13 HMO agrees that CalOptima may make publicly available, as frequently as CalOptima deems necessary, reports of HMO's compliance with the Contract's requirements and performance metrics, including Members' access to care, the quality of care received by Members, and HMO's other performance trends, as applicable to HMO's obligations hereunder.

5. Add the following new Section 6.4.14 to the Contract:

6.4.14 As long as CalOptima's disclosures under this Section 6.4 otherwise comply with applicable laws, no CalOptima disclosure under this Section 6.4 shall constitute a breach of this Contract.

6. Delete Attachment E, *Capitation Rates,* in its entirety and replace it with new Attachment E, *Capitation Rates,* attached to this Amendment and incorporated into the Contract by this reference, which includes rates for Medi-Cal Members, including Medi-Cal Expansion Members.

7. Delete Attachment E-10, *Funding for Enhanced Care Management (ECM) Services*, in its entirety and replace it with new Attachment E-10, *Funding for Enhanced Care Management (ECM) Services,* attached to this Amendment and incorporated into the Contract by this reference.

8. Delete Attachment G, California Regulatory Requirements, in its entirety and replace it with new Attachment G, California Regulatory Requirements, attached to this Amendment and incorporated into the Contract by this reference.

9. Add to the Contract the new Attachment H, *Delegation Agreement*, which is attached hereto and incorporated into the Contract by this reference. This new Attachment H shall replace and terminate any other prior delegation agreements, including any *Delegation Acknowledgement and Acceptance Agreement*, between the Parties

10. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

11. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern.

12. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

(signature page follows)

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR HMO:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ATTACHMENT E
CAPITATION RATES

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

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child/Adult	00-00 year, Both	[redacted]	[redacted]	[redacted]
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40-64 years, Both			
	65+ years, Both			
Medi-Cal Expansion	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
SPD	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
WCM	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
ESRD	All ages, Both	[redacted]	[redacted]	[redacted]

AIDS	All ages, Both		[redacted]			[redacted]			[redacted]	

Overall Average Capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy. The Parties agree that the above rates compensate HMO for all services outlined in Attachment A, CalOptima Medi-Cal Division of Financial Responsibility, including ongoing compensation for COVID-19 diagnostic and screening testing services. The Parties further agree that future amendments to the Contract increasing the above rates due to a declared public health emergency shall constitute a negotiated and agreed upon new provision to the Contract delegating financial responsibility to HMO to cover the additional Medi-Cal Covered Services required by such declared public health emergency.
Supplemental OB Delivery Care Payment will be payable for all qualified deliveries based on DHCS guidance.

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment - All	[redacted]	[redacted]	[redacted]

ATTACHMENT E-10

Funding for Enhanced Care Management (ECM) Services

CalOptima shall make an ECM Supplemental Payment to HMO for ECM services provided to an ECM Member, in accordance with the terms and conditions of CalOptima Policy FF.4002 and this Attachment.

1. ECM Services Supplemental Payment

   1.1 CalOptima shall pay HMO the ECM Supplemental Payment rate of [redacted] Per Member Per Month for each Member who receives three (3) or more hours of ECM services in a given month as identified by twelve (12) or more units, subject to HMO's compliance with all of the following conditions:

   - Member is identified as an ECM-eligible Member as determined by CalOptima based on DHCS ECM eligibility criteria and in accordance with CalOptima Policy GG.1354;
   - Member is authorized to receive ECM services;
   - Member receives one of the ECM core service components (as set forth in Section 6.23.9.4 of the Contract) in the prior month;
   - HMO bills and reports ECM services to CalOptima consistent with CalOptima Policy FF.4002 and DHCS requirements; and
   - If applicable, the HMO paid the provider delegated by HMO to render ECM services; and the HMO authorized such ECM services.

   1.2 For purposes of this Attachment E-10, the term "**Per Member Per Month**" means an all-inclusive case rate that applies whenever HMO, as the ECM Provider, has provided the minimum level of service payable to an ECM-enrolled Member. This rate is paid on the basis of submitted claims and is not to be considered a capitation payment.

2. HMO shall submit ECM billing data for the ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

3. Upon validation of the ECM billing data and in accordance with CalOptima Policy FF.4002 CalOptima shall pay ninety (90) percent of all clean claims within thirty (30) calendar days of the date of receipt and ninety-nine (99) percent of all clean claims within ninety (90) calendar days of the date of receipt. The date of receipt shall be the date CalOptima receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

4. In addition to Section 9.4 of this Contract, HMO agrees to CalOptima's recovery of any overpayment of ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

ATTACHMENT G
CALIFORNIA REGULATORY REQUIREMENTS

This Attachment G sets forth the Medi-Cal program requirements and other California statutory and regulatory provisions applicable to this Contract. In the event of a conflict between this Attachment G and any other provision in the Contract, the provisions in this Attachment G control.

1. Definitions.

1.1 "**Downstream Subcontractor**" means an individual or an entity that has an agreement with a Subcontractor or a Downstream Subcontractor that includes a delegation of HMO's and Subcontractor's duties and obligations under the Contract.

1.2 "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following: (i) placing the Member's health in serious jeopardy; (ii) serious impairment of bodily functions; (iii) serious dysfunctions to any bodily organ or part; or (iv) death.

1.3 "**Fully Delegated Downstream Subcontractor**" means a Downstream Subcontractor that contractually assumes all duties and obligations of HMO under the Contract, through a Downstream Subcontractor agreement.

1.4 "**Fully Delegated Subcontractor**" means a Subcontractor that contractually assumes all duties and obligations of HMO where HMO has assumed all duties and obligations of CalOptima, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.

1.5 "**Health Equity**" means the reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations.

1.6 "**Laws**" means, without limitation, federal, state, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Attachment G.

1.7 "**Quality Improvement and Health Equity Transformation Program**" or "**QIHETP**" means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in Laws, Government Program Requirements.

2. Compliance with Laws. This Contract shall be governed by and construed in accordance with all Laws and applicable regulations governing the DHCS Contract, including 42 Code of Federal Regulations ("**CFR**") § 438.230; the Knox Keene Act, Health and Safety Code §§ 1340 *et seq*., unless otherwise excluded under the DHCS Contract; 28 CCR §§ 1300.43 *et seq*; Welfare & Institutions ("**W&I**") Code §§ 14000 and 14200 *et seq*.; and 22 CCR §§ 53800 *et seq.*, 53900 *et seq*. HMO will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including all applicable requirements specified in the DHCS Contract, Laws, sub-regulatory guidance, and DHCS All Plan Letters ("**APLs**") and policy letters, and CalOptima Policies. HMO shall comply with all monitoring requirements of the Contract, the DHCS Contract, and any other monitoring requests by DHCS and CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.4), (A.5), (A.11), (B.7), (B.8), and (B.11)]

3. Provider Data. As applicable, HMO and its Subcontractors will submit to CalOptima complete, accurate, reasonable, and timely provider data, Program Data, Template Data, and any other reports or data as requested by CalOptima to meet its reporting requirements to DHCS. HMO shall submit all provider data

to CalOptima in the form, format, and timeframe requested by CalOptima. HMO will make corrections to provider data as requested by CalOptima. HMO data shall include all data required under the Contract – including reports and HMO rosters. For purposes of this section (1) "**Program Data**" means data that includes but is not limited to: Grievance data, Appeals data, medical exemption request denial reports and other continuity of care data, out-of-network request data, and PCP assignment data as of the last calendar day of the reporting month; and (2) "**Template Data**" means data reports submitted to DHCS by CalOptima, which includes, but is not limited to, data of Member populations, health care benefit categories, or program initiatives. [DHCS Contract, Exhibit A, Attachment III, §§ 1.2.5, 2.1.4, 2.1.5, 2.1.6, 3.1.5(A.6) and (B.10)]

4. Encounter Data As applicable, HMO will submit to CalOptima complete, accurate, reasonable, and timely Encounter Data requested by CalOptima in order to meet its reporting requirements to DHCS in compliance with applicable DHCS APLs, including APL 14-020 and any superseding or amendment APLs. All Encounter Data shall be submitted to CalOptima no later than ninety (90) days from the Date of Service in the form and format as designated by CalOptima. HMO will cooperate as requested by CalOptima if corrections to Encounter Data are required for CalOptima to comply with reporting requirements to DHCS. [DHCS Contract, Exhibit A, Attachment III, §§ 2.1.2, 3.1.5(A.6) and (B.10)]

5. Reports. HMO and its Participating Providers agree to submit all reports required and requested by CalOptima to comply with applicable laws in a form acceptable to CalOptima. [DHCS APL 19-001, Attachment A, Requirement 6]

6. California Health and Human Services ("**CalHHS**") Data Exchange. HMO shall (i) execute the CalHHS Data Sharing Agreement ("**DSA**"); (ii) comply with the DSA requirements, including the CalHHS policies and procedures incorporated into the DSA; and (iii) participate in the real-time exchange of, or provision of access to, health information between and among other DSA participants, including CalOptima and any other Participating Providers providing services to Members. [Health & Safety ("**H&S**") Code § 130290]

7. Additional Subcontracting Requirements. If HMO is allowed to subcontract services under this Contract and does so subcontract, then HMO shall, upon request, provide copies of such Subcontracts to CalOptima and/or DHCS.

7.1 Subcontracts for Provision of Covered Services. HMO shall maintain copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Contract. HMO will ensure that such contacts are in writing. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.7)]

7.2 Subcontracts. HMO shall require all Subcontracts and downstream Subcontracts that relate to the provision of Covered Services be in writing and include all applicable provisions of the Contract and this Medi-Cal Program Addendum including:

7.2.1 The 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.

7.2.2 As applicable, Section 2, *Compliance with Laws*; Section 3, *Provider Data*; Section 4, *Encounter Data*; Section 7, *Additional Subcontractor Requirements*; Section 8, *Records Retention*; Section 9, *Access to Books and Records*; Section 10, *Records Related to Recovery for Litigation*; Section 11, *Transfer*; Section 12, *Unsatisfactory Performance*; Section 13, *Hold Harmless*; Section 14, *Prohibition on Member Claims and Member Billing*; Section 15, *Prospective Requirements*; Section 16, *Network Provider Training*; Section 17, *Language Assistance and Interpreter Services*; Section 18, *Fraud, Waste, and Abuse Reporting*; Section 19, *Provider Identified Overpayments*; Section 20, *Health Care*

Provider's Bill of Rights; Section 21, *Provider Grievances*; Section 22, *Effective Dates*; Section 23, *Assignment and Sub-delegation*; Section 24, *Quality Improvement & Utilization Management*; Section 25, *Emergency Services and Post-Stabilization Delegation*; Section 28, *Amendment and Termination*; Section 29, *Delegated Activities*; Section 30, *Utilization Data*; Section 59, *DHCS Beneficiary*; and any other section of this Attachment G that is applicable to the obligations Subcontractor has undertaken.

7.2.3 An agreement that Subcontractors shall notify HMO of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

7.2.4 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 14.12 of the base 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.

[DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.12)]

8. Records Retention. HMO and Subcontractors shall maintain and retain all books and records of all items and services provided to Members, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the DHCS Contract, 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. HMO's books and records shall be maintained within, or be otherwise accessible within, the State and pursuant to H&S Code § 1381(b). 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 agency immediate and direct access and inspection of all such records at the time of any onsite audit or review.

This provision shall survive the expiration or termination of this Contract.

[DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.9) and (B.14); H&S Code § 1381; 28 CCR 1300.81]

9. Access to Books and Records. HMO agrees, and shall ensure its Subcontractors agree in Subcontracts, to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining directly or indirectly to the goods and services furnished under the terms of the Contract available for the purpose of an audit, inspection, evaluation, examination or copying at any time (i) in accordance with inspections and audits as directed by CalOptima, Regulators, the Department of Justice ("**DOJ**"), Office of Attorney General Division of Medi-Cal Fraud and Elder Abuse ("**DMFEA**"), DHCS's External Quality Review Organization contractor, and any other State or federal entity and their duly authorized designees statutorily entitled to have oversight responsibilities over CalOptima and/or HMO and its Subcontractors; (ii) at all reasonable times at HMO's and Subcontractor's respective places of business or at such other mutually agreeable location in the State; and (iii) in a form maintained in accordance with the general standards applicable to such book or record keeping. HMO and Subcontractors shall provide access to all security areas and facilities and cooperate and assist State representatives in the performance of their duties. If DHCS, CMS, DMFEA, or DOJ or any other authorized State or federal agency, determines there is a credible allegation of fraud against HMO, CalOptima reserves the right to suspend or terminate the HMO from participation in the Medi-Cal program; immediately suspend payments to HMO; seek recovery of payments made to HMO or any Subcontractor; impose other sanctions provided under the DHCS Contract, and conduct additional monitoring.

HMO and Subcontractors shall cooperate in the audit process by signing any consent forms or documents required by but not limited to: DHCS, DMHC, the DOJ, Attorney General, Federal Bureau of Investigation,

Bureau of Medi-Cal Fraud, and/or CalOptima to release any records or documentation HMO may possess in order to verify HMO's records.

This provision shall survive the expiration or termination of this Contract and Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 1.3.4(D), § 3.1.5(A.8) and (B.13); Exhibit E, § 1.1.22(B); APL 19-001, Attachment A; APL 17-001]

10. Records Related to Recovery for Litigation. Upon request by CalOptima, HMO shall timely gather, preserve and provide to CalOptima, DHCS, CMS, DMFEA, and any authorized State or federal agency in the form and manner specified by such entity, any information, subject to any lawful privileges, in HMO's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If HMO asserts that any requested documents are covered by a privilege, HMO shall: (i) identify such privileged documents with sufficient particularity to reasonably identify the documents while retaining the privilege; and (ii) state the privilege being claimed that supports withholding production of the document. HMO agrees to promptly provide CalOptima with copies of any documents provided to any party in any litigation by or against CalOptima or DHCS. HMO acknowledges that time is of the essence in responding to such requests. HMO shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by HMO or its Subcontractors related to this Contract or Subcontracts. HMO further agrees to timely gather, preserve, and provide to DHCS any records in HMO's or its Subcontractor's possession. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.10) and (B.15); Exhibit E, § 1.1.27]

11. Transfer. HMO agrees and will require its Subcontractors to assist CalOptima in the transfer of Member care if in the event of: (i) termination of the DHCS Contract for any reason in accordance with the terms of the DHCS Contract; (ii) termination of this Contract for any reason; or (iii) a Subcontract terminates for any reason. Such assistance will include making available to CalOptima and DHCS copies of each Member's medical records and files, and any other pertinent information necessary to provide affected Members with case management and continuity of care. Such records will be made available at no cost to CalOptima, DHCS, or Members. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.11) and (B.16); Exhibit E, § 1.1.17(B)]

12. Unsatisfactory Performance. HMO agrees that the Contract or HMO's participation in the Medi-Cal program will be terminated, or subject to other remedies, if DHCS or CalOptima determine that HMO has not performed satisfactorily. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.12)]

13. Hold Harmless. HMO and its Subcontractors shall accept CalOptima's payment as described in this Contract as payment in full for all Covered Services and Administrative Services. HMO and its Subcontractors agree to hold harmless both the State and Members in the event that CalOptima cannot or will not pay for obligations undertaken by HMO pursuant to this Contract. This provision does not [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.13) and (B.18)]

14. Prohibition on Member Claims and Member Billing. HMO and its Subcontractors will not bill or otherwise collect reimbursement from a Member for any services provided under this Contract. HMO and Subcontractors will ensure that Members are not balance billed for any service provided out of network. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.14), 3.3.6, 5.2.7]

15. Prospective Requirements. CalOptima will inform HMO of prospective requirements added by State or federal law, or DHCS to the DHCS Contract that would impact HMO's obligations before the requirement becomes effective. HMO agrees to comply with the new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by CalOptima or DHCS. HMO will ensure Subcontractors are (i) informed of prospective requirements that would impact their obligations before the requirements become effective and (ii) agree to comply with new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by CalOptima or DHCS. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.15), (B.22), and (B.23)]

16. Network Provider Training. HMO shall participate in training required by CalOptima in order for CalOptima to comply with the DHCS Contract. Such provider training may include, utilization management training, quality of care for children (early periodic screening, diagnosis and testing) training, Member's rights, and advanced directives. Training will also include training on cultural competency and linguistic programs as outlined in this section. HMO shall ensure that all Subcontractors receive all applicable training. [DHCS Contract, Exhibit A, Attachment III, §§ 2.3(F), 3.2.5, 5.1.1, 6.1.3(C)]

16.1 Diversity, Health Equity, Cultural Competency, and Sensitivity Training. HMO shall ensure that annual diversity, Health Equity, cultural competency/humility and sensitivity training is provided for employees and staff at key points of contact, pursuant to the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.16) and (B.24), 5.2.11(C)]

16.2 Cultural/Linguistic Training Programs. HMO shall participate in and comply with any applicable performance standards, policies, procedures, and programs established from time to time by CalOptima and federal and State agencies and provided or made available to HMO with respect to cultural and linguistic services, including attending training programs and collecting and furnishing cultural and linguistic data to CalOptima and federal and State agencies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.11]

16.3 Discharge Planning and Transitional Care Training. HMO will educate its discharge planning staff on the services, supplies, medications, and durable medical equipment requiring prior authorization, and CalOptima's policies regarding discharge planning and transitional care services, as applicable. [DHCS Contract, Exhibit A, Attachment III, § 4.3.10(A.6) and (A.7)]

17. Language Assistance and Interpreter Services. HMO and its Subcontractors will comply with language assistance standards developed pursuant to H&S Code § 1367.04 and the DHCS Contract. HMO agrees to provide or arrange for the provision of interpreter services for Members. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.17) and (B.25), 5.1.3(F)]

18. Fraud, Waste, and Abuse Reporting. HMO shall report suspected fraud, waste, or abuse to CalOptima in accordance with the Contract. HMO agrees to provide CalOptima with all information reasonably requested by CalOptima, DHCS, or other State and federal agencies with jurisdiction in order for CalOptima to comply with fraud, waste, or abuse investigations and reporting requirements. In the course of a fraud, waste, or abuse investigation, CalOptima may share with HMO information that DHCS has disclosed to CalOptima ("**FWA Confidential Data**"). HMO acknowledges and agrees to maintain FWA Confidential Data confidentially. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.2(D), 3.1.5(A.18) and (B.26)]

19. Provider Identified Overpayments. In addition to Overpayment requirements under the Contract, HMO shall report in writing to CalOptima when it has received an Overpayment, identify the reason for the Overpayment, and promptly return the overpayment to CalOptima as outlined within sixty (60) days of the date HMO identified the Overpayment. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.6, 3.1.5(A.19), (B.27)]

20. Health Care Providers' Bill of Rights. Notwithstanding anything in this Contract to the contrary, HMO shall be entitled to the protections of the Health Care Providers' Bill of Rights, as set forth in H&S Code § 1375.7, in the administration of this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.20)]

21. Provider Grievances. HMO has the right to submit a dispute or grievance through CalOptima's formal process to resolve provider disputes and grievances pursuant to H&S Code § 1367(h)(1). CalOptima's process to resolve HMO disputes or grievances are set forth in this Contract and the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.20), 3.2.2(B)]

22. Effective Dates. This Contract and its amendments will become effective only as set forth in the DHCS Contract, which requires filing and approval by DHCS of template contracts and amendments, and Subcontractor and Downstream Subcontractor agreements and amendments. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.2, 3.1.5(B.4)]

23. Assignment and Sub-delegation. HMO agrees that any assignment or delegation of an obligation or responsibility under this Contract by HMO to a Subcontractor shall be void unless prior written approval is obtained from CalOptima and DHCS. HMO further agrees that assignment or delegation by a Subcontractor is void unless prior written approval is obtained from DHCS. CalOptima or DHCS may withhold consent at their sole and absolute discretion. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.5) and (B.6); APL 19-001, Attachment A, Requirement 14]

24. Quality Improvement & Utilization Management. HMO agrees to cooperate and participate in CalOptima's QMI program including participating in QI Program, UM Program, QIHETP, and population needs assessments. [DHCS Contract, Exhibit A, Attachment III, §§ 2.2.4, 3.1.5(B.19)]

25. Emergency Services and Post-Stabilization Delegation.

25.1 Emergency Services and Post-Stabilization Delegation. HMO must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has an agreement with HMO.

25.1.1 HMO must not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR § 438.114(a)(i)-(iii). Further, HMO must not deny payment for treatment obtained when a representative of HMO instructs the Member to seek Emergency Services. Emergency Services must not be subject to prior authorization by HMO.

25.1.2 HMO must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to cover Emergency Services based on the emergency department provider, hospital, or fiscal agent not notifying HMO, the Member's PCP, CalOptima, or DHCS of the Member's screening and treatment for Emergency Services. A Member who has an Emergency Medical Condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Member.

25.2 Non-Contracting HMO Emergency Services Payment.

25.2.1 HMO shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from HMO, or the Member is stabilized sufficiently to permit discharge. The treating provider is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on HMO. Emergency Services shall not be subject to prior authorization by HMO.

25.2.2 At a minimum, HMO must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

25.2.3 For all non-contracting providers, reimbursement by HMO or its Subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered by a non-contracting provider pursuant to this provision shall be made in accordance with the DHCS Contract, 42 USC § 1396u-2(b)(2)(D), W&I Code § 14091.3, and other Laws.

25.3 Post-Stabilization Care Services. Except for response time periods set forth in 42 CFR 422.113(c)(2)(ii) and (iii)(A), HMO will pay for post-stabilization care services in accordance with 42 CFR § 422.113(c) and DHCS APL 23-009 (and any successor guidance). HMO is financially responsible for post-stabilization care services obtained within or outside of HMO's network that are authorized by HMO, Subcontractors, or Downstream Subcontractors.

25.3.1 In accordance with 28 CCR § 1300.71.4, HMO must approve or disapprove a request for post-stabilization care services made by a provider on behalf of a Member within thirty (30) minutes of the request. If HMO fails to approve or disapprove authorization within the required timeframe, the authorization is deemed approved.

25.3.2 HMO is also financially responsible for post-stabilization care services obtained within or outside of HMO's network that are not authorized by HMO, Subcontractor, or a Downstream Subcontractor but administered to maintain, improve, or resolve the Member's stabilized condition if HMO, Subcontractor, Downstream Subcontractor, or a Participating HMO do not respond to a request for authorization within thirty (30) minutes; HMO, Subcontractor, Downstream Subcontractor or Participating HMO cannot be contacted; or HMO, Subcontractor, or Downstream Subcontractor and the treating provider cannot reach an agreement concerning the Member's care. In this situation, the treating provider may continue with care of the Member until HMO, Subcontractor, or Downstream Subcontractor is reached and assumes responsibility for the Member's care or one of the criteria of 42 CFR § 422.113(c)(3) is satisfied.

25.3.3 HMO's financial responsibility for post-stabilization care services it has not authorized ends when a Participating Provider with privileges at the treating hospital assumes responsibility for the Member's care, a Participating Provider assumes responsibility for the Member's care through transfer, HMO's representative and the treating provider reach an agreement concerning the Member's care; or the Member is discharged.

25.3.4 Consistent with 42 CFR §§ 438.114(e), 422.113(c)(2), and 422.214, HMO is financially responsible for payment of post-stabilization care services, following an emergency admission, at the hospital's Medi-Cal FFS payment rates for general acute care inpatient services rendered by a non-contracting, Medi-Cal certified hospital, unless a lower rate is agreed to in writing and signed by the hospital.

25.3.4.1 For the purposes of this Section 25, the Medi-Cal FFS payment amounts for dates of service when the post-stabilization care services were rendered must be the Medi-Cal FFS payment method known as diagnosis-related groups, which for the purposes of this Section 25.3.4 must apply to all acute care hospitals, including public hospitals that are reimbursed under the certified public expenditure basis methodology (W&I Code § 14166 *et seq*.), less any associated direct or indirect medical education payments to the extent applicable.

25.3.4.2 Payment made by HMO to a hospital that accurately reflects the payment amounts required by this Section 25.3.4 shall constitute payment in full, and must not be subject to subsequent adjustments or reconciliations by HMO,

except as provided by Medicaid Laws. A hospital's tentative and final cost settlement processes required by 22 CCR § 51536 shall not have any effect on payments made by HMO pursuant to this Section 25.3.4.

25.4 Emergency Services or Post-Stabilization Claims Disputes. Disputed Emergency Services or post-stabilization care services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 3831 North Freeway Blvd, Suite 200, Sacramento, CA 95834, for resolution under W&I Code § 14454 and 22 CCR § 53620 *et seq*. (except 22 CCR § 53698). HMO agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within thirty (30) calendar days of the effective date of a DHCS decision and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHCS within thirty (30) calendar days shall result in liability offsets in accordance with W&I Code §§ 14454(c) and 14115.5 and 22 CCR § 53702 and may subject HMO to sanctions pursuant to W&I Code § 14197.7.

[DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.9)]

26. Telehealth. When providing any Covered Services through telehealth and subsequently billing for those telehealth Covered Services, Provider Group shall ensure that it complies with all applicable statutory and regulatory requirements, including H&S Code § 1374.13; W&I Code §§ 14132.72, 14132.100, and 14132.725; Business & Professions Code § 2290.5, and DHCS APL 23-007 (and any successor guidance) (collectively "**Telehealth Requirements**"). These Telehealth Requirements include (i) obtaining and documenting Member consent to use telehealth, (ii) ensuring the services can be appropriately delivered via telehealth, (iii) establishing all new patients through telehealth using an approved methodology, (iv) complying with all privacy and confidentiality laws in rendering services, and (v) satisfying the required documentation and coding requirements, as further outlined in CalOptima Policies. Claims for Covered Services provided through telehealth may not be reimbursable under the Contract if Provider Group did not comply with Telehealth Requirements.

27. Electronic Prescriptions. HMO shall ensure that any Participating Providers who may issue prescriptions under Business & Professions Code § 4040(a) have the capacity to prescribe electronically and shall issue electronic prescriptions in accordance with Business & Professions Code § 688.

28. Amendment and Termination. HMO agrees to notify DHCS if this Contract or an agreement with a Subcontractor is amended or terminated for any reason. For purposes of this section, notice is considered given when the notice is properly addressed and deposited in the United States Postal Service as first-class registered mail, postage prepaid. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.17); APL 19-001, Attachment A, Requirement 13]

29. Delegated Activities. If HMO is specifically delegated by CalOptima, delegated activities and reporting requirements will be further set forth in a separate attachment or addendum to this Contract. Such delegation may include, claims processing, utilization management, quality improvement, Health Equity activities, credentialing activities, and any other obligation that CalOptima is permitted to delegated to HMO, to the extent agreed upon between CalOptima and HMO. HMO agrees to perform and will require its Subcontractors to perform the obligations and functions of CalOptima undertaken pursuant to the Contract, including but not limited to reporting responsibilities, in compliance with CalOptima's obligations under the DHCS Contract in accordance with 42 CFR § 438.230(c)(1)(ii). HMO agrees to the revocation of the delegated activities and/or obligations, and/or any other specific remedies in instances where DHCS or CalOptima determine that HMO has not performed satisfactorily. If CalOptima delegates quality improvement activities, the Parties agree that the Contract will include provisions that address, at a minimum: (i) quality improvement responsibilities, and specific delegated functions and activities of CalOptima and HMO; (ii) CalOptima's oversight, monitoring, and evaluation processes and HMO's

agreement to such processes; (iii) CalOptima's reporting requirements and approval processes, including, HMO's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly; and (iv) CalOptima's actions/remedies if HMO's obligations are not met. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.1, 3.1.5(B.1), (B.8), (B.20), and (B.28); APL 19-001, Attachment A, Requirement 22]

30. Utilization Data. If and to the extent that the HMO is responsible for the coordination of care for Members, CalOptima shall share with HMO, in accordance with the appropriate Declaration of Confidentiality signed by HMO and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and HMO shall receive the utilization data provided by CalOptima and use solely for the purpose of Member care coordination. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.21); APL 19-001, Attachment A, Requirement 23]

31. Medical Decisions. HMO will ensure that medical decisions or any course of treatment in the provision of Covered Services by HMO, Subcontractors, or Downstream Subcontractors are not unduly influenced by fiscal and administrative management. [DHCS Contract, Exhibit A, Attachment III, § 1.1.5]

32. Capacity, Licensure, and Enrollment. HMO and its Subcontractors shall furnish to Medi-Cal Members those Medically Necessary Covered Services that HMO and Subcontractor is authorized to provide under this Contract, consistent with the scope of HMO's and/or Subcontractor's license, certification, and/or accreditation, and in accordance with professionally recognized standards. HMO and its Subcontractors agree to comply with required provider screening, enrollment, and credentialing and recredentialing requirements. HMO warrants that it has and shall maintain through the Term adequate staff to comply with its obligations under the Contract and will require. [DHCS Contract, Exhibit A, Attachment III, § 1.3.3]

33. Medi-Cal Enrollment. If HMO is a provider type that is not able to enroll in Medi-Cal through the DHCS, HMO 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 22 CCR § 51000.35.

34. Prohibition Against Payment to Excluded Providers. HMO agrees that CalOptima is prohibited from contracting with individuals excluded from participation in State or federal programs and agrees that CalOptima shall not pay HMO if HMO is excluded from State or federal programs, as outlined in Sections 3.31 and 5.12 of the Contract. HMO further agrees to not contract with or make payments to Subcontractors excluded from State or federal programs. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.4, 3.3.18]

35. Ownership Disclosure Statement. Prior to commencing services under this Contract, HMO shall provide CalOptima with the disclosures required by 42 CFR §§ 438.608(c)(2), 438.602(c), and 455.105, including the names of the officers and owners of HMO holding more than five percent (5%) of the stock issued by HMO, and major creditors holding more than five percent (5%) of the debt of HMO by completing the form in Attachment B, and HMO shall notify CalOptima whenever changes occur to the information provided therein. HMO shall promptly notify CalOptima of any change in the required disclosures. [DHCS Contract, Exhibit A, Attachment III, § 1.3.5; Exhibit E, § 1.1.11(A.5)]

    35.1 If Participating Provider is not eligible to enroll in Medi-Cal, HMO 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 22 CCR § 51000.35 for its Participating Providers.

36. Performance Improvement Projects. HMO and Subcontractors shall comply with all applicable performance standards and participate in performance improvement projects ("**PIP**s"), including any

collaborative PIP workgroups, as may be directed by CMS, DHCS, or CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 2.2.9(A)-(B)]

37. No Punitive Action. CalOptima will not take punitive action against HMO if HMO requests an expedited resolution of or supports a provider or Member appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member (i) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, including any information the Member needs in order to decide among all relevant treatment options; (ii) for the risks, benefits, and consequences of treatment or non-treatment; (iii) for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment; and (iv) to express preferences about future treatment decisions. [DHCS Contract, Exhibit A, Attachment III, §§ 3.2.7, 4.6.5(A)]

38. Claims Processing. CalOptima will process claims in accordance with the DHCS Contract, H&S Code §§ 1371 through 1371.36 and their implementing regulations, and as outlined in the CalOptima Policies. If HMO is responsible for claims payments, HMO will pay claims consistent with this provision. [DHCS Contract, Exhibit A, Attachment III, § 3.3.5]

39. Cost Avoidance/Other Health Coverage. HMO acknowledges that Medi-Cal is a payor of last resort except for services in which Medi-Cal is required to be the primary payer. Accordingly, CalOptima shall not pay claims for services provided to a Member who has third-party coverage without proof that HMO has first exhausted all other payment sources. HMO shall not refuse to provide Covered Services to Members when OHC is indicated in the Member's Medi-Cal eligibility record. HMO shall review the Member's eligibility record for third party coverage, and if the Member has third-party coverage, HMO must notify the Member to seek the service from the third-party coverage. [DHCS Contract, Exhibit E, § 1.1.25(G)]

40. Public Record. Notwithstanding any other term of the Contract, this Contract and all information received in accordance with the DHCS Contract will be public record on file with DHCS, except as specifically provided by Laws. DHCS ensures the confidentiality of information and contractual provisions filed with DHCS to the extent the information and provisions are specifically exempted by Laws. [DHCS Contract, Exhibit A, Attachment III, § 3.1.11]

41. Provider Preventable Condition. CalOptima will not pay for a provider preventable condition as described in 42 CFR § 438.3(g). HMO will ensure it does not pay for provider preventable conditions. [DHCS Contract, Exhibit A, Attachment III, § 3.3.17]

42. Member Rights. HMO and Subcontractors will not retaliate or take any adverse action against a Member for exercising the Member's rights under the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(A.1.r)]

43. Medical Records. All medical records shall be maintained in accordance with CalOptima Policies. HMO shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Subcontractor site. [DHCS Contract, Exhibit A, Attachment III, § 5.2.14]

44. Timely Access/Standards of Accessibility. HMO and Subcontractors will comply with applicable standards of accessibility and timely access requirements as outlined in the Contract and in CalOptima Policies. HMO and Subcontractors will comply with CalOptima's procedures for monitoring HMO's and Subcontractor's compliance with this section. [DHCS Contract, Exhibit A, Attachment III, § 5.2.5]

45. Minor Consent Services. HMO and its Subcontractors are prohibited from disclosing, and agree not to disclose, any information related to minor consent services without the express consent of the minor

Member. HMO and its Subcontractors will comply with CalOptima's requirements for services to minor Members as outlined in the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.8(D)]

46. Emergency Preparedness Requirements. HMO agrees to cooperate with and comply with CalOptima's Emergency requirements, CalOptima Policies, and training to ensure continuity of care for Members during an Emergency. For purposes of this section, "**Emergency**" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by a public health crisis, natural and man-made hazards, or disasters. HMO will (i) annually submit to CalOptima evidence of adherence to CMS Emergency Preparedness Final Rule 81 Fed. Reg. 63859 and 84 Fed. Reg. 51732; (ii) advise CalOptima of HMO's Emergency plan; and (iii) notify CalOptima within twenty-four (24) hours of an Emergency if HMO closes down, is unable to meet the demands of a medical surge or is otherwise affected by an Emergency. [DHCS Contract, Exhibit A, Attachment III, §§ 6.1, 6.1.3(C)]

47. State's Right to Monitor. HMO and Subcontractors shall comply with all monitoring provisions of this Contract, the DHCS Contract, and any monitoring requests by CalOptima and Regulators. 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 HMO's operation for compliance with the provisions of this Contract and Laws. Such monitoring, inspection, or evaluation activities will include inspection and auditing of HMO, Subcontractor, and HMO's and Subcontractors' facilities, management systems and procedures, and books and records, at any time, pursuant to 42 CFR § 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the HMO. Access will be undertaken in such a manner as to not unduly delay the work of the HMO and/or the Subcontractor(s). [DHCS Contract, Exhibit D(f) § 8; Exhibit E, § 1.1.22(B)]

48. Laboratory Testing. HMO agrees that if any performance under this Contract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC § 263a and the regulations thereto. [DHCS Contract, Exhibit D(f), § 18]

49. Third Party Tort Liability. HMO and Subcontractors 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, worker's compensation, class action claims or casualty liability insurance awards and uninsured motorist coverage. HMO 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 that may result in casualty insurance payments, tort liability, Workers' Compensation awards, class action claims, or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under W&I Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9. [DHCS Contract, Exhibit E, §§ 1.1.25 and 1.1.26]

50. 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. HMO's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least seventy-five (75) days prior to the proposed effective date. [Exhibit A, Attachment III, § 5.2.9]

51. Confidentiality of Medi-Cal Members.

51.1 HMO and its Subcontractors shall have policies and procedures in place to guard against unlawful disclosure of protected health information, personally identifying information, and any other Member confidential information in accordance with 45 CFR Parts 160 and 164, Civil Code §§ 1798 *et seq.*

HMO and its Subcontractors shall obtain prior written authorization from the Member in order to disclose such information unless exempted by 22 CCR § 51009. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(B)]

51.2 In accordance with 42 CFR § 431.300 *et seq*., as well as W&I Code § 14100.2 and regulations adopted thereunder, HMO and its employees, agents, and Subcontractors shall protect from unauthorized disclosure the names and other identifying information, records, data, and data elements concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to HMO, its employees, and/or agents as a result of services performed under this Contract, except for statistical information not identifying any such persons. HMO and its employees, agents, and Subcontractors shall not use or 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.

51.2.1 HMO and its employees, agents, and Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. HMO may release medical records in accordance with Laws pertaining to the release of this type of information. HMO is not required to report requests for medical records made in accordance with Laws.

51.2.2 With respect to any identifiable information concerning a Member under this Contract that is obtained by HMO or its Subcontractors, HMO will, at the termination or expiration of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the HMO by CalOptima for this purpose.

51.2.3 For purposes of this Section 51.2, identity shall include the name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

[DHCS Contract, Exhibit D(f) § 14; Exhibit E, § 1.1.23]

52. Debarment Certification. By signing this Contract, HMO agrees to comply with applicable federal suspension and debarment regulations, including 2 CFR 180 and 2 CFR 376.

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

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

52.1.2 Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for: (i) 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; (ii) a violation of federal or State antitrust statutes; or (iii) commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

52.1.3 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 Section 52.1.2, above;

52.1.4 Have not within a three (3)-year period preceding the Effective Date had one or more public transactions (federal, state, or local) terminated for cause or default;

52.1.5 Have not, within a three (3)-year period preceding this Contract, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376;

52.1.6 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 Part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

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

52.2 If the HMO is unable to certify to any of the statements in this Section 52, HMO shall submit an explanation to CalOptima prior to the Effective Date and then immediately upon any change in the certifications above during the Term.

52.3 The terms and definitions in this Section 52 not otherwise defined in the Contract have the meanings set out in 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

52.4 If the HMO knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause.

[DHCS Contract, Exhibit (D)(f) § 20]

53. DHCS Directives. If required by DHCS, HMO and its Subcontractors shall cease specified services for Members, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS. [DHCS Contract, Exhibit (D)(f) § 34)]

54. Lobbying Restrictions and Disclosure Certification.

54.1 This Section 54 is applicable to federally funded contracts in excess of one hundred thousand dollars ($100,000) per 31 USC § 1352. If this Section 54 is applicable to the Contract, HMO shall comply with the requirements in this Section 54, as well as complete the disclosure forms in Attachment B prior to the Effective Date.

54.2 Certification and Disclosure Requirements.

54.2.1 If this Contract is subject to 31 USC § 1352 and exceeds one hundred thousand dollars ($100,000) at any tier, HMO shall file the certification and disclosure forms in Attachment E prior to the Effective Date.

54.2.2 HMO shall file a disclosure (in the form set forth in Attachment E, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if HMO has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant that would be prohibited under Section 54.3 if paid for with appropriated funds.

54.2.3 HMO 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 HMO under Section 54.2.2. An event that materially affects the accuracy of the information reported includes:

54.2.3.1 A cumulative increase of twenty-five thousand dollars ($25,000) or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

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

54.2.3.3 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.

54.2.4 Each Subcontractor who requests or receives from HMO or Subcontractor a contract, subcontract, grant, or subgrant exceeding one hundred thousand dollars ($100,000) at any tier under this Contract shall file a certification, and a disclosure form, if required, to the next tier above that Subcontractor.

54.2.5 All disclosure forms (but not certifications) completed under this Section 54.2 and Attachment E shall be forwarded from tier to tier until received by CalOptima. CalOptima shall forward all disclosure forms to DHCS program contract manager.

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

[DHCS Contract, Exhibit (D)(f) § 37.b]

55. Air or Water Pollution Requirements. Any federally funded agreement and/or Subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt by Laws. If applicable, HMO agrees to comply with all standards, orders, or requirements issued under the Clean Air Act (42 USC §§ 7401 *et seq*.), as amended, and the Clean Water Act (33 USC §§ 1251 *et seq*.), as amended. [DHCS Contract, Exhibit (D)(f) § 12]

56. Smoke-Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994, 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 eighteen (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 one thousand dollars ($1,000) for each violation and/or the imposition of an

administrative compliance order on the responsible party. HMO shall comply with the applicable requirements of the Pro-Children Act. HMO further agrees that it will insert this certification into any Subcontracts, if required by the Pro-Children Act. [DHCS Contract, Exhibit (D)(f) § 21]

57. Domestic Partners. Pursuant to H&S Code § 1261, if HMO is licensed pursuant to H&S Code § 1250, HMO agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child. [H&S Code § 1261]

58. Conflict of Interest. HMO agrees to avoid conflicts of interest or the appearance of a conflict of interest and shall (i) comply with conflict of interest avoidance requirements of the DHCS Contract; (ii) comply with any conflict avoidance plan issued by CalOptima; and (iii) notify CalOptima within ten (10) calendar days of becoming aware of any potential, suspected, or actual conflict of interest. [DHCS Contract, Exhibit H]

59. DHCS Beneficiary. HMO expressly agrees and acknowledges that (i) DHCS is a direct beneficiary of the Contract and any Subcontractor or Downstream Subcontractor agreement with respect to the obligations and functions undertaken under the Contract and (ii) DHCS may directly enforce any and all provisions of the Subcontractor agreement or Downstream Subcontractor agreement. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.29)]

60. Employment Non-Discrimination. During the performance of this Contract, neither HMO nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, medical condition, mental disability, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, military and veteran status. HMO and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and shall comply with the provisions of the Fair Employment and Housing Act (Government Code §§ 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 11000 *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code § 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. HMO and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. HMO shall include the non-discrimination and compliance provisions of this Section 60 in all Subcontracts. [DHCS Contract, Exhibit E. § 1.1.28]

60.1 HMO and all Subcontractors shall comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations promulgated under the above-listed statutes. HMO and all Subcontractors shall comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I Code section 14029.91, and State implementing regulations. [DHCS Contract, Exhibit E. §1.1.29]

61. Member Non-Discrimination. Neither HMO nor Subcontractors shall discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, including the statutes identified in Section 60 above. For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service that is

different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; (v) assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, to the Members to be served; (vi) treating a Member or potential Member differently from others in determining whether they satisfy any admission, Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service; (vii) utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination; (viii) failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and (ix) failing to ensure meaningful access to programs and activities for limited English proficiency Members and potential Members.

61.1 HMO shall take affirmative action to ensure all Members are provided Covered Services without unlawful discrimination, except where needed to provide equal access to limited English proficiency Members or Members with disabilities, or where medically indicated. For the purposes of this Section 61, 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 Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

61.2 HMO shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

61.3 HMO shall require all Participating Providers to cooperate with CalOptima's Member Complaint Policy and time requirements to Appeal within designated time frames.

[DHCS Contract, Exhibit E §1.1.30]

62. Program Integrity and Compliance Program. HMO will establish a robust integrity and compliance program with administrative and management policies and procedures designed to prevent and detect fraud, waste, and abuse in compliance with the requirements of 42 CFR § 438.608. [DHCS Contract, Exhibit A, Attachment III, § 1.3]

63. Key Personnel Changes. HMO will report to CalOptima within ten (10) calendar days any changes in HMO's executive-level personnel, including the chief executive officer, chief financial officer, chief operations officer, the medical director, the chief health equity officer, or the compliance officer and government relations persons. HMO will also report to CalOptima changes in executive-level personnel of any Subcontractors and Downstream Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 1.1.8]

64. Medical Loss Ratio. HMO will comply with all medical loss ratio requirements, including reporting and remittance requirements as required by DHCS and CalOptima. When reporting medical loss ratio, HMO will distinguish which amounts were actually paid for benefits or activities that improve health care quality and which amounts were actually paid for Administrative Services, taxes, or other activities in accordance with the Center for Medicaid and CHIP Services Informational Bulletin published May 15, 2019, with the

subject "Medical Loss Ratio Requirements Related to Third-Party Vendors. [DHCS Contract, Exhibit A, Attachment III, § 1.2.5]

65. "Intentionally Left Blank"

66. Lead Screening. As applicable, HMO shall ensure the provision of a blood lead screening test to Members at ages and intervals specified in 17 CCR §§ 37000-37100 and applicable APLs. HMO will follow the Childhood Lead Poising in Prevention Branch guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including making referrals to the local public health department. HMO shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's medical record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent or guardian shall be documented in the Member's medical record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's medical record. Documented attempts that demonstrate HMO's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement. [DHCS Contract, Exhibit A, Attachment III, § 5.3.4(D)]

67. Financial Viability. If HMO accepts financial risk for the provision of Covered Services, HMO will comply with CalOptima's system, Laws, and DHCS Contract's requirements to evaluate and monitor HMO's financial viability. [DHCS Contract, Exhibit A, Attachment III, § 3.1.6]

68. "Intentionally Left Blank"

69. "Intentionally Left Blank"

ATTACHMENT H
Delegation Attachment H

For purposes of this Attachment H, [insert Provider/Physician/Physician Group/Hospital naming convention] shall be referred to as "**Delegate**". Delegate agrees to perform the delegated services in accordance with the responsibilities outlined in this Attachment H for CalOptima and its Members assigned to Delegate.

This Attachment H shall supersede all prior delegation agreements between the Parties and remain in effect for the term of the Contract.

1. Definitions

a. "**Standards and Requirements**" means currently applicable NCQA accreditation standards; DHCS, DMHC, CMS requirements; state and federal statutes, regulations, and sub-regulatory requirements; and CalOptima Policies and contractual requirements, including the State Contract.

2. Delegate Obligations

a. **Standards and Requirements:** Delegate agrees (either itself or through a CalOptima-approved Subcontractor or downstream entity) to provide the delegated services set forth in Schedules A, B, C, and D, as applicable, ("**Delegated Services**") in accordance with the terms of this Attachment H and Standards and Requirements. Delegate shall comply with new or revised Standards and Requirements from and after the effective date of any new or revised standard or rule. Changes necessary to comply with new/revised Standards and Requirements are not a change to a material term of this Attachment H requiring approval by either party.

b. **Policies and Procedures:** Delegate shall comply with CalOptima's policies and procedures, including but not limited to CalOptima Policy GG.1619: Delegation Oversight. Delegate shall submit to CalOptima copies of Delegate's written policies and procedures for each delegated service as part of a readiness assessment and at least once each year during the term of the Contract. Delegate's policies and procedures are subject to annual review and/or review upon request by CalOptima.

c. **Subdelegation:** Delegate agrees not to subdelegate any Delegated Services without prior written notice to and approval by CalOptima. Delegate shall provide CalOptima a written and complete list of subdelegates, vendors, subcontractors, and offshore entities performing services for or on behalf of Delegate at least sixty (60) days before the date Delegated Services are to begin under this Attachment H. The parties shall update the list shall no later than sixty (60) days before any changes approved by CalOptima take effect, including new subdelegates or offshore entities or the movement of Delegated Services from one subdelegate or offshore entity location to another. CalOptima may audit Delegate's subdelegates with advance notice, and Delegate will ensure its contracts with Subcontractors and subdelegates provide such an audit right for CalOptima. All Delegate contracts with subdelegated entities shall require the subdelegated entity to perform all Delegated Service(s) in compliance with the Contract, including this Attachment H and all Standards and Requirements. Delegate is responsible for ensuring each subdelegate complies with the Standards and Requirements. Subdelegation shall not relieve Delegate of its obligations or liability under the Contract, including this Attachment H and its Schedules A, B, C, and D (as applicable). Delegate represents and warrants that it shall take all steps necessary to cause subdelegates to comply with this Attachment H, including all Schedules.

d. **Offshore Entities:** Delegate represents and warrants it does not and will not use any offshore entity to perform Delegated Services unless and until:

i. Delegate provides sixty (60) days' advance written notice to CalOptima before entering into any agreement to subcontract any Delegated Service to an offshore entity;

ii. CalOptima, in its sole discretion, agrees in writing to the subdelegation of Delegated Services to the offshore entity;

iii. Delegate and offshore entity consent to and cooperate with CalOptima's right to audit the offshore entity. Delegate shall also audit the offshore entity before the offshore entity's provision of Delegated Services and annually as long as Delegate subdelegates Delegated Services to the offshore entity; and

iv. CalOptima and Delegate file the proposed subdelegation of functions or services to the offshore entity with the appropriate regulatory authorities for approval and receive regulatory approval Delegate and the delegated offshore entity shall comply with any requirements that the applicable regulatory authority may issue at any time during the term of the Contract.

e. **Systems & System Conversions:** Delegate agrees to take all necessary steps to ensure the Delegate's systems perform in a manner that assures Delegate's compliance with all Standards and Requirements. Delegate shall provide CalOptima at least sixty (60) days' prior written notice of any systems conversions or modifications that directly impact its obligations under this Attachment H. All systems processing and/or storing of protected health information ("**PHI**") and/or personally identifiable information ("**PII**") must have at least one (1) system risk assessment/security review conducted annually that demonstrates to CalOptima that Delegate's administrative, physical, quality, and technical controls are functioning effectively in compliance with Standards and Requirements. Delegate agrees to cooperate with CalOptima and facilitate CalOptima's performance of any system risk assessment, security reviews, compliance, and/or system reviews, as required by law and its regulators.

3. **Delegate Representations and Warranties**

a. **Good Standing; Exclusion Lists:** Delegate represents and warrants to CalOptima that:

i. Delegate is, and will remain throughout the Term of the Contract, in good standing under Standards and Requirements governing its existence and operations, and it is in compliance with and shall continue to comply with all laws and regulations applicable to this Attachment H and the duties and obligations under this Attachment H, including, but not limited to, Standards and Requirements related to Delegated Services (whether or not Delegate is directly obligated under or regulated by such Standards and Requirements);

ii. Delegate is in compliance with any licensing requirements and agrees to maintain such compliance under Standards and Requirements for the express purpose of performing each delegated service; and

iii. Neither Delegate nor any of Delegate's Subcontractors, as applicable, that are or will be fully or partially responsible for Delegate's performance of its obligations under this Attachment H have (A) pled guilty or no contest to or been convicted of any felony involving dishonesty or breach of trust; (B) been excluded from participation in any federal or state-funded health program; or (C) been listed in the Department of Health and Human Services Office of Inspector ("**OIG**") exclusion list or the General Services Administrative ("**GSA**") exclusion list. If the Delegate or any of Subcontractors or downstream entities, as applicable, are listed in the OIG or GSA exclusion lists after the effective date of the Contract, CalOptima shall have the right, in its sole discretion and judgment, to disqualify

the listed person(s) from providing any part of the Delegated Services, or exercise CalOptima's rights to terminate Delegated Services under this Attachment H or to take other remedial steps.

b. **Program Representations:** Delegate warrants that each Delegated Service shall meet or exceed: (a) all CalOptima standards, policies, and procedures outlined in this Attachment H and CalOptima Policies, including the provider manual(s); (b) all Standards and Requirements applicable to Delegated Service; and (c)NCQA standards. In the event CalOptima or an accrediting organization's standards or any laws and regulations are materially changed or revised, Delegate agrees to comply with or implement, as applicable, and to the satisfaction of CalOptima, any such change or revision within the earlier of sixty (60) calendar days of receiving notice of such change or within such time frame as may be required by the accrediting organization, applicable laws and regulations, or CalOptima. The parties agree any such change or revision shall not be considered a change to a material term of this Attachment H, consistent with Section 2(a).

c. **Incentives:** Delegate further represents and warrants that as of the Effective Date and throughout the term of the Contract compensation, incentives or remuneration to persons performing such functions under this Attachment H shall not be based, directly or indirectly, on the quantity, frequency or percentage of or in any way relating to denials of Covered Services.

d. **Compliance - Government Programs:** Delegate shall (and shall cause its Subcontractors and downstream entities, as applicable) to institute, operate, and maintain an effective compliance program to detect, correct, and prevent the incidence of non-compliance with applicable state and federal regulatory requirements and the incidence of fraud, waste, and abuse. Such compliance program shall be appropriate to Delegate's, and, as applicable, Subcontractors and downstream entity organization and operations and shall include: (a) written policies, procedures, and standards of conduct articulating the entity's commitment to comply with Standards and Requirements, as well as providing mechanisms for employee/Subcontractor use in adhering to expectations regarding the reporting of potential non-compliance or fraud, waste, and abuse issues (internally and to CalOptima, as applicable); (b) for all officers, directors, employees, Subcontractors, agents, and downstream entities of Delegate, as applicable, required participation in effective compliance and anti-fraud training and education (this required training includes general compliance and fraud, waste and abuse training completion and code of conduct dissemination, initially within ninety (90) days of hire/contracting and at least annually after that; Delegate and Subcontractors and downstream entities, as applicable, may use CalOptima's code of conduct and training or an equivalent approved by CalOptima); and (c) processes to oversee and ensure compliance with these requirements.

e. **Notice of Adverse Action:** Delegate agrees to notify CalOptima promptly of: (a) any litigation brought against Delegate related to any Delegated Service or similar services provided by Delegate to other persons; (b) any actions taken or investigations initiated by any government agency involving Delegate or any entity in which Delegate holds more than a five percent (5%) interest; or (c) any legal actions or investigations, or notice thereof, initiated against Delegate by governmental agencies or individuals regarding fraud, abuse, false claim, or kickbacks. Upon CalOptima's request, Delegate agrees to provide all known details of the nature, circumstances, and disposition of any suits, claims, actions, investigations, or listings to CalOptima.

f. **Standard Operating Hours:** Delegate attests to standard operating hours for all contracted lines of business and all Delegated Services in this Attachment H.

4. **Rights and Obligations of CalOptima**

a. **Oversight:** Delegate agrees to allow and cooperate with CalOptima to maintain oversight of the Delegated Services, including, but is not limited to:

i. **Annual Audits:** Delegate shall allow CalOptima to conduct annual audits and/or review of Delegated Services upon thirty (30) calendar days' prior written notice or upon shorter notice in the event CalOptima determines a shorter period is necessary to ensure CalOptima or Delegate's compliance with Standards and Requirements. Cooperation with an annual audit shall include permitting CalOptima to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to delegated services performed by Delegate and any subdelegate, downstream or offshore entity, as applicable.

ii. **Corrective Action Plan:** If CalOptima has reason to believe Delegate failed to carry out a delegated service per the terms of this Attachment H or CalOptima's performance expectations, CalOptima will require the Delegate to submit, within a specified timeframe, a corrective action plan ("**CAP**") to address any compliance or other problems identified by CalOptima. Once the CAP is approved by CalOptima, Delegate will be required to implement, within ten (10) business days, or as designated by CalOptima, the approved CAP and permit increased audits of Delegate's performance to ensure compliance with such CAP. CalOptima may take further remediation actions as outlined in Section 14.

iii. **External Audits:** Delegate shall allow and cooperate with CalOptima or CalOptima's designated agent(s), federal, state, and local governmental authorities having jurisdiction, and any applicable accrediting organization to audit, interview staff, and access view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services during regular business hours upon at least thirty (30) calendar days' prior written notice, or upon shorter notice if CalOptima determines a shorter period is necessary to ensure CalOptima's compliance with Standards and Requirements. Any such audit shall be permitted during the term of this Attachment H and for six (6) years thereafter (or longer if required by law), with Delegate and CalOptima responsible for their own expenses incurred related to such audit. This Section 4(a)(iii) shall survive the termination of the Contract, regardless of the cause of termination.

iv. **Onsite Monitoring:** Delegate shall permit and cooperate with CalOptima or CalOptima's designated agent(s), federal, state and local governmental authorities having jurisdiction, and any applicable accrediting organization to conduct routine and non-routine on-site visits and monitoring at any site at any time where the Delegate performs Delegated Services under the terms of this Attachment H with five (5) business days' advance notice for routine monitoring and one (1) day notice for non-routine monitoring (or upon shorter notice as required by Standards and Requirements). Cooperation with on-site monitoring shall include allowing CalOptima or CalOptima's designated agent(s), federal, state and local governmental authorities having jurisdiction, and any applicable accrediting organization, to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services.

v. **Accreditation Review:** Delegate shall permit and cooperate with NCQA to conduct on-site review of any documents related to services provided by Delegate under this Attachment H during a health plan accreditation survey of CalOptima by NCQA or other accrediting organization. Cooperation with such NCQA or other accrediting organizations,

on-site review, and accreditation survey shall include permitting NCQA or other accrediting organizations to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services.

vi. **Authority over Delegated Services:** CalOptima retains discretionary authority over all Delegated Services, including final decision-making and the operation thereof.

5. Records and Confidential Information

a. **Records:** Delegate agrees to retain Delegated Services records for the longer of ten (10) years following the date of service or the period required by Standards and Requirements. Delegate agrees to provide CalOptima or CalOptima's designated agent(s), federal, state, and local governmental authorities having jurisdiction, and any applicable accrediting organization, access to all delegated services records during regular business hours. This record retention provision (Section 5) shall survive the termination of the Contract regardless of the cause giving rise to the termination.

6. **Reporting:** Delegate shall provide Delegated Service reports via electronic submission to CalOptima's delegation oversight representative, as follows:

a. As outlined in the Schedules A, B, C and D, as applicable.

b. All other reports as required by CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting and the Report Binder.

c. CalOptima shall provide Member experience data to Delegate on an on-going basis. Member experience data shall be provided at least annually and include complaints, results of Member satisfaction surveys (such as CAHPS), and results of focused studies.

d. Delegate shall provide clinical performance data monthly or upon request and shall include HEDIS measure rates, HEDIS member-detail care gap reports, and other clinical data. Data shall be provided on Delegate's assigned secure file transfer protocol site.

7. **Conflicting or Overlapping Standards and Requirements:** If one or more regulatory or accreditation bodies have Standards or Requirements that create conflict or overlap, Delegate shall comply with the most stringent applicable Standards and Requirements for each Delegated Service. If Delegate is unsure of which standards may apply in a given situation, Delegate should contact healthnetworkdepartment@caloptima.org.

8. Claims Delegation:

a. Timely Adjudication of Claims:

i. Except for OneCare Member claims, Delegate will process claims from and pay Providers in compliance with timeliness requirements outlined in Standards and Requirements, including, without limitation, California Health and Safety Code Section 1371, 28 CCR Sections 1300.71 and 1300.77.4.

ii. For Medi-Cal Members, Delegate shall also comply with DHCS standards.

iii. For OneCare members, Delegate shall comply with federal laws and regulations applicable to Medicare organizations.

iv. If Delegate delegates to a Subcontractor (*e.g.*, management company, claims administrator, subcontracted capitated provider) the obligation to process claims on Delegate's behalf, then Delegate shall: (A) notify CalOptima of such delegation in advance, and (B) require

the Subcontractor to comply with the claims processing procedure requirements in this Attachment H and Standards and Requirements.

b. **Claims Forwarding**: If Delegate receives a claim for services provided to a Member and the claim is the financial responsibility of CalOptima or another health plan, Health Network, or Provider, Delegate shall timely forward the claim to CalOptima or the applicable health plan, Health Network, or Provider within ten (10) working days pursuant to 28 CCR Section 1300.71(b)(3).

c. **Failure to Make Payment:** Notwithstanding anything in this Attachment H, if Delegate fails to pay a Provider for Covered Services under the delegate's financial responsibility within the time frames outlined in this Attachment H and Standards and Requirements, (allowing for permissible disputes and appeals) and CalOptima reasonably determines that such amount is due and payable by Delegate, CalOptima may, after providing no fewer than ten (10) business days' prior written notice to Delegate, pay the amount due and deduct and offset such payment from any amount then or thereafter payable by CalOptima to Delegate.

9. **Utilization Management Delegation:** Delegate will maintain a well-structured and documented utilization management ("**UM**") program and will make UM decisions in a fair, impartial, and consistent manner, consistent with all Standards and Requirements, including CalOptima's UM program, and this Contract.

   a. Timely Decisions Made by Appropriately Licensed Professionals: Delegate will process UM requests in accordance with Standards and Requirements timelines for pre-service, concurrent, urgent, and post-service requests. The UM decisions will be made by appropriately licensed professionals and based upon all relevant clinical information.

   b. **Member and Provider Notification:** Delegate will provide verbal, electronic and/or written UM denial notices to Members and treating Providers within Standards and Requirements timelines. Such notices will be written in using sixth (6^{th}) grade language, contain the specific protocol, benefit provision, and/or guideline that is the basis for denial, and include detailed instructions for appealing the UM decision. Further, Provider notices shall contain the name and direct telephone number, if available, or a general number and extension of the UM denial decision maker.

   c. UM System Controls: At all times, Delegate shall maintain detailed policies and procedures in its UM system controls that meet all Standards and Requirements. The UM system controls will define date(s) of receipt and notification, document the process for recording dates, specify authority to modify dates, define system tracking of modifications to dates, and describe how compliance with system policies and procedures are monitored and enforced.

10. **Credentialing Delegation:** Delegate will maintain a well-structured and documented credentialing program for evaluating and selecting licensed Providers to provide care to Members that comply with all Standards and Requirements and this Contract.

    a. **Credentialing Committee:** Delegate will operate a Credentialing Committee comprised of Participating Providers that makes recommendations regarding credentialing and re-credentialing Providers. Delegate will further ensure that credentialing files received from Providers that meet established credentialing or recredentialing criteria are reviewed and approved by Delegate's medical director, designated physician, or Credentialing Committee.

    b. **Timely Verification and Recredentialing:** Delegate will verify information using primary sources within one hundred (180) days of credentialing, or within a shorter timeframe if required by Standards and Requirements, to ensure Providers have the legal authority and relevant training and experience to provide quality care. Delegate will recredential Participating Providers within thirty-six (36) months of their prior credentialing/re-credentialing approval date.

c. **Actions Against Providers:** Delegate will maintain policies and procedures for taking actions against Providers for violations of applicable standards and regulations that include the range of actions available to the Delegate and how Delegate makes appeal processes known to Providers.

d. **Credentialing System Controls**: At all times, Delegate will maintain detailed policies and procedures in its credentialing system controls that meet all Standards and Requirements. The system controls will define how primary source verification information is received, dated, and stored; document authority to modify information; define system tracking of modifications; and describe how compliance with system policies and procedures are monitored and enforced.

e. **Final Network Determination:** CalOptima retains the right to approve, suspend, and terminate individual Practitioners, Providers, and sites from the Delegate's network relative to CalOptima's Medi-Cal and/or OneCare program(s), even if CalOptima delegates credentialing and recredentialing decision-making to Delegate. CalOptima has the right to make the final determination of such participation in Delegate's network as it relates to CalOptima programs.

11. **Case Management Delegation:** Delegate will maintain a well-structured and documented case management program for members with multiple and/or complex health care conditions consistent with Standards and Requirements and this Contract.

    a. **Case Management Referral:** Delegate will have multiple referral avenues for Members and will accept referrals from sources including medical management, discharge planning, Member, Member's caregiver, and individual Practitioner. Delegate will begin the case management assessment process within thirty (30) days of referral to case management.

    b. **Case Management Process:** Delegate's case management process will address initial assessment of Member's health status, behavioral health status, daily living, and social determinants of health; evaluation of Member's needs, preferences, and limitations; and development of an individualized case management plan for each assigned Member, including ongoing communication strategies.

    c. **Case Management Systems:** Delegate will use a case management system that supports evidence-based, clinical guidelines to conduct assessment and management, automatic documentation of staff activity on case, and automated prompts for follow-up.

12. **Related Requirements**: Delegate will comply with all Standards and Requirements related to all Delegated Services, including, but not limited to:

    a. **New Provider Training**: Delegate will initiate training for all new Participating Providers no later than ten (10) business days from placing a Provider on active status in the network and shall complete the training within thirty (30) calendar days of placing a Provider on active status in the network. This training must include cultural and linguistic requirements, health inequities and identified cultural groups, and language and literacy needs.

13. **Regulatory Fines:** CalOptima and Delegate acknowledge that Delegated Services under this Attachment H are subject to regulation by governmental agencies with jurisdiction over the parties. If Delegate does not or is not able to fulfill any or all its obligations under this Attachment H, and if CalOptima is subject to any fines or fees from a governmental agency as a direct result thereof, Delegate agrees to pay to CalOptima the amount of such fines and any penalties incurred by CalOptima, including any applicable interest paid by CalOptima. CalOptima shall have sole discretion to pay such fees, fines, or penalties and/or to settle or compromise with such governmental agencies.

14. **Remediation for Delay or Failure to Implement CAP and/or Failures that May Cause Harm to Members:** If Delegate delays implementation of a CAP submitted and approved under Section 4(a)(ii), fails to complete a CAP within the timeframe specified in the CAP, or delegation failures that could

jeopardize the health, safety, or welfare of Members, CalOptima may take any of the following remedial measures, in general order of escalation:

a. Freeze Delegate Enrollment and/or Pause Auto-Assignment: CalOptima may freeze enrollment to the Delegate, through pausing auto-assignment of Members, or disallowing Member selection to the Delegate, or both.

b. **Withhold Quality, Shared Savings, or Incentive Payments:** CalOptima may withhold or delay any applicable quality or other incentive payments or shared savings payments until the CAP is fully implemented or Delegate's failure is fully cured, as determined by CalOptima in its sole discretion.

c. **Financial Penalties/Monetary Sanctions**: CalOptima may impose financial penalties/monetary sanctions if a Delegate fails to complete a CAP within the timeframe specified or demonstrates other failures impacting Member health, safety, or welfare:

i. Per Member sanctions of $25,000 per Member:

1. Delegate fails to provide medically necessary services that the Delegate is required to provide.
2. Delegate inappropriately delays/denies Covered Services.
3. Delegate fails to appropriately resolve a Member appeal consistent with Standards and Requirements.
4. Delegate incorrectly charges premium or unnecessary out-of-pockets costs.
5. Delegate inaccurately or untimely provides plan benefit information (*e.g.*, wrong denial notices).

ii. Aggregate sanctions for failures that impact populations of Members

1. One percent (1%) off the monthly capitation amount for a first violation.
2. Two percent (2%) off the monthly capitation amount for a second violation.
3. Three percent (3%) off the monthly capitation amount for each subsequent violation.

iii. Per determination: If CalOptima does not have the Member-specific data or the per Member impact cannot be clearly analyzed, CalOptima may calculate the penalty under the per determination basis.

iv. Delegate may appeal a financial penalty or monetary sanction through CalOptima's appeal process outlined in CalOptima Policy.

d. **Use of a Monitor at Expense of Delegate:** In cases of continued non-compliance or failures that could jeopardize the health, safety, or welfare of Members, CalOptima may require the Delegate to engage and pay for an external auditor or other consultant acceptable to and approved by CalOptima, in order to correct the identified deficiency(ies) or areas of non-compliance, to CalOptima's satisfaction.

e. Modification of Delegation: If, for any reason, CalOptima or any state or federal governmental agency with jurisdiction is dissatisfied with the performance of the Delegated Services, CalOptima may, upon written notice to Delegate, modify Delegate's status (concerning all or a particular Delegated Service) from "fully delegated" to "delegated with corrective action." Such notice shall set forth the deficiencies perceived by CalOptima and/or any state or federal governmental agency

in Delegate's performance of Delegated Services. If Delegate does not correct such deficiencies to the reasonable satisfaction of CalOptima and/or the governmental agency within ninety (90) days of such notice (or a shorter timeframe as determined by CalOptima in its reasonable discretion), CalOptima may, in its sole discretion, (a) extend the period given to Delegate to correct such deficiencies; (b) terminate all or any portion(s) of the delegation to Delegate; or (c) terminate this Attachment H.

f. **Termination of Delegation with Notice:** Notwithstanding Section 14(e), CalOptima may, upon sixty (60) days' prior written notice to Delegate, terminate all or any portion(s) of the delegation to Delegate if, after consulting with Delegate, CalOptima or any state or federal governmental agency determines that Delegate (i) no longer meets all criteria for performance of the Delegated Service(s), or (ii) is not performing, or is not reasonably likely to perform, the Delegated Service(s) in full compliance Standards and Requirements. If, within such sixty (60)-day notice period, Delegate cures such deficiencies to CalOptima's reasonable satisfaction, CalOptima may withdraw such termination.

g. **Immediate Termination of Delegation:** Notwithstanding Sections 14(e) and 14(f) of this Attachment H, CalOptima may, upon prior written notice, immediately terminate all or any portion(s) of the delegation to Delegate of the delegated service(s) if, after consulting with Delegate, CalOptima or any Government Official reasonably determines that the continued performance of the Delegated Service(s) by Group would jeopardize the health, safety, or welfare of members assigned to Delegate under this Attachment H. Such de-delegation shall terminate when Delegate demonstrates to the satisfaction of CalOptima that members' health, safety, or welfare is no longer in jeopardy.

h. **Material Breach**: Delegate agrees that Delegate's failure to agree to or begin reasonable implementation of a CAP designed to correct identified deficiencies in Delegated Services under this Attachment H shall be considered a material breach of the Contract. Additionally, Delegate agrees that Delegated Services failures that could jeopardize the health, safety, or welfare of Members shall be considered a material breach of the Contract. Any such material breach of this Attachment H shall permit CalOptima to implement or engage in any or all oversight or other CalOptima rights and obligations described in the Contract, including under Section 13.

15. **Termination of Delegation (De-Delegation):** In the event CalOptima terminates delegation, or assumes all or any portion(s) of the Delegated Service(s) under this Attachment H, the following provisions shall apply:

    a. **CalOptima's Assumption of Payment of Claims:** If Delegate's claims procedures fail to comply with the obligations outlined in Schedule A of this Attachment H, CalOptima may, as required or permitted by Standards and Requirements, assume responsibility for the processing of claims that are Delegate's financial responsibility under this Attachment H. Such assumption may be altered to the extent Delegate has established and fully implemented an approved CAP consistent with California Health and Safety Code Section 1375.4(b)(4) and 28 CCR § 1300.75.4.8.

    b. **Capitation reduction for de-delegation:** Upon termination or assumption by a CalOptima of all or any portion(s) of a Delegated Service pursuant to this Attachment H, CalOptima may, in its sole discretion, reduce the net monthly Capitation Payment otherwise payable to Delegate by the percentage set forth below. Such amounts are not intended to represent the portion of the Capitation Payment allocated to cover the cost of performance of the Delegated Service(s) by Delegate nor an estimate of the costs incurred by CalOptima as a result of the termination of the delegation; rather,

the amounts set forth below are intended as a performance fee for Delegate's failure to meet the standards established for performance of the Delegated Service.

	Medi-Cal	OneCare
Utilization Management/ Case Management	3.0%	3.0%
Credentialing	1.0%	1.0%
Claims Processing		
- non-contracted only	1.0%	1.0%
- all claims	7.0%	7.0%
- non-contracted only payment withhold *	8.5%	8.5%
- all claims payment withhold	85.0%	85.0%

* = Subject to actual claims paid experience.

c. **Obligation to Cooperate:** Upon termination of the Contract for any reason, Delegate agrees to cooperate fully with CalOptima and comply with CalOptima procedures, if any, in the transfer of Delegate's obligations under this Attachment H to CalOptima or another CalOptima delegate. Delegate agrees to promptly provide CalOptima with any and all information and documentation necessary for such transfer. This shall include copies of all Delegated Services notes and accompanying records and information submitted by Providers as requested by CalOptima.

Schedule A

Claims Payment Delegation

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Claims policies, procedures, and compliance	[insert LOB]	1. Annually submit updated, reviewed, and approved claims payment policies and procedures. 2. Provide oversight to any Subcontractors and subdelegated entities that perform claims processing or payment to ensure compliance with Standards and Requirements. 3. Submit all required reports and audit materials, as defined in Schedule A.	1. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 2. Review all required reports timely and provide substantive feedback.	Submitted to CalOptima's Delegation Oversight Committee ("Delegation Oversight") as part of the annual audit: 1. Updated, reviewed, and approved claims processing policies and procedures. 2. Evidence of oversight of Subcontractors and subdelegates	Annual audit, or more frequently as needed, using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare line of business ("LOB"). Delegate must meet at a minimum 95% compliance for each LOB.	1. CAP 2. Remediation steps outlined in Section 14
Claims processing		1. Identify and acknowledge electronic claims within two (2) working days of receipt. 2. Identify and acknowledge paper claims within fifteen (15) working days of receipt. 3. For Medi-Cal claims, process and adjudicate ninety percent (90%) of all Clean Claims for Covered Services	1. Annual claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute	Submitted via monthly XML process: 1. Claims XML Universe 2. Claims Universe Case Files	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit	1. CAP 2. Remediation steps as outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		within thirty (30) calendar days of receipt. 4. For OneCare claims, process and adjudicate ninety-five percent (95%) of Clean Claims for Covered Services within thirty (30) calendar days of receipt. a. Process and adjudicate all other Clean Claims from non-Participating Providers for Covered Services within sixty (60) calendar days from date of receipt. b. Process and adjudicate ninety-nine percent (99%) of all Clean Claims from Participating Providers for Covered Services within ninety (90) calendar days of receipt	Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	3. Claims Timeliness Report 4. DHCS Post-Payment Recovery Report (Medi-Cal Only)	Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	
Exclusion and preclusion monitoring		1. Verify Practitioner or Provider entity participation status prior to adjudicating any received claims as required by CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring 2. If Delegate pays a claim from an excluded Practitioner or Provider entity, Delegate must notify CalOptima, recover the payment, and prevent future payments to the excluded Provider.	1. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	1. Quarterly overpayment report outlined in reporting binder		1. CAP 2. Remediation steps as outlined in Section 14
Interest payment for late paid claims		Medi-Cal:			Annual audit, or more frequently as needed, using	1. Corrective Action Plan (CAP)

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		1. Pay interest and applicable penalties on all uncontested claims not paid within forty-five (45) business days. 2. For emergency services, automatically include the greater of fifteen dollars ($15) for each twelve (12)-month period (or portion thereof) on a non-prorated basis, or interest at the rate of fifteen percent (15%) per year for the period of time the payment is late. 3. For all other late payments, include interest at the rate of fifteen percent (15%) per year for the period of time the payment is late. 4. If Delegate fails to include the interest due on a late claim payment, the Delegate shall pay an additional ten-dollar ($10) penalty. OneCare: 1. Interest shall begin to accrue on the thirty-first (31st) calendar day for non-Participating Provider, non-Clean Claims, and (61st) calendar days for Participating Provider Clean Claims, calculated based on calendar days. 2. Delegate shall pay interest at the rate used for Section 3902(a) of Title 3l, U.S. Code and rounded to the nearest penny. The interest rate is determined by the applicable rate on the day of payment.			NCQA Methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum 95% compliance.	2. Remediation steps as outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		Interest shall be calculated using the following formula: a. [Payment Amount x Rate x Days] divided by [365 (366 in a leap year)] = Interest Payment				
Coordination of benefits		1. Have processes and procedures in place to identify payers that are primary and secondary to determine amounts payable and coordinate benefits for members with other health coverage ("OHC"), in accordance with Medicare and Medi-Cal crossover claims guidelines. 2. If a Member has OHC, consider the OHC plan as primary. 3. If a Member has both Medicare and OHC, both Medicare and OHC shall pay claims for services prior to Delegate. 4. Remain the secondary health plan and payer of last resort. 5. Identity and report to CalOptima any OHC or other private or public health insurance for Members 6. Identify and report to CalOptima any explanation of payment ("EOP") or explanation of medical benefits ("EOMB") received with other coverage payment	1. Annual claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	1. Monthly Post Payment Recovery Template	Policy review as part of annual audit	1. CAP 2. Remediation steps outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Third party liability		1. Notify CalOptima within five (5) calendar days of becoming aware of potential third-party liability (including casualty insurance, tort, workers compensation liability) related to Covered Services for a Member. 2. Make no claim for recovery of the value of covered services in an instance of Third Party Liability in which the DHCS has lien rights.	1. Annual claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	1. Report occurrences consistent with CalOptima Health Policy FF.2007: Reporting of Potential Third Party Liability	Policy review as part of annual audit	1. CAP 2. Remediation steps outlined in Section 14
Level 1 Provider dispute resolution		1. Acknowledge receipt of electronically submitted Level 1 disputes within two (2) working days; acknowledge receipt of hard-copy disputes within fifteen (15) working days. 2. Resolve Level 1 provider disputes or amended disputes related to claims payment decisions within forty five (45) days.			Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for	1. CAP 2. Remediation steps outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
					OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	

Schedule B

Utilization Management Delegation

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
UM Program policies, procedures, and compliance	[insert LOB]	1. Annually submit updated, reviewed, and approved written UM Program documentation outlining the structure, scope, responsible parties, criteria, timelines, policies, procedures, and processes that meet all Standards and Requirements. 2. Conduct an annual evaluation of the UM Program that verifies the program meets all Standards and Requirements, ensures all UM decisions are made by qualified professionals, evaluates the appropriateness of UM criteria, assesses the interrater reliability, ensures the criteria are consistently applied and available to Providers, and ensures all denials are reviewed by a physician or other appropriate professional. 3. Provide oversight to any Subcontractors and/or subdelegated entities that perform UM to ensure compliance with Standards and Requirements. 4. Submit all required reports and audit materials timely.	1. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 2. Review all required reports timely and provide substantive feedback.	Submitted via FTP: 1. Annual UM Program and Workplan 2. Semi-Annual Work Plan 3. Annual UM Evaluation 4. Annual UM Evaluation (Prior year) 5. All required documents for Annual Audit pursuant to the CalOptima Reporting Policy.	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB.	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
UM decision timeliness		Comply with all Standards and Requirements for notification of UM decisions, including CalOptima Health Policy GG.1508: Authorization and Processing of Referrals. Further, Delegate will make UM decisions in a timely manner and notify Providers and Members electronically or in writing: 1. Urgent concurrent and preservice decisions within seventy-two (72) hours of request 2. Medi-Cal non-urgent pre-service decisions within five (5) working days from receipt of information reasonably necessary to render a decision, but no longer than fourteen (14) calendar days of request. 3. OneCare non-urgent pre-service decisions within fourteen (14) calendar days of request 4. Post-service decisions within thirty (30) calendar days of request	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	Submitted via monthly XML process: 1. Utilization Management (UM) XML Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14
UM decision clinical information		1. Gather and use all clinical information relevant to the Member's care when making UM decisions 2. Adhere to policies set forth in CalOptima Health Policy GG.1535:	1. Annual UM Program audits, or as often as necessary, and ongoing	Submitted via XML: 1. Utilization Management (UM) XML Universe	Annual audit, or more frequently as needed using NCQA methodology	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		Utilization Review Criteria and Guidelines	performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	
Written notification of UM denials and appeal rights		Delegate shall comply with all Standards and Requirements for written notification applicable for Medi-Cal or an integrated denial notice applicable for OneCare, including CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. Delegate shall use a readability scoring tool and ensure notices for Members do not use language exceeding a sixth (6^{th})-grade level. Further, written or electronic notification of UM denials for Members and Providers must include the following:	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	Submitted via XML: 1. Utilization Management (UM) XML Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		1. The specific reason for the denial in easily understood language. 2. A reference to the benefit provision, guideline, protocol or other similar criteria upon which the denial is based. 3. A statement that the Member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criteria on which the denial decision is based, upon request. 4. The Provider notice must be addressed to the requesting Provider (not organization) and include the name and direct telephone number, if available, or general number and extension of the decision maker 5. A description of appeal rights, including the right to submit written comments, documents or other relevant information. 6. An explanation of the appeal process, including Members' rights to representation and time frames 7. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials a. Timeframe for filing b. Timeframe for decision	3. Review all required reports timely and provide substantive feedback.		ninety-five percent (95%) compliance	

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		c. Process for expedited appeal, including where to direct appeal and what information to include 8. Notice that expedited external review can occur concurrently with internal appeals process for urgent care				
UM system controls		Delegate will maintain policies and procedures in its UM system controls that meet all NCQA requirements and: 1. Define date of receipt consistent with NCQA requirements 2. Define date of notification consistent with NCQA requirements 3. Describe process for recording dates in system 4. Specify titles/roles of staff authorized to modify dates once initially recorded and circumstances when modifications are appropriate 5. Specify how the system tracks: a. Date modifications b. When the date was modified c. Who modified the date. d. Why the date was modified. 6. Describe system controls to protect data from unauthorized modification	1. Pre-delegation system review. 2. Annual review of delegate system policies and system control report. 3. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 4. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 5. Review all required reports	All required documentation for annual audit pursuant to the CalOptima Health Reporting Policy HH.2003: Health Network and Delegated Entity Reporting, including the CalOptima Timely and Appropriate Submission Grid and Supplemental Attachment	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		7. Describe how compliance with policies and procedures are monitored at least annually and how Delegate takes appropriate action when applicable 8. At least annually, monitors compliance with UM system controls by: a. Identifying and analyzing all modifications to dates that did not meet established policies and procedures. b. Acting on all findings and implementing a quarterly monitoring process until improvement is demonstrated for one finding over three (3) consecutive quarters.	timely and provide substantive feedback.			
Level 1 Provider dispute resolution		1. Process and resolve Level 1 Provider disputes related to post-service UM decisions according to Standards and Requirements, including CalOptima Policies	1. Annual audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements	Submitted via XML: 1. UM Retrospective Post-Service Decision Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
			for delegated activity. 3. Review all required reports timely and provide substantive feedback.		OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	

Schedule C Case Management Delegation

Delegated Case Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Case management activities		1. [List of CM activities delegated as of date of the Attachment H] 2. Changes necessary to comply with new/revised laws and regulations or new/revised accreditation standards and Requirements will not be considered a change to a material term of this Attachment H requiring approval by either party	1. [List of CM activities retained by CalOptima]	N/A	N/A	N/A
Case management policies, procedures, and compliance	[insert LOB]	1. Annually submit updated, reviewed, and approved written Case Management ("CM") program documentation outlining the structure, scope, responsible parties, criteria, timelines, policies, procedures, and processes that meet all Standards and Requirements. CM program shall include basic care management, care coordination, complex care management services, and transitional care services. The CM program shall include care management of OneCare Members, EPSDT, children with special health care needs, early intervention services, care transitions, and whole-child model. 2. Conduct an annual evaluation of the CM program that verifies the program meets all Standards and Requirements, ensures the appropriate identification,	1. Pre-delegation reviews. 2. Annual CM program audits, or as often as necessary. 3. Quarterly case file audits. 4. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 5. Review all required reports timely and provide.	All required documentation for CM program annual audit Submitted via FTP: 1. Monthly Case Management Log 2. Quarterly case files as identified by CalOptima	Annual policy review or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet ninety-five percent (95) Quarterly case file review	1. CAP 2. Remediation steps outlined in Section 14

Delegated Case Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		stratification, and management of members. 3. Provide oversight to any subdelegated entities, vendors, or consultants that perform CM to ensure compliance with Standards and Requirements. 4. Submit all required reports and audit materials timely.	substantive feedback if appropriate.		Delegate must meet minimum of 75% compliance for two consecutive quarters. Score is the combined percentage of each audited case across all applicable line of business	
Case management program referral		Delegate identifies Members with multiple or complex health care conditions, obtains access to care, and coordinates their care. Delegate has multiple referral programs (including but not limited to): 1. Medical management 2. Discharge planning 3. Member or caregiver 4. Practitioner	1. Pre-delegation reviews. 2. Conduct quarterly case file reviews or as often as necessary. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	Submitted via FTP: 1. Monthly Case Management Log 2. Quarterly case files as identified by CalOptima	Quarterly case file review, or more frequently as needed, using NCQA Methodology Delegate must meet minimum of 75% compliance for two	1. CAP 2. Remediation steps outlined in Section 14

Delegated Case Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
			4. Review all required reports timely and provide substantive feedback if appropriate.		consecutive quarters. Score is the combined percentage of each audited case across all applicable line of business.	
Case management systems		Delegate uses a CM system that supports: 1. Evidence-based clinical guidelines to conduct initial assessment and ongoing management. 2. Automatic documentation of date, time and individual who takes action on a case or interacts with a Member. 3. Automated prompts for follow-up	1. Pre-delegation reviews. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	All required documentation for CM program annual audit		1. CAP 2. Remediation steps outlined in Section 14

Schedule D Credentialing Delegation

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Credentialing policies, procedures, and compliance		Annually, Delegate will submit updated, reviewed, and approved written Credentialing Program documentation outlining the credentialing process for evaluating and selecting licensed Providers to provide care to Members that comply with all Standards and Requirements and CalOptima contract provisions. The program documentation must specify: 1. Types of Providers to credential and recredential. 2. Verification sources. 3. Criteria for credentialing and recredentialing. 4. Process for making credentialing or recredentialing decisions. 5. Process for managing credentialing files. 6. Non-discrimination policies and procedures. 7. Process for communication with Providers in the credentialing process and for notifying Providers within sixty (60) calendar days from the Credentialing Committee's decision, including informing Providers of the rights to review information about their application, correct errors, and check status of application.	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.	Submitted to Delegation Oversight annually via the audit process: 1. Credentialing program documentation	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		8. Roles and direct responsibility of Delegate's Medical Director or other designated physician in the Credentialing Program. 9. Confidentiality policies and procedures. 10. Policies and procedures designed to ensure accuracy of provider directories. 11. How Delegate considers Provider performance during recredentialing, including but not limited to, Member complaints/grievances. 12. For the Medicare LOB, ensure participating physicians haven't opted out of Medicare. 13. For the Medi-Cal LOB, ensure all Providers are confirmed as screened and enrolled for participation in Medi-Cal where there is an enrollment pathway. 14. Prevents credentialing of Providers that employ or contract with Providers, that have been excluded or sanctioned by Medicare or Medi-Cal or are excluded on any other state or federal exclusion, sanction, restriction or preclusion list. 15. Demonstrates compliance with CalOptima policies regarding credential all provider types GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment				

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		and Reassessment of Organizational Providers.				
Credentialing Committee		Delegate will operate a Credentialing Committee that makes recommendations regarding credentialing and re-credentialing decisions: 1. Committee is comprised of Participating Providers. 2. Reviews credentials for Providers who do not meet thresholds established by the Committee. 3. Ensures that files that meet Credentialing Committee-established criteria are reviewed and approved by Delegate's Medical Director, designated physician, or Credentialing Committee.	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.		Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14
Organizational Providers		The Delegate shall assess and approve, initially and in an ongoing manner, Provider organizations. Before the Delegate contracts with an organizational Provider, and for at least every thirty six (36) months thereafter, it:	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as		Annual audit, or more frequently as needed using NCQA methodology	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		1. Confirms that the Provider is in good standing with state and federal regulatory bodies. 2. Confirms that the Provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the Provider is not accredited. 4. Ensures that the Provider is Medi-Cal enrolled, if an enrollment pathway exists.	necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.		for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	
Verification of credentials		Delegate will conduct timely verification within one hundred eighty (180) days of credentialing of information (or a shorter time frame as required by Standards and Requirements) to ensure Providers have the legal authority and relevant training and experience to provide quality care to Members. Delegate will verify credentialing information through primary sources, unless otherwise indicated. 1. All National Provider Identifier (NPI) numbers, where applicable 2. A current and valid license to practice	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements	1. Credentialing Monthly Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		3. A valid DEA or CDS certificate, as applicable 4. Education and training, consistent with Standards and Regulations 5. Board certification status, as applicable 6. Work history 7. History of professional liability claims that resulted in settlements or judgements paid on behalf of practitioner 8. Sanction information: a. OIG b. System for Award Management (SAM) c. Medicare Opt-Out, if applicable d. Medi-Cal Suspended & Ineligible List e. CMS Preclusion List f. DHCS Medi-Cal Restricted Provider Database 9. For Medi-Cal LOB: For primary care Practitioners, Delegate will obtain evidence of passing the DHCS Facility Site Review 10. For Medi-Cal LOB: Delegate shall verify enrollment into the Medi-Cal program. Verification information located at	for delegated activity. 3. Review all required reports timely and provide substantive feedback.		a minimum one-hundred percent (95%) compliance	

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers				
Credentialing applications		Delegate will require Providers to submit a credentialing/re-credentialing application that includes a signed attestation that includes: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use 3. History of loss of license and felony convictions 4. History of loss or limitation of privileges or disciplinary actions 5. Current malpractice insurance coverage 6. The application's accuracy and completeness 7. Hospital admitting privileges at a CalOptima contracted Hospital or if Delegate is financially responsible for Hospital services, a Delegate-contracted Hospital 8. Practice coverage, including names of answering service and covering physicians	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	1. Credentialing Monthly Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps as outlined in Section 14
Recredentialing cycle		1. Delegate will recredential Participating Providers within thirty-six (36) months of their prior approval date.	1. Annual Credentialing Program audits, or as often as necessary, and	1. Credentialing Monthly Universe	Annual audit, or more frequently as needed using NCQA	1. CAP 2. Remediation steps as

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		2. In between recredentialing cycles, Delegate will perform ongoing monitoring and interventions between recredentialing cycles and take appropriate action against Providers when Delegate identifies occurrences of poor quality. Monitoring shall include collecting and reviewing: Medicare and Medi-Cal/Medicaid sanctions or limitations on licensure, complaints, and information of adverse events.	ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	outlined in Section 14
Actions against Providers		1. Delegate has policies and procedures for taking actions against Providers that include the range of actions available to Delegate and how it makes appeal processes known to Providers. These policies and procedures establish that the majority of the appeal panel are peers of the Provider in question, and prohibit Delegate from attorney representation at appeal hearings unless the Provider is also represented. 2. If Delegate takes action against a Provider for quality reasons, Delegate will report the action to the appropriate	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	1. Delegate must report any Business & Professions Code §§ 805 and/or 805.01 actions immediately to CalOptima Quality Improvement Department at MyCredentialingUpdates@caloptima.org	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		authorities and offers a formal appeal process. 3. Delegate will use objective evidence and patient care considerations to decide on altering a Provider's relationship with Delegate if the Provider doesn't meet Delegate's quality standards.	3. Review all required reports timely and provide substantive feedback.		one-hundred percent (95%) compliance	
Identification of HIV/AIDS Specialists		Delegate has policies and procedures for identifying HIV/AIDS Specialists: 1. Documentation describes how the Delegate identifies and annually reconfirms appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist, according to California regulations. 2. Documents that Delegate provides list of qualified Specialists to Delegate's department responsible for authorizing standing referrals	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.	1. Credentialing Monthly Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Credentialing system controls		Delegate has policies and procedures in its Credentialing Program system controls that meet all NCQA requirements and: 1. How primary source verification information is received, dated and stored. 2. How modified information is tracked and dated from its initial verification. a. When modified b. How modified c. Who modified d. Why modified 3. Identifies staff who are authorized to review, modify and delete information and circumstances when modification or deletion is appropriate. 4. Security controls in place to prevent unauthorized modification. a. Limiting physical access to location that houses credentialing information b. Preventing unauthorized access, changes to, and release of credentialing information c. Password-protecting electronic systems, including user requirements, to prevent passwords from being	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.	1. Annual report on monitoring of system controls	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one -hundred percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		compromised and policies and procedures regarding changing or withdrawing passwords if compromised passwords or individuals should no longer have electronic access to the system 5. How Delegate monitors its compliance with its Credentialing System Control policies and procedures at least annually and takes appropriate action when applicable.				
Subdelegation of credentialing		If Delegate subdelegates (subject to CalOptima's prior written approval) credentialing functions to another entity, Delegate will perform oversight of the subdelegated relationship in accordance with all Standards and Requirements, including but not limited to: 1. Using a written delegation agreement including all Standards and Requirements 2. Performing a pre-delegation review 3. Requiring at least semi-annual reporting 4. Having a described process Delegate will use to evaluate subdelegated entity's performance	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide		Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps as outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		5. Describing to subdelegate remedies available to Delegate if subdelegate does not fulfill its obligations	substantive feedback.			

AMENDMENT [XX] TO
CONTRACT FOR HEALTH CARE SERVICES

This Amendment [XX] to the Contract for Health Care Services ("**Amendment**") is effective as of July 1, 2024 ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and, [health network name] ("**Hospital**"). CalOptima and Hospital may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Hospital have entered into a Contract for Health Care Services, originally effective [insert date], ("**Contract**"), by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. The Department of Healthcare Services ("**DHCS**") is implementing a Targeted Rate Increase, as defined further below, and the Parties desire to outline Hospital's obligation related to the Targeted Rate Increase.

C. CalOptima and Hospital desire to amend the Contract on the terms and conditions set forth herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Add the following new Section 1.101 *Targeted Rate Increase*, to the Contract:

   1.101 "Targeted Rate Increase" or "TRI" means the set of provider rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) as implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. The first phase of TRIs are effective for dates of service beginning January 1, 2024. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates, including Hospital and its Subcontractors, must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment previously due to provider. The TRI applies to both fee-for-service and other provider payment arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

2. Add the following new Section 2.6.1.1 to the Contract:

   2.6.1.1 Hospital shall evaluate and adjust as necessary its capitation payments to Participating Providers that provide TRI-eligible services to ensure such capitation payments meet the TRI requirements. If adjustment to Participating Provider capitation payments is necessary, Hospital shall adjust such capitation payments retroactive to January 1, 2024, by no later than December 1, 2024. Hospital's reimbursement for TRI-eligible services shall comply with DHCS requirements, Laws, and CalOptima Policies.

3. Add the following new Section 2.6.19 to the Contract:

   2.6.19. By no later than July 31, 2024, Hospital shall implement the DHCS-mandated TRI to its fee-for-service provider payments that qualify for the TRI retroactive to dates of service rendered on or after January 1, 2024. If adjustment to fee-for-service provider payments is necessary, Hospital shall adjust such fee-for-service provider payments retroactive to January 1, 2024, by no later than October 31, 2024. If a rate in an agreement between Hospital and a Participating Provider for a TRI-eligible service is less than the Medi-Cal

TRI fee schedule, the Medi-Cal TRI fee schedule shall control. Hospital's reimbursement for TRI-eligible services shall comply with DHCS requirements, Laws, and CalOptima Policies.

4. Add the following new Section 6.4.13 to the Contract:

6.4.13 Hospital agrees that CalOptima may make publicly available, as frequently as CalOptima deems necessary, reports of Hospital's compliance with the Contract's requirements and performance metrics, including Members' access to care, the quality of care received by Members, and Hospital's other performance trends, as applicable to Hospital's obligations hereunder.

5. Add the following new Section 6.4.14 to the Contract:

6.4.14 As long as CalOptima's disclosures under this Section 6.4 otherwise comply with applicable laws, no CalOptima disclosure under this Section 6.4 shall constitute a breach of this Contract.

6. Delete Attachment E, *Capitation Rates,* in its entirety and replace it with new Attachment E, *Capitation Rates,* attached to this Amendment and incorporated into the Contract by this reference, which includes rates for Medi-Cal Members, including Medi-Cal Expansion Members.

7. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

8. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern.

9. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

(signature page follows)

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR HOSPITAL:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ATTACHMENT E
CAPITATION RATES

Payments by CalOptima to Hospital for Covered Services rendered to Members in accordance with the Contract shall be on a Per Member/Per Month (PMPM) basis at the rates outlined below, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child/Adult	00-00 year, Both	[redacted]	[redacted]	[redacted]
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40-64 years, Both			
	65+ years, Both			
Medi-Cal Expansion	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
SPD	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
WCM	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
ESRD	All ages, Both	[redacted]	[redacted]	[redacted]
AIDS	All ages, Both	[redacted]	[redacted]	[redacted]

Overall Average Capitation for all Health Networks. Actual Capitation Payment is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima Policies. The Parties agree that the above rates compensate Hospital for all services outlined in Attachment A, *CalOptima Medi-Cal Division of Financial Responsibility*, including ongoing compensation for COVID-19 diagnostic and screening testing services. The Parties further agree that future amendments to the Contract increasing the above rates due to a declared public health emergency shall constitute a negotiated and agreed upon new provision to the Contract delegating financial responsibility to Hospital to cover the additional Medi-Cal Covered Services required by such declared public health emergency.

Supplemental OB Delivery Care Payment will be payable for all qualified deliveries based on DHCS guidance.

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment - All	[redacted]	[redacted]	[redacted]

AMENDMENT [XX] TO

CONTRACT FOR HEALTH CARE SERVICES

This Amendment [XX] to the Contract for Health Care Services ("**Amendment**") is effective as of July 1, 2024 ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and, [health network name] ("**Physician**"). CalOptima and Physician may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services, originally effective [insert date], ("**Contract**"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. The Department of Healthcare Services ("**DHCS**") is implementing a Targeted Rate Increase, as defined further below, and the Parties desire to outline Physician's obligation related to the Targeted Rate Increase.

C. CalOptima and Physician desire to amend the Contract on the terms and conditions set forth herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Add the following new Section 1.113, *Targeted Rate Increase*, to the Contract:

   1.113 "Targeted Rate Increase" or "TRI" means the set of provider rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) as implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. The first phase of TRIs are effective for dates of service beginning January 1, 2024. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates, including Physician and its Subcontractors, must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment previously due to provider. The TRI applies to both fee-for-service and other provider payment arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

2. Add the following new Section 2.7.1.1 to the Contract:

   2.7.1.1 Physician shall evaluate and adjust as necessary its capitation payments to Participating Providers that provide TRI-eligible services to ensure such capitation payments meet the TRI requirements. If adjustment to Participating Provider capitation payments is necessary, Physician shall adjust such capitation payments retroactive to January 1, 2024, by no later than December 1, 2024. Physician's reimbursement for TRI-eligible services shall comply with DHCS requirements, Laws, and CalOptima Policies.

3. Add the following new Section 2.7.17.4 to the Contract:

   2.7.17.4. By no later than July 31, 2024, Physician shall implement the DHCS-mandated TRI to its fee-for-service provider payments that qualify for the TRI retroactive to dates of service rendered on or after January 1, 2024. If adjustment to fee-for-service provider

payments is necessary, Physician shall adjust such fee-for-service provider payments retroactive to January 1, 2024, by no later than October 31, 2024. If a rate in an agreement between Physician and a Participating Provider for a TRI-eligible service is less than the Medi-Cal TRI fee schedule, the Medi-Cal TRI fee schedule shall control. Physician's reimbursement for TRI-eligible services shall comply with DHCS requirements, Laws, and CalOptima Policies.

4. Add the following new Section 6.4.13 to the Contract:

6.4.13 Physician agrees that CalOptima may make publicly available, as frequently as CalOptima deems necessary, reports of Physician's compliance with the Contract's requirements and performance metrics, including Members' access to care, the quality of care received by Members, and Physician's other performance trends, as applicable to Physician's obligations hereunder.

5. Add the following new Section 6.4.14 to the Contract:

6.4.14 As long as CalOptima's disclosures under this Section 6.4 otherwise comply with applicable laws, no CalOptima disclosure under this Section 6.4 shall constitute a breach of this Contract.

6. Delete Attachment E, *Capitation Rates,* in its entirety and replace it with new Attachment E, *Capitation Rates,* attached to this Amendment and incorporated into the Contract by this reference, which includes rates for Medi-Cal Members, including Medi-Cal Expansion Members.

7. Delete Attachment E-9, *Funding for Enhanced Care Management (ECM) Services*, in its entirety and replace it with new Attachment E-9, *Funding for Enhanced Care Management (ECM) Services,* attached to this Amendment and incorporated into the Contract by this reference.

8. Add to the Contract the new Attachment H, *Delegation Agreement*, which is attached hereto and incorporated into the Contract by this reference. This new Attachment H shall replace and terminate any other prior delegation agreements, including any *Delegation Acknowledgement and Acceptance Agreement*, between the Parties.

9. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

10. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern.

11. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

(signature page follows)

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PHYSICIAN:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ATTACHMENT E
CAPITATION RATES

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

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child/Adult	00-00 year, Both	[redacted]	[redacted]	[redacted]
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40-64 years, Both			
	65+ years, Both			
Medi-Cal Expansion	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
SPD	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
WCM	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
ESRD	All ages, Both	[redacted]	[redacted]	[redacted]

AIDS	All ages, Both	[redacted]	[redacted]	[redacted]

Overall Average Capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy. The Parties agree that the above rates compensate Physician for all services outlined in Attachment A, *CalOptima Medi-Cal Division of Financial Responsibility*, including ongoing compensation for COVID-19 diagnostic and screening testing services. The Parties further agree that future amendments to the Contract increasing the above rates due to a declared public health emergency shall constitute a negotiated and agreed upon new provision to the Contract delegating financial responsibility to Physician to cover the additional Medi-Cal Covered Services required by such declared public health emergency.

Supplemental OB Delivery Care Payment will be payable for all qualified deliveries based on DHCS guidance.

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment - All	[redacted]	[redacted]	[redacted]

ATTACHMENT E-9
Funding for Enhanced Care Management (ECM) Services

CalOptima shall make an ECM Supplemental Payment to Physician for ECM services provided to an ECM Member, in accordance with the terms and conditions of CalOptima Policy FF.4002 and this Attachment.

1. ECM Services Supplemental Payment

   1.1 CalOptima shall pay Physician the ECM Supplemental Payment rate of [redacted] Per Member Per Month for each Member who receives three (3) or more hours of ECM services in a given month as identified by twelve (12) or more units, subject to Physician's compliance with all of the following conditions:

   - Member is identified as an ECM-eligible Member as determined by CalOptima based on DHCS ECM eligibility criteria and in accordance with CalOptima Policy GG.1354;
   - Member is authorized to receive ECM services;
   - Member receives one of the ECM core service components (as set forth in Section 6.23.9.4 of the Contract) in the prior month;
   - Physician bills and reports ECM services to CalOptima consistent with CalOptima Policy FF.4002 and DHCS requirements; and
   - If applicable, the Physician paid the provider delegated by Physician to render ECM services; and the Physician authorized such ECM services.

   1.2 For purposes of this Attachment E-9, the term "**Per Member Per Month**" means an all-inclusive case rate that applies whenever Physician, as the ECM Provider, has provided the minimum level of service payable to an ECM-enrolled Member. This rate is paid on the basis of submitted claims and is not to be considered a capitation payment.

2. Physician shall submit ECM billing data for the ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

3. Upon validation of the ECM billing data and in accordance with CalOptima Policy FF.4002 CalOptima shall pay ninety (90) percent of all clean claims within thirty (30) calendar days of the date of receipt and ninety-nine (99) percent of all clean claims within ninety (90) calendar days of the date of receipt. The date of receipt shall be the date CalOptima receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

4. In addition to Section 9.4 of this Contract, Physician agrees to CalOptima's recovery of any overpayment of ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

ATTACHMENT H
Delegation Attachment H

For purposes of this Attachment H, [insert Provider/Physician/Physician Group/Hospital naming convention] shall be referred to as "**Delegate**". Delegate agrees to perform the delegated services in accordance with the responsibilities outlined in this Attachment H for CalOptima and its Members assigned to Delegate.

This Attachment H shall supersede all prior delegation agreements between the Parties and remain in effect for the term of the Contract.

1. Definitions

a. "**Standards and Requirements**" means currently applicable NCQA accreditation standards; DHCS, DMHC, CMS requirements; state and federal statutes, regulations, and sub-regulatory requirements; and CalOptima Policies and contractual requirements, including the State Contract.

2. Delegate Obligations

a. **Standards and Requirements:** Delegate agrees (either itself or through a CalOptima-approved Subcontractor or downstream entity) to provide the delegated services set forth in Schedules A, B, C, and D, as applicable, ("**Delegated Services**") in accordance with the terms of this Attachment H and Standards and Requirements. Delegate shall comply with new or revised Standards and Requirements from and after the effective date of any new or revised standard or rule. Changes necessary to comply with new/revised Standards and Requirements are not a change to a material term of this Attachment H requiring approval by either party.

b. **Policies and Procedures:** Delegate shall comply with CalOptima's policies and procedures, including but not limited to CalOptima Policy GG.1619: Delegation Oversight. Delegate shall submit to CalOptima copies of Delegate's written policies and procedures for each delegated service as part of a readiness assessment and at least once each year during the term of the Contract. Delegate's policies and procedures are subject to annual review and/or review upon request by CalOptima.

c. **Subdelegation:** Delegate agrees not to subdelegate any Delegated Services without prior written notice to and approval by CalOptima. Delegate shall provide CalOptima a written and complete list of subdelegates, vendors, subcontractors, and offshore entities performing services for or on behalf of Delegate at least sixty (60) days before the date Delegated Services are to begin under this Attachment H. The parties shall update the list shall no later than sixty (60) days before any changes approved by CalOptima take effect, including new subdelegates or offshore entities or the movement of Delegated Services from one subdelegate or offshore entity location to another. CalOptima may audit Delegate's subdelegates with advance notice, and Delegate will ensure its contracts with Subcontractors and subdelegates provide such an audit right for CalOptima. All Delegate contracts with subdelegated entities shall require the subdelegated entity to perform all Delegated Service(s) in compliance with the Contract, including this Attachment H and all Standards and Requirements. Delegate is responsible for ensuring each subdelegate complies with the Standards and Requirements. Subdelegation shall not relieve Delegate of its obligations or liability under the Contract, including this Attachment H and its Schedules A, B, C, and D (as applicable). Delegate represents and warrants that it shall take all steps necessary to cause subdelegates to comply with this Attachment H, including all Schedules.

d. **Offshore Entities:** Delegate represents and warrants it does not and will not use any offshore entity to perform Delegated Services unless and until:

   i. Delegate provides sixty (60) days' advance written notice to CalOptima before entering into any agreement to subcontract any Delegated Service to an offshore entity;

   ii. CalOptima, in its sole discretion, agrees in writing to the subdelegation of Delegated Services to the offshore entity;

iii. Delegate and offshore entity consent to and cooperate with CalOptima's right to audit the offshore entity. Delegate shall also audit the offshore entity before the offshore entity's provision of Delegated Services and annually as long as Delegate subdelegates Delegated Services to the offshore entity; and

iv. CalOptima and Delegate file the proposed subdelegation of functions or services to the offshore entity with the appropriate regulatory authorities for approval and receive regulatory approval Delegate and the delegated offshore entity shall comply with any requirements that the applicable regulatory authority may issue at any time during the term of the Contract.

e. **Systems & System Conversions:** Delegate agrees to take all necessary steps to ensure the Delegate's systems perform in a manner that assures Delegate's compliance with all Standards and Requirements. Delegate shall provide CalOptima at least sixty (60) days' prior written notice of any systems conversions or modifications that directly impact its obligations under this Attachment H. All systems processing and/or storing of protected health information ("**PHI**") and/or personally identifiable information ("**PII**") must have at least one (1) system risk assessment/security review conducted annually that demonstrates to CalOptima that Delegate's administrative, physical, quality, and technical controls are functioning effectively in compliance with Standards and Requirements. Delegate agrees to cooperate with CalOptima and facilitate CalOptima's performance of any system risk assessment, security reviews, compliance, and/or system reviews, as required by law and its regulators.

3. **Delegate Representations and Warranties**

a. **Good Standing; Exclusion Lists:** Delegate represents and warrants to CalOptima that:

i. Delegate is, and will remain throughout the Term of the Contract, in good standing under Standards and Requirements governing its existence and operations, and it is in compliance with and shall continue to comply with all laws and regulations applicable to this Attachment H and the duties and obligations under this Attachment H, including, but not limited to, Standards and Requirements related to Delegated Services (whether or not Delegate is directly obligated under or regulated by such Standards and Requirements);

ii. Delegate is in compliance with any licensing requirements and agrees to maintain such compliance under Standards and Requirements for the express purpose of performing each delegated service; and

iii. Neither Delegate nor any of Delegate's Subcontractors, as applicable, that are or will be fully or partially responsible for Delegate's performance of its obligations under this Attachment H have (A) pled guilty or no contest to or been convicted of any felony involving dishonesty or breach of trust; (B) been excluded from participation in any federal or state-funded health program; or (C) been listed in the Department of Health and Human Services Office of Inspector ("**OIG**") exclusion list or the General Services Administrative ("**GSA**") exclusion list. If the Delegate or any of Subcontractors or downstream entities, as applicable, are listed in the OIG or GSA exclusion lists after the effective date of the Contract, CalOptima shall have the right, in its sole discretion and judgment, to disqualify the listed person(s) from providing any part of the Delegated Services, or exercise CalOptima's rights to terminate Delegated Services under this Attachment H or to take other remedial steps.

b. **Program Representations:** Delegate warrants that each Delegated Service shall meet or exceed: (a) all CalOptima standards, policies, and procedures outlined in this Attachment H and CalOptima Policies, including the provider manual(s); (b) all Standards and Requirements applicable to Delegated Service; and (c)NCQA standards. In the event CalOptima or an accrediting organization's standards or any laws and regulations are materially changed or revised, Delegate agrees to comply with or implement, as applicable, and to the satisfaction of CalOptima, any such change or revision within the earlier of sixty (60) calendar

days of receiving notice of such change or within such time frame as may be required by the accrediting organization, applicable laws and regulations, or CalOptima. The parties agree any such change or revision shall not be considered a change to a material term of this Attachment H, consistent with Section 2(a).

c. **Incentives:** Delegate further represents and warrants that as of the Effective Date and throughout the term of the Contract compensation, incentives or remuneration to persons performing such functions under this Attachment H shall not be based, directly or indirectly, on the quantity, frequency or percentage of or in any way relating to denials of Covered Services.

d. **Compliance - Government Programs:** Delegate shall (and shall cause its Subcontractors and downstream entities, as applicable) to institute, operate, and maintain an effective compliance program to detect, correct, and prevent the incidence of non-compliance with applicable state and federal regulatory requirements and the incidence of fraud, waste, and abuse. Such compliance program shall be appropriate to Delegate's, and, as applicable, Subcontractors and downstream entity organization and operations and shall include: (a) written policies, procedures, and standards of conduct articulating the entity's commitment to comply with Standards and Requirements, as well as providing mechanisms for employee/Subcontractor use in adhering to expectations regarding the reporting of potential non-compliance or fraud, waste, and abuse issues (internally and to CalOptima, as applicable); (b) for all officers, directors, employees, Subcontractors, agents, and downstream entities of Delegate, as applicable, required participation in effective compliance and anti-fraud training and education (this required training includes general compliance and fraud, waste and abuse training completion and code of conduct dissemination, initially within ninety (90) days of hire/contracting and at least annually after that; Delegate and Subcontractors and downstream entities, as applicable, may use CalOptima's code of conduct and training or an equivalent approved by CalOptima); and (c) processes to oversee and ensure compliance with these requirements.

e. **Notice of Adverse Action:** Delegate agrees to notify CalOptima promptly of: (a) any litigation brought against Delegate related to any Delegated Service or similar services provided by Delegate to other persons; (b) any actions taken or investigations initiated by any government agency involving Delegate or any entity in which Delegate holds more than a five percent (5%) interest; or (c) any legal actions or investigations, or notice thereof, initiated against Delegate by governmental agencies or individuals regarding fraud, abuse, false claim, or kickbacks. Upon CalOptima's request, Delegate agrees to provide all known details of the nature, circumstances, and disposition of any suits, claims, actions, investigations, or listings to CalOptima.

f. **Standard Operating Hours:** Delegate attests to standard operating hours for all contracted lines of business and all Delegated Services in this Attachment H.

4. **Rights and Obligations of CalOptima**

a. **Oversight:** Delegate agrees to allow and cooperate with CalOptima to maintain oversight of the Delegated Services, including, but is not limited to:

i. **Annual Audits:** Delegate shall allow CalOptima to conduct annual audits and/or review of Delegated Services upon thirty (30) calendar days' prior written notice or upon shorter notice in the event CalOptima determines a shorter period is necessary to ensure CalOptima or Delegate's compliance with Standards and Requirements. Cooperation with an annual audit shall include permitting CalOptima to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to delegated services performed by Delegate and any subdelegate, downstream or offshore entity, as applicable.

ii. **Corrective Action Plan:** If CalOptima has reason to believe Delegate failed to carry out a delegated service per the terms of this Attachment H or CalOptima's performance expectations, CalOptima will require the Delegate to submit, within a specified timeframe, a corrective action plan ("**CAP**") to address any compliance or other problems identified by CalOptima. Once the CAP

is approved by CalOptima, Delegate will be required to implement, within ten (10) business days, or as designated by CalOptima, the approved CAP and permit increased audits of Delegate's performance to ensure compliance with such CAP. CalOptima may take further remediation actions as outlined in Section 14.

iii. **External Audits:** Delegate shall allow and cooperate with CalOptima or CalOptima's designated agent(s), federal, state, and local governmental authorities having jurisdiction, and any applicable accrediting organization to audit, interview staff, and access view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services during regular business hours upon at least thirty (30) calendar days' prior written notice, or upon shorter notice if CalOptima determines a shorter period is necessary to ensure CalOptima's compliance with Standards and Requirements. Any such audit shall be permitted during the term of this Attachment H and for six (6) years thereafter (or longer if required by law), with Delegate and CalOptima responsible for their own expenses incurred related to such audit. This Section 4(a)(iii) shall survive the termination of the Contract, regardless of the cause of termination.

iv. **Onsite Monitoring:** Delegate shall permit and cooperate with CalOptima or CalOptima's designated agent(s), federal, state and local governmental authorities having jurisdiction, and any applicable accrediting organization to conduct routine and non-routine on-site visits and monitoring at any site at any time where the Delegate performs Delegated Services under the terms of this Attachment H with five (5) business days' advance notice for routine monitoring and one (1) day notice for non-routine monitoring (or upon shorter notice as required by Standards and Requirements). Cooperation with on-site monitoring shall include allowing CalOptima or CalOptima's designated agent(s), federal, state and local governmental authorities having jurisdiction, and any applicable accrediting organization, to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services.

v. **Accreditation Review:** Delegate shall permit and cooperate with NCQA to conduct on-site review of any documents related to services provided by Delegate under this Attachment H during a health plan accreditation survey of CalOptima by NCQA or other accrediting organization. Cooperation with such NCQA or other accrediting organizations, on-site review, and accreditation survey shall include permitting NCQA or other accrediting organizations to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services.

vi. **Authority over Delegated Services:** CalOptima retains discretionary authority over all Delegated Services, including final decision-making and the operation thereof.

5. Records and Confidential Information

a. **Records:** Delegate agrees to retain Delegated Services records for the longer of ten (10) years following the date of service or the period required by Standards and Requirements. Delegate agrees to provide CalOptima or CalOptima's designated agent(s), federal, state, and local governmental authorities having jurisdiction, and any applicable accrediting organization, access to all delegated services records during regular business hours. This record retention provision (Section 5) shall survive the termination of the Contract regardless of the cause giving rise to the termination.

6. **Reporting:** Delegate shall provide Delegated Service reports via electronic submission to CalOptima's delegation oversight representative, as follows:

a. As outlined in the Schedules A, B, C and D, as applicable.

b. All other reports as required by CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting and the Report Binder.

c. CalOptima shall provide Member experience data to Delegate on an on-going basis. Member experience data shall be provided at least annually and include complaints, results of Member satisfaction surveys (such as CAHPS), and results of focused studies.

d. Delegate shall provide clinical performance data monthly or upon request and shall include HEDIS measure rates, HEDIS member-detail care gap reports, and other clinical data. Data shall be provided on Delegate's assigned secure file transfer protocol site.

7. **Conflicting or Overlapping Standards and Requirements:** If one or more regulatory or accreditation bodies have Standards or Requirements that create conflict or overlap, Delegate shall comply with the most stringent applicable Standards and Requirements for each Delegated Service. If Delegate is unsure of which standards may apply in a given situation, Delegate should contact healthnetworkdepartment@caloptima.org.

8. **Claims Delegation:**

   a. **Timely Adjudication of Claims:**

      i. Except for OneCare Member claims, Delegate will process claims from and pay Providers in compliance with timeliness requirements outlined in Standards and Requirements, including, without limitation, California Health and Safety Code Section 1371, 28 CCR Sections 1300.71 and 1300.77.4.

      ii. For Medi-Cal Members, Delegate shall also comply with DHCS standards.

      iii. For OneCare members, Delegate shall comply with federal laws and regulations applicable to Medicare organizations.

      iv. If Delegate delegates to a Subcontractor (*e.g.*, management company, claims administrator, subcontracted capitated provider) the obligation to process claims on Delegate's behalf, then Delegate shall: (A) notify CalOptima of such delegation in advance, and (B) require the Subcontractor to comply with the claims processing procedure requirements in this Attachment H and Standards and Requirements.

   b. **Claims Forwarding**: If Delegate receives a claim for services provided to a Member and the claim is the financial responsibility of CalOptima or another health plan, Health Network, or Provider, Delegate shall timely forward the claim to CalOptima or the applicable health plan, Health Network, or Provider within ten (10) working days pursuant to 28 CCR Section 1300.71(b)(3).

   c. **Failure to Make Payment:** Notwithstanding anything in this Attachment H, if Delegate fails to pay a Provider for Covered Services under the delegate's financial responsibility within the time frames outlined in this Attachment H and Standards and Requirements, (allowing for permissible disputes and appeals) and CalOptima reasonably determines that such amount is due and payable by Delegate, CalOptima may, after providing no fewer than ten (10) business days' prior written notice to Delegate, pay the amount due and deduct and offset such payment from any amount then or thereafter payable by CalOptima to Delegate.

9. **Utilization Management Delegation:** Delegate will maintain a well-structured and documented utilization management ("**UM**") program and will make UM decisions in a fair, impartial, and consistent manner, consistent with all Standards and Requirements, including CalOptima's UM program, and this Contract.

   a. **Timely Decisions Made by Appropriately Licensed Professionals:** Delegate will process UM requests in accordance with Standards and Requirements timelines for pre-service, concurrent, urgent, and post-service requests. The UM decisions will be made by appropriately licensed professionals and based upon all relevant clinical information.

b. **Member and Provider Notification:** Delegate will provide verbal, electronic and/or written UM denial notices to Members and treating Providers within Standards and Requirements timelines. Such notices will be written in using sixth (6th) grade language, contain the specific protocol, benefit provision, and/or guideline that is the basis for denial, and include detailed instructions for appealing the UM decision. Further, Provider notices shall contain the name and direct telephone number, if available, or a general number and extension of the UM denial decision maker.

c. **UM System Controls:** At all times, Delegate shall maintain detailed policies and procedures in its UM system controls that meet all Standards and Requirements. The UM system controls will define date(s) of receipt and notification, document the process for recording dates, specify authority to modify dates, define system tracking of modifications to dates, and describe how compliance with system policies and procedures are monitored and enforced.

10. **Credentialing Delegation:** Delegate will maintain a well-structured and documented credentialing program for evaluating and selecting licensed Providers to provide care to Members that comply with all Standards and Requirements and this Contract.

    a. **Credentialing Committee:** Delegate will operate a Credentialing Committee comprised of Participating Providers that makes recommendations regarding credentialing and re-credentialing Providers. Delegate will further ensure that credentialing files received from Providers that meet established credentialing or recredentialing criteria are reviewed and approved by Delegate's medical director, designated physician, or Credentialing Committee.

    b. **Timely Verification and Recredentialing:** Delegate will verify information using primary sources within one hundred (180) days of credentialing, or within a shorter timeframe if required by Standards and Requirements, to ensure Providers have the legal authority and relevant training and experience to provide quality care. Delegate will recredential Participating Providers within thirty-six (36) months of their prior credentialing/re-credentialing approval date.

    c. **Actions Against Providers:** Delegate will maintain policies and procedures for taking actions against Providers for violations of applicable standards and regulations that include the range of actions available to the Delegate and how Delegate makes appeal processes known to Providers.

    d. **Credentialing System Controls**: At all times, Delegate will maintain detailed policies and procedures in its credentialing system controls that meet all Standards and Requirements. The system controls will define how primary source verification information is received, dated, and stored; document authority to modify information; define system tracking of modifications; and describe how compliance with system policies and procedures are monitored and enforced.

    e. **Final Network Determination:** CalOptima retains the right to approve, suspend, and terminate individual Practitioners, Providers, and sites from the Delegate's network relative to CalOptima's Medi-Cal and/or OneCare program(s), even if CalOptima delegates credentialing and recredentialing decision-making to Delegate. CalOptima has the right to make the final determination of such participation in Delegate's network as it relates to CalOptima programs.

11. **Case Management Delegation:** Delegate will maintain a well-structured and documented case management program for members with multiple and/or complex health care conditions consistent with Standards and Requirements and this Contract.

    a. **Case Management Referral:** Delegate will have multiple referral avenues for Members and will accept referrals from sources including medical management, discharge planning, Member, Member's caregiver, and individual Practitioner. Delegate will begin the case management assessment process within thirty (30) days of referral to case management.

b. **Case Management Process:** Delegate's case management process will address initial assessment of Member's health status, behavioral health status, daily living, and social determinants of health; evaluation of Member's needs, preferences, and limitations; and development of an individualized case management plan for each assigned Member, including ongoing communication strategies.

c. **Case Management Systems:** Delegate will use a case management system that supports evidence-based, clinical guidelines to conduct assessment and management, automatic documentation of staff activity on case, and automated prompts for follow-up.

12. **Related Requirements**: Delegate will comply with all Standards and Requirements related to all Delegated Services, including, but not limited to:

    a. **New Provider Training**: Delegate will initiate training for all new Participating Providers no later than ten (10) business days from placing a Provider on active status in the network and shall complete the training within thirty (30) calendar days of placing a Provider on active status in the network. This training must include cultural and linguistic requirements, health inequities and identified cultural groups, and language and literacy needs.

13. **Regulatory Fines:** CalOptima and Delegate acknowledge that Delegated Services under this Attachment H are subject to regulation by governmental agencies with jurisdiction over the parties. If Delegate does not or is not able to fulfill any or all its obligations under this Attachment H, and if CalOptima is subject to any fines or fees from a governmental agency as a direct result thereof, Delegate agrees to pay to CalOptima the amount of such fines and any penalties incurred by CalOptima, including any applicable interest paid by CalOptima. CalOptima shall have sole discretion to pay such fees, fines, or penalties and/or to settle or compromise with such governmental agencies.

14. **Remediation for Delay or Failure to Implement CAP and/or Failures that May Cause Harm to Members:** If Delegate delays implementation of a CAP submitted and approved under Section 4(a)(ii), fails to complete a CAP within the timeframe specified in the CAP, or delegation failures that could jeopardize the health, safety, or welfare of Members, CalOptima may take any of the following remedial measures, in general order of escalation:

    a. **Freeze Delegate Enrollment and/or Pause Auto-Assignment:** CalOptima may freeze enrollment to the Delegate, through pausing auto-assignment of Members, or disallowing Member selection to the Delegate, or both.

    b. **Withhold Quality, Shared Savings, or Incentive Payments:** CalOptima may withhold or delay any applicable quality or other incentive payments or shared savings payments until the CAP is fully implemented or Delegate's failure is fully cured, as determined by CalOptima in its sole discretion.

    c. **Financial Penalties/Monetary Sanctions**: CalOptima may impose financial penalties/monetary sanctions if a Delegate fails to complete a CAP within the timeframe specified or demonstrates other failures impacting Member health, safety, or welfare:

        i. Per Member sanctions of $25,000 per Member:

            1. Delegate fails to provide medically necessary services that the Delegate is required to provide.

            2. Delegate inappropriately delays/denies Covered Services.

            3. Delegate fails to appropriately resolve a Member appeal consistent with Standards and Requirements.

            4. Delegate incorrectly charges premium or unnecessary out-of-pockets costs.

            5. Delegate inaccurately or untimely provides plan benefit information (*e.g.*, wrong denial notices).

        ii. Aggregate sanctions for failures that impact populations of Members

1. One percent (1%) off the monthly capitation amount for a first violation.
2. Two percent (2%) off the monthly capitation amount for a second violation.
3. Three percent (3%) off the monthly capitation amount for each subsequent violation.

iii. Per determination: If CalOptima does not have the Member-specific data or the per Member impact cannot be clearly analyzed, CalOptima may calculate the penalty under the per determination basis.

iv. Delegate may appeal a financial penalty or monetary sanction through CalOptima's appeal process outlined in CalOptima Policy.

d. **Use of a Monitor at Expense of Delegate:** In cases of continued non-compliance or failures that could jeopardize the health, safety, or welfare of Members, CalOptima may require the Delegate to engage and pay for an external auditor or other consultant acceptable to and approved by CalOptima, in order to correct the identified deficiency(ies) or areas of non-compliance, to CalOptima's satisfaction.

e. **Modification of Delegation:** If, for any reason, CalOptima or any state or federal governmental agency with jurisdiction is dissatisfied with the performance of the Delegated Services, CalOptima may, upon written notice to Delegate, modify Delegate's status (concerning all or a particular Delegated Service) from "fully delegated" to "delegated with corrective action." Such notice shall set forth the deficiencies perceived by CalOptima and/or any state or federal governmental agency in Delegate's performance of Delegated Services. If Delegate does not correct such deficiencies to the reasonable satisfaction of CalOptima and/or the governmental agency within ninety (90) days of such notice (or a shorter timeframe as determined by CalOptima in its reasonable discretion), CalOptima may, in its sole discretion, (a) extend the period given to Delegate to correct such deficiencies; (b) terminate all or any portion(s) of the delegation to Delegate; or (c) terminate this Attachment H.

f. **Termination of Delegation with Notice:** Notwithstanding Section 14(e), CalOptima may, upon sixty (60) days' prior written notice to Delegate, terminate all or any portion(s) of the delegation to Delegate if, after consulting with Delegate, CalOptima or any state or federal governmental agency determines that Delegate (i) no longer meets all criteria for performance of the Delegated Service(s), or (ii) is not performing, or is not reasonably likely to perform, the Delegated Service(s) in full compliance Standards and Requirements. If, within such sixty (60)-day notice period, Delegate cures such deficiencies to CalOptima's reasonable satisfaction, CalOptima may withdraw such termination.

g. **Immediate Termination of Delegation:** Notwithstanding Sections 14(e) and 14(f) of this Attachment H, CalOptima may, upon prior written notice, immediately terminate all or any portion(s) of the delegation to Delegate of the delegated service(s) if, after consulting with Delegate, CalOptima or any Government Official reasonably determines that the continued performance of the Delegated Service(s) by Group would jeopardize the health, safety, or welfare of members assigned to Delegate under this Attachment H. Such de-delegation shall terminate when Delegate demonstrates to the satisfaction of CalOptima that members' health, safety, or welfare is no longer in jeopardy.

h. **Material Breach**: Delegate agrees that Delegate's failure to agree to or begin reasonable implementation of a CAP designed to correct identified deficiencies in Delegated Services under this Attachment H shall be considered a material breach of the Contract. Additionally, Delegate agrees that Delegated Services failures that could jeopardize the health, safety, or welfare of Members shall be considered a material breach of the Contract. Any such material breach of this Attachment H shall permit CalOptima to implement or engage in any or all oversight or other CalOptima rights and obligations described in the Contract, including under Section 13.

15. **Termination of Delegation (De-Delegation):** In the event CalOptima terminates delegation, or assumes all or any portion(s) of the Delegated Service(s) under this Attachment H, the following provisions shall apply:

a. **CalOptima's Assumption of Payment of Claims:** If Delegate's claims procedures fail to comply with the obligations outlined in Schedule A of this Attachment H, CalOptima may, as required or permitted by Standards and Requirements, assume responsibility for the processing of claims that are Delegate's financial responsibility under this Attachment H. Such assumption may be altered to the extent Delegate has established and fully implemented an approved CAP consistent with California Health and Safety Code Section 1375.4(b)(4) and 28 CCR § 1300.75.4.8.

b. **Capitation reduction for de-delegation:** Upon termination or assumption by a CalOptima of all or any portion(s) of a Delegated Service pursuant to this Attachment H, CalOptima may, in its sole discretion, reduce the net monthly Capitation Payment otherwise payable to Delegate by the percentage set forth below. Such amounts are not intended to represent the portion of the Capitation Payment allocated to cover the cost of performance of the Delegated Service(s) by Delegate nor an estimate of the costs incurred by CalOptima as a result of the termination of the delegation; rather, the amounts set forth below are intended as a performance fee for Delegate's failure to meet the standards established for performance of the Delegated Service.

	Medi-Cal	OneCare
Utilization Management/ Case Management	3.0%	3.0%
Credentialing	1.0%	1.0%
Claims Processing		
- non-contracted only	1.0%	1.0%
- all claims	7.0%	7.0%
- non-contracted only payment withhold *	8.5%	8.5%
- all claims payment withhold	85.0%	85.0%

* = Subject to actual claims paid experience.

c. **Obligation to Cooperate:** Upon termination of the Contract for any reason, Delegate agrees to cooperate fully with CalOptima and comply with CalOptima procedures, if any, in the transfer of Delegate's obligations under this Attachment H to CalOptima or another CalOptima delegate. Delegate agrees to promptly provide CalOptima with any and all information and documentation necessary for such transfer. This shall include copies of all Delegated Services notes and accompanying records and information submitted by Providers as requested by CalOptima.

Schedule A
Claims Payment Delegation

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Claims policies, procedures, and compliance	[insert LOB]	1. Annually submit updated, reviewed, and approved claims payment policies and procedures. 2. Provide oversight to any Subcontractors and subdelegated entities that perform claims processing or payment to ensure compliance with Standards and Requirements. 3. Submit all required reports and audit materials, as defined in Schedule A.	1. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 2. Review all required reports timely and provide substantive feedback.	Submitted to CalOptima's Delegation Oversight Committee ("Delegation Oversight") as part of the annual audit: 1. Updated, reviewed, and approved claims processing policies and procedures. 2. Evidence of oversight of Subcontractors and subdelegates	Annual audit, or more frequently as needed, using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare line of business ("LOB"). Delegate must meet at a minimum 95% compliance for each LOB.	1. CAP 2. Remediation steps outlined in Section 14
Claims processing		1. Identify and acknowledge electronic claims within two (2) working days of receipt. 2. Identify and acknowledge paper claims within fifteen (15) working days of receipt. 3. For Medi-Cal claims, process and adjudicate ninety percent (90%) of all	1. Annual claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or	Submitted via monthly XML process: 1. Claims XML Universe 2. Claims Universe Case Files	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program	1. CAP 2. Remediation steps as outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		Clean Claims for Covered Services within thirty (30) calendar days of receipt. 4. For OneCare claims, process and adjudicate ninety-five percent (95%) of Clean Claims for Covered Services within thirty (30) calendar days of receipt. a. Process and adjudicate all other Clean Claims from non-Participating Providers for Covered Services within sixty (60) calendar days from date of receipt. b. Process and adjudicate ninety-nine percent (99%) of all Clean Claims from Participating Providers for Covered Services within ninety (90) calendar days of receipt	distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	3. Claims Timeliness Report 4. DHCS Post-Payment Recovery Report (Medi-Cal Only)	Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	
Exclusion and preclusion monitoring		1. Verify Practitioner or Provider entity participation status prior to adjudicating any received claims as required by CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring 2. If Delegate pays a claim from an excluded Practitioner or Provider entity, Delegate must notify CalOptima, recover the payment, and prevent future payments to the excluded Provider.	1. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	1. Quarterly overpayment report outlined in reporting binder		1. CAP 2. Remediation steps as outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Interest payment for late paid claims		Medi-Cal: 1. Pay interest and applicable penalties on all uncontested claims not paid within forty-five (45) business days. 2. For emergency services, automatically include the greater of fifteen dollars ($15) for each twelve (12)-month period (or portion thereof) on a non-prorated basis, or interest at the rate of fifteen percent (15%) per year for the period of time the payment is late. 3. For all other late payments, include interest at the rate of fifteen percent (15%) per year for the period of time the payment is late. 4. If Delegate fails to include the interest due on a late claim payment, the Delegate shall pay an additional ten-dollar ($10) penalty. OneCare: 1. Interest shall begin to accrue on the thirty-first (31st) calendar day for non-Participating Provider, non-Clean Claims, and (61st) calendar days for Participating Provider Clean Claims, calculated based on calendar days. 2. Delegate shall pay interest at the rate used for Section 3902(a) of Title 31, U.S. Code and rounded to the nearest penny.			Annual audit, or more frequently as needed, using NCQA Methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum 95% compliance.	1. Corrective Action Plan (CAP) 2. Remediation steps as outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		The interest rate is determined by the applicable rate on the day of payment. Interest shall be calculated using the following formula: a. [Payment Amount x Rate x Days] divided by [365 (366 in a leap year)] = Interest Payment				
Coordination of benefits		1. Have processes and procedures in place to identify payers that are primary and secondary to determine amounts payable and coordinate benefits for members with other health coverage ("OHC"), in accordance with Medicare and Medi-Cal crossover claims guidelines. 2. If a Member has OHC, consider the OHC plan as primary. 3. If a Member has both Medicare and OHC, both Medicare and OHC shall pay claims for services prior to Delegate. 4. Remain the secondary health plan and payer of last resort. 5. Identity and report to CalOptima any OHC or other private or public health insurance for Members 6. Identify and report to CalOptima any explanation of payment ("EOP") or explanation of medical benefits	1. Annual claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	1. Monthly Post Payment Recovery Template	Policy review as part of annual audit	1. CAP 2. Remediation steps outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		("EOMB") received with other coverage payment				
Third party liability		1. Notify CalOptima within five (5) calendar days of becoming aware of potential third-party liability (including casualty insurance, tort, workers compensation liability) related to Covered Services for a Member. 2. Make no claim for recovery of the value of covered services in an instance of Third Party Liability in which the DHCS has lien rights.	1. Annual claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	1. Report occurrences consistent with CalOptima Health Policy FF.2007: Reporting of Potential Third Party Liability	Policy review as part of annual audit	1. CAP 2. Remediation steps outlined in Section 14
Level 1 Provider dispute resolution		1. Acknowledge receipt of electronically submitted Level 1 disputes within two (2) working days; acknowledge receipt of hard-copy disputes within fifteen (15) working days. 2. Resolve Level 1 provider disputes or amended disputes related to claims			Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS	1. CAP 2. Remediation steps outlined in Section 14

Delegated Claims Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		payment decisions within forty five (45) days.			Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	

Schedule B
Utilization Management Delegation

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
UM Program policies, procedures, and compliance	[insert LOB]	1. Annually submit updated, reviewed, and approved written UM Program documentation outlining the structure, scope, responsible parties, criteria, timelines, policies, procedures, and processes that meet all Standards and Requirements. 2. Conduct an annual evaluation of the UM Program that verifies the program meets all Standards and Requirements, ensures all UM decisions are made by qualified professionals, evaluates the appropriateness of UM criteria, assesses the interrater reliability, ensures the criteria are consistently applied and available to Providers, and ensures all denials are reviewed by a physician or other appropriate professional. 3. Provide oversight to any Subcontractors and/or subdelegated entities that perform UM to ensure compliance with Standards and Requirements. 4. Submit all required reports and audit materials timely.	1. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 2. Review all required reports timely and provide substantive feedback.	Submitted via FTP: 1. Annual UM Program and Workplan 2. Semi-Annual Work Plan 3. Annual UM Evaluation 4. Annual UM Evaluation (Prior year) 5. All required documents for Annual Audit pursuant to the CalOptima Reporting Policy.	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB.	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
UM decision timeliness		Comply with all Standards and Requirements for notification of UM decisions, including CalOptima Health Policy GG.1508: Authorization and Processing of Referrals. Further, Delegate will make UM decisions in a timely manner and notify Providers and Members electronically or in writing: 1. Urgent concurrent and preservice decisions within seventy-two (72) hours of request 2. Medi-Cal non-urgent pre-service decisions within five (5) working days from receipt of information reasonably necessary to render a decision, but no longer than fourteen (14) calendar days of request. 3. OneCare non-urgent pre-service decisions within fourteen (14) calendar days of request 4. Post-service decisions within thirty (30) calendar days of request	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	Submitted via monthly XML process: 1. Utilization Management (UM) XML Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14
UM decision clinical information		1. Gather and use all clinical information relevant to the Member's care when making UM decisions 2. Adhere to policies set forth in CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring.	Submitted via XML: 1. Utilization Management (UM) XML Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
			2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	
Written notification of UM denials and appeal rights		Delegate shall comply with all Standards and Requirements for written notification applicable for Medi-Cal or an integrated denial notice applicable for OneCare, including CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. Delegate shall use a readability scoring tool and ensure notices for Members do not use language exceeding a sixth (6th)-grade level. Further, written or electronic notification of UM denials for Members and Providers must include the following: 1. The specific reason for the denial in easily understood language.	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide	Submitted via XML: 1. Utilization Management (UM) XML Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		2. A reference to the benefit provision, guideline, protocol or other similar criteria upon which the denial is based. 3. A statement that the Member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criteria on which the denial decision is based, upon request. 4. The Provider notice must be addressed to the requesting Provider (not organization) and include the name and direct telephone number, if available, or general number and extension of the decision maker 5. A description of appeal rights, including the right to submit written comments, documents or other relevant information. 6. An explanation of the appeal process, including Members' rights to representation and time frames 7. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials a. Timeframe for filing b. Timeframe for decision c. Process for expedited appeal, including where to direct appeal and what information to include	substantive feedback.			

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		8. Notice that expedited external review can occur concurrently with internal appeals process for urgent care				
UM system controls		Delegate will maintain policies and procedures in its UM system controls that meet all NCQA requirements and: 1. Define date of receipt consistent with NCQA requirements 2. Define date of notification consistent with NCQA requirements 3. Describe process for recording dates in system 4. Specify titles/roles of staff authorized to modify dates once initially recorded and circumstances when modifications are appropriate 5. Specify how the system tracks: a. Date modifications b. When the date was modified c. Who modified the date. d. Why the date was modified. 6. Describe system controls to protect data from unauthorized modification 7. Describe how compliance with policies and procedures are monitored at least annually and how Delegate	1. Pre-delegation system review. 2. Annual review of delegate system policies and system control report. 3. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 4. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 5. Review all required reports timely and provide substantive feedback.	All required documentation for annual audit pursuant to the CalOptima Health Reporting Policy HH.2003: Health Network and Delegated Entity Reporting, including the CalOptima Timely and Appropriate Submission Grid and Supplemental Attachment	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		takes appropriate action when applicable 8. At least annually, monitors compliance with UM system controls by: a. Identifying and analyzing all modifications to dates that did not meet established policies and procedures. b. Acting on all findings and implementing a quarterly monitoring process until improvement is demonstrated for one finding over three (3) consecutive quarters.				
Level 1 Provider dispute resolution		1. Process and resolve Level 1 Provider disputes related to post-service UM decisions according to Standards and Requirements, including CalOptima Policies	1. Annual audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports	Submitted via XML: 1. UM Retrospective Post-Service Decision Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum	1. CAP 2. Remediation steps outlined in Section 14

Delegated Utilization Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
			timely and provide substantive feedback.		ninety-five percent (95%) compliance	

Schedule C Case Management Delegation

Delegated Case Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Case management activities		1. [List of CM activities delegated as of date of the Attachment H] 2. Changes necessary to comply with new/revised laws and regulations or new/revised accreditation standards and Requirements will not be considered a change to a material term of this Attachment H requiring approval by either party	1. [List of CM activities retained by CalOptima]	N/A	N/A	N/A
Case management policies, procedures, and compliance	[insert LOB]	1. Annually submit updated, reviewed, and approved written Case Management ("CM") program documentation outlining the structure, scope, responsible parties, criteria, timelines, policies, procedures, and processes that meet all Standards and Requirements. CM program shall include basic care management, care coordination, complex care management services, and transitional care services. The CM program shall include care management of OneCare Members, EPSDT, children with special health care needs, early intervention services, care transitions, and whole-child model. 2. Conduct an annual evaluation of the CM program that verifies the program meets all Standards and Requirements, ensures the appropriate identification, stratification, and management of members.	1. Pre-delegation reviews. 2. Annual CM program audits, or as often as necessary. 3. Quarterly case file audits. 4. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 5. Review all required reports timely and provide. substantive	All required documentation for CM program annual audit Submitted via FTP: 1. Monthly Case Management Log 2. Quarterly case files as identified by CalOptima	Annual policy review or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet ninety-five percent (95) Quarterly case file review Delegate	1. CAP 2. Remediation steps outlined in Section 14

Delegated Case Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		3. Provide oversight to any subdelegated entities, vendors, or consultants that perform CM to ensure compliance with Standards and Requirements. 4. Submit all required reports and audit materials timely.	feedback if appropriate.		must meet minimum of 75% compliance for two consecutive quarters. Score is the combined percentage of each audited case across all applicable line of business	
Case management program referral		Delegate identifies Members with multiple or complex health care conditions, obtains access to care, and coordinates their care. Delegate has multiple referral programs (including but not limited to): 1. Medical management 2. Discharge planning 3. Member or caregiver 4. Practitioner	1. Pre-delegation reviews. 2. Conduct quarterly case file reviews or as often as necessary. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports	Submitted via FTP: 1. Monthly Case Management Log 2. Quarterly case files as identified by CalOptima	Quarterly case file review, or more frequently as needed, using NCQA Methodology Delegate must meet minimum of 75% compliance for two consecutive quarters.	1. CAP 2. Remediation steps outlined in Section 14

Delegated Case Management Activity	Line of Business	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
			timely and provide substantive feedback if appropriate.		Score is the combined percentage of each audited case across all applicable line of business.	
Case management systems		Delegate uses a CM system that supports: 1. Evidence-based clinical guidelines to conduct initial assessment and ongoing management. 2. Automatic documentation of date, time and individual who takes action on a case or interacts with a Member. 3. Automated prompts for follow-up	1. Pre-delegation reviews. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	All required documentation for CM program annual audit		1. CAP 2. Remediation steps outlined in Section 14

Schedule D Credentialing Delegation

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Credentialing policies, procedures, and compliance		Annually, Delegate will submit updated, reviewed, and approved written Credentialing Program documentation outlining the credentialing process for evaluating and selecting licensed Providers to provide care to Members that comply with all Standards and Requirements and CalOptima contract provisions. The program documentation must specify: 1. Types of Providers to credential and recredential. 2. Verification sources. 3. Criteria for credentialing and recredentialing. 4. Process for making credentialing or recredentialing decisions. 5. Process for managing credentialing files. 6. Non-discrimination policies and procedures. 7. Process for communication with Providers in the credentialing process and for notifying Providers within sixty (60) calendar days from the Credentialing Committee's decision, including informing Providers of the rights to review information about their application, correct errors, and check status of application.	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.	Submitted to Delegation Oversight annually via the audit process: 1. Credentialing program documentation	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		8. Roles and direct responsibility of Delegate's Medical Director or other designated physician in the Credentialing Program. 9. Confidentiality policies and procedures. 10. Policies and procedures designed to ensure accuracy of provider directories. 11. How Delegate considers Provider performance during recredentialing, including but not limited to, Member complaints/grievances. 12. For the Medicare LOB, ensure participating physicians haven't opted out of Medicare. 13. For the Medi-Cal LOB, ensure all Providers are confirmed as screened and enrolled for participation in Medi-Cal where there is an enrollment pathway. 14. Prevents credentialing of Providers that employ or contract with Providers, that have been excluded or sanctioned by Medicare or Medi-Cal or are excluded on any other state or federal exclusion, sanction, restriction or preclusion list. 15. Demonstrates compliance with CalOptima policies regarding credential all provider types GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organizational Providers.				

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Credentialing Committee		Delegate will operate a Credentialing Committee that makes recommendations regarding credentialing and re-credentialing decisions: 1. Committee is comprised of Participating Providers. 2. Reviews credentials for Providers who do not meet thresholds established by the Committee. 3. Ensures that files that meet Credentialing Committee-established criteria are reviewed and approved by Delegate's Medical Director, designated physician, or Credentialing Committee.	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.		Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14
Organizational Providers		The Delegate shall assess and approve, initially and in an ongoing manner, Provider organizations. Before the Delegate contracts with an organizational Provider, and for at least every thirty six (36) months thereafter, it: 1. Confirms that the Provider is in good standing with state and federal regulatory bodies.	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing		Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		2. Confirms that the Provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the Provider is not accredited. 4. Ensures that the Provider is Medi-Cal enrolled, if an enrollment pathway exists.	performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.		Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	
Verification of credentials		Delegate will conduct timely verification within one hundred eighty (180) days of credentialing of information (or a shorter time frame as required by Standards and Requirements) to ensure Providers have the legal authority and relevant training and experience to provide quality care to Members. Delegate will verify credentialing information through primary sources, unless otherwise indicated. 1. All National Provider Identifier (NPI) numbers, where applicable 2. A current and valid license to practice 3. A valid DEA or CDS certificate, as applicable	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports	1. Credentialing Monthly Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		4. Education and training, consistent with Standards and Regulations 5. Board certification status, as applicable 6. Work history 7. History of professional liability claims that resulted in settlements or judgements paid on behalf of practitioner 8. Sanction information: a. OIG b. System for Award Management (SAM) c. Medicare Opt-Out, if applicable d. Medi-Cal Suspended & Ineligible List e. CMS Preclusion List f. DHCS Medi-Cal Restricted Provider Database 9. For Medi-Cal LOB: For primary care Practitioners, Delegate will obtain evidence of passing the DHCS Facility Site Review 10. For Medi-Cal LOB: Delegate shall verify enrollment into the Medi-Cal program. Verification information located at https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers	timely and provide substantive feedback.		(95%) compliance	

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Credentialing applications		Delegate will require Providers to submit a credentialing/re-credentialing application that includes a signed attestation that includes: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use 3. History of loss of license and felony convictions 4. History of loss or limitation of privileges or disciplinary actions 5. Current malpractice insurance coverage 6. The application's accuracy and completeness 7. Hospital admitting privileges at a CalOptima contracted Hospital or if Delegate is financially responsible for Hospital services, a Delegate-contracted Hospital 8. Practice coverage, including names of answering service and covering physicians	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	1. Credentialing Monthly Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps as outlined in Section 14
Recredentialing cycle		1. Delegate will recredential Participating Providers within thirty-six (36) months of their prior approval date. 2. In between recredentialing cycles, Delegate will perform ongoing monitoring and interventions between recredentialing cycles and take appropriate action against Providers when Delegate identifies occurrences of	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring.	1. Credentialing Monthly Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program	1. CAP 2. Remediation steps as outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		poor quality. Monitoring shall include collecting and reviewing: Medicare and Medi-Cal/Medicaid sanctions or limitations on licensure, complaints, and information of adverse events.	2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	
Actions against Providers		1. Delegate has policies and procedures for taking actions against Providers that include the range of actions available to Delegate and how it makes appeal processes known to Providers. These policies and procedures establish that the majority of the appeal panel are peers of the Provider in question, and prohibit Delegate from attorney representation at appeal hearings unless the Provider is also represented. 2. If Delegate takes action against a Provider for quality reasons, Delegate will report the action to the appropriate authorities and offers a formal appeal process. 3. Delegate will use objective evidence and patient care considerations to decide on altering a Provider's relationship	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide	1. Delegate must report any Business & Professions Code §§ 805 and/or 805.01 actions immediately to CalOptima Quality Improvement Department at MyCredentialingUpdates@caloptima.org	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		with Delegate if the Provider doesn't meet Delegate's quality standards.	substantive feedback.			
Identification of HIV/AIDS Specialists		Delegate has policies and procedures for identifying HIV/AIDS Specialists: 1. Documentation describes how the Delegate identifies and annually reconfirms appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist, according to California regulations. 2. Documents that Delegate provides list of qualified Specialists to Delegate's department responsible for authorizing standing referrals	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.	1. Credentialing Monthly Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 14
Credentialing system controls		Delegate has policies and procedures in its Credentialing Program system controls that meet all NCQA requirements and: 1. How primary source verification information is received, dated and stored.	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and	1. Annual report on monitoring of system controls	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS	1. CAP 2. Remediation steps outlined in Section 14

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		2. How modified information is tracked and dated from its initial verification. a. When modified b. How modified c. Who modified d. Why modified 3. Identifies staff who are authorized to review, modify and delete information and circumstances when modification or deletion is appropriate. 4. Security controls in place to prevent unauthorized modification. a. Limiting physical access to location that houses credentialing information b. Preventing unauthorized access, changes to, and release of credentialing information c. Password-protecting electronic systems, including user requirements, to prevent passwords from being compromised and policies and procedures regarding changing or withdrawing passwords if compromised passwords or individuals should no longer have electronic access to the system	ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.		Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one -hundred percent (95%) compliance	

Delegated Credentialing Activity	LOB	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		5. How Delegate monitors its compliance with its Credentialing System Control policies and procedures at least annually and takes appropriate action when applicable.				
Subdelegation of credentialing		If Delegate subdelegates (subject to CalOptima's prior written approval) credentialing functions to another entity, Delegate will perform oversight of the subdelegated relationship in accordance with all Standards and Requirements, including but not limited to: 1. Using a written delegation agreement including all Standards and Requirements 2. Performing a pre-delegation review 3. Requiring at least semi-annual reporting 4. Having a described process Delegate will use to evaluate subdelegated entity's performance 5. Describing to subdelegate remedies available to Delegate if subdelegate does not fulfill its obligations	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal and CMS Program Audit Protocols for OneCare LOB. Delegate must meet at a minimum one-hundred percent (95%) compliance	1. CAP 2. Remediation steps as outlined in Section 14

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
21. Authorize Amendments to the CalOptima Health Medi-Cal Fee-for-Service Hospital Services Contracts

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

Recommended Actions
Authorize the Chief Executive Officer to execute amendments to the CalOptima Health Medi-Cal Fee-for-Service Hospital Services Contracts to:

1. Update rates for inpatient hospital services when contracted at All Patients Refined Diagnosis Related Groups (APR-DRG) rates, effective July 1, 2024.
2. Update rates for certain outpatient hospital claims, effective July 1, 2024.
3. Add language to operationalize a payment methodology to comply with the Department of Health Care Services mandatory targeted rate increases, effective January 1, 2024.

Background and Discussion
Staff requests that the CalOptima Health Board of Directors (Board) authorize amending the Medi-Cal Fee-for-Service (FFS) Hospital Services Contracts to reflect updated reimbursement rates and to incorporate Department of Health Care Services (DHCS) requirements that managed care plans comply with the DHCS mandatory targeted rate increase (TRI) for specific services, effective January 1, 2024. CalOptima Health's hospital provider partners are a vital part of its delivery system and support CalOptima Health in providing care for its over 900,000 members. Amending the FFS hospital provider contracts is periodically necessary to remain compliant with state requirements.

Provider Rate Increase
The Board committed $210.5 million in rate increases for contracted health networks and eligible FFS providers for Fiscal Year (FY) 2024-25 at the May 2, 2024, Board meeting. This increase will ensure financial stability, network adequacy, and member access to care within the CalOptima Health delivery system over the next 30 months.

The Medi-Cal FFS hospitals contract amendments include the following rate updates:

- For hospitals contracted at APR-DRG:
  - Inpatient hospital services for Medi-Cal Classic members will increase from the current rate of 112% of the Medi-Cal Fee Schedule to 125% of the Medi-Cal Fee Schedule.
  - Inpatient hospital services for Medi-Cal Expansion members will increase from the current rate of 117.3% to 125% of the Medi-Cal Fee Schedule.

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- For certain hospital outpatient claims, increase the rate from 140% to 240% of the Medi-Cal Fee Schedule when including at least one of the following services: Observation Status, Emergency Room, Operating Room, or GI Laboratory.

DHCS Targeted Rate Increase
The DHCS TRI is a set of payment increases applicable to eligible providers within the Medi-Cal FFS delivery system and Medi-Cal managed care plans for targeted services, which became effective January 2024 pursuant to the 2023 Budget Act and Assembly Bill 118 (Chapter 42, Statutes of 2023). Staff proposes including a single comprehensive provision in contracts supporting TRI implementation for all future provider types that DHCS identifies as eligible. CalOptima Health shall institute a payment methodology to comply with requirements related to the TRI. Proposition 56 supplemental payments for physician services will be subsumed under the applicable TRI payments.

Staff requests the Board approve the above recommended actions, allowing for the execution of these contract amendments to comply with regulatory requirements and support member access to quality care for CalOptima Health members.

Fiscal Impact
Management has included expenses associated with the Medi-Cal FFS hospital services contracts in the proposed FY 2024-25 Operating Budget, which is pending Board approval. The aggregate annual fiscal impact of the proposed rate updates to contracted Medi-Cal FFS hospitals is approximately $50.9 million. This amount is part of the $210.5 million commitment from unallocated reserves approved by the Board on May 2, 2024. As applicable, staff will continue to include updated expenses in future operating budgets.

Rationale for Recommendation
The above requested amendments serve to support CalOptima Health's delivery system, maintain compliance with the latest State requirements, and maintain a robust provider network.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Medi-Cal FFS Hospital Services Contract Amendment

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

AMENDMENT [XX] TO
HOSPITAL SERVICES CONTRACT

This Amendment [XX] to the 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 Health ("**CalOptima**"), and [add provider name], a California corporation, ("**Hospital**"). CalOptima and Hospital may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Hospital have entered into a Hospital Services Contract, originally effective [insert date], ("**Contract**"), by which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

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

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Add the following new Section [1.63], *Targeted Rate Increase*, to the Contract:

   [1.63] "**Targeted Rate Increase**" or "**TRI**" means the set of provider rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) as implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. The first phase of TRIs are effective for dates of service beginning January 1, 2024. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment previously due to Provider. The TRI applies to both fee-for-service and other provider payment arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

2. Delete Section [2.26], *Hospital Quality Improvement Program*, in its entirety and replace it with the following new Section [2.26], *Hospital Quality Improvement Program and Reporting*, to the Contract:

   2.26 Hospital Quality Improvement Program and Reporting. Hospital shall establish, maintain and operate a quality improvement program, which shall include an annual quality improvement work plan and an annual performance evaluation of such work plan, which is consistent with current industry standards, Quality Improvement System for Managed Care (QISMC), NCQA, Leapfrog, and/or JCAHO.

   2.26.1 Hospital agrees that CalOptima may use performance data for quality and reporting purposes, including quality improvement activities, public reporting to consumers, and performance data reporting to CalOptima's Regulators, as identified in CalOptima Policies and required by CalOptima's Regulators and applicable laws.

   2.26.2 Hospital agrees that CalOptima may make publicly available, as frequently as CalOptima deems necessary, reports of Hospital's compliance with the Contract's requirements and performance metrics, including Members' access to care, the quality of care received by Members, and Hospital's other performance trends, as applicable to Hospital's obligations hereunder.

2.26.3 As long as CalOptima's disclosures under this Section 2.26 otherwise comply with applicable laws, no CalOptima disclosure under this Section 2.26 shall constitute a breach of this Contract.

3. Delete Attachment B, *Compensation*, of the Contract in its entirety and replace it with the new Attachment B, *Compensation*, attached to this Amendment and incorporated into the Contract by this reference, which includes rates for Members, including Medi-Cal Expansion Members.

4. Delete Attachment B-1, *Medi-Cal Compensation Rates for Adult Expansion Members*, of the Contract in its entirety.

5. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

6. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern.

7. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR HOSPITAL:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ATTACHMENT B

COMPENSATION

CalOptima shall reimburse Hospital, and Hospital shall accept as payment in full from CalOptima the lesser of billed charges or the following amounts for Covered Services provided to Members under this Contract:

I. General Compensation Requirements

1. All billing and reimbursement must be in accordance with applicable Program, Government Contract, and Regulator payment guidelines, including Medi-Cal and Medicare.

2. Inpatient admissions to Hospital prior to the effective date of any rate amendment to this Attachment B, where a Member is still inpatient on the date of the rate amendment, shall be paid at the rates in place under this Contract at the time of admission for the entire length of the stay.

3. CalOptima may revise the rates in this Attachment B, in accordance with Laws, during the Term to reflect changes in Laws, the State budget, or compensation under the Government Contracts. CalOptima shall provide written notice to Hospital as soon as practicable upon becoming aware of the change.

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II. Medi-Cal

2.1. Inpatient Facility Services: [redacted]

2.2. Inpatient Acute Administrative Days: [redacted] and per CalOptima Policies regarding the criteria for authorizing acute administrative days.

2.3. Outpatient Services (excluding drugs):

Hospital Service	Qualifying Codes	Fee Schedule Multiplier
Observation status	HCPCS Z7514	[redacted]
Emergency room	HCPCS Z7502	
Operating room	HCPCS Z7506	
GI lab	Revenue codes 075X	

2.3.1 All claims for outpatient services are subject to Notes subsection b) and c) of this Section II below.

2.4. Outpatient Services - All other (excluding drugs): [redacted]

2.5. Outpatient Administered Drugs: [redacted]

2.6. Targeted Rate Increase Services. If applicable, for services subject to the TRI provided by a qualified professional, Hospital will be reimbursed at the greater of the contracted rates, outlined above plus any applicable supplemental payments, or the Medi-Cal TRI fee schedule rate in effect for the date of service; provided, however, in no event will Hospital be reimbursed at less than the Medi-Cal TRI fee schedule in effect for the date of service. Reimbursement for TRI services shall comply with DHCS Medi-Cal Program

requirements, laws, and CalOptima Policies. This provision is retroactive to TRI services provided beginning January 1, 2024, or as otherwise specified by DHCS.

Notes:

a) Inpatient services include Emergency Services when a Member is admitted within twenty-four (24) hours of an emergency department visit. Inpatient rates are all inclusive.

b) Conditions and terms applicable to the fee schedule multipliers:

i. Outpatient drugs, blood, and blood products are excluded line items from the above fee schedule multiplier and paid at [redacted].
ii. Outpatient services not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.
iii. The default outpatient Medi-Cal fee schedule multiplier is [redacted]. To qualify for a higher payment multiplier, the qualifying code(s) must be present and payable on the claim.
iv. For outpatient claims that meet multiple hospital service categories, the highest Medi-Cal fee schedule multiplier applies to the entire claim except for excluded line items paid at [redacted].
v. The fee schedule multiplier for Emergency room services is inclusive of any trauma activation team.

c) Outpatient services not contained in the Medi-Cal fee schedule at the time of services are not reimbursable.

III. OneCare

3.1 Inpatient Acute Care: [redacted]

3.2 Outpatient Care: [redacted]

Notes:

- For Medicare Part A or Part B services provided to OneCare Members, Hospital's compensation shall equal the applicable rate shown on this Attachment B.
- All physician fees are excluded from these OneCare rates.

IV. PACE

4.1 Inpatient Acute Care: [redacted]

4.2 Outpatient Care: [redacted]

Notes:

a) For Medicare Part A or Part B services provided to CalOptima PACE Members, Hospital's compensation shall equal the applicable rate shown on this Attachment B.
b) All physician fees are excluded from these PACE rates.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

22. Authorize Amendments to the CalOptima Health Medi-Cal Fee-for-Service Professional Services, Community Clinics, and Federally Qualified Health Centers Contracts

Contacts

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

Recommended Actions

Authorize the Chief Executive Officer to execute amendments to the CalOptima Health Medi-Cal Fee-for-Service Contracts for:

1. Professional Services: Update rates for Applied Behavior Analysis (ABA) providers, effective July 1, 2024.
2. Professional Services, Community Clinics, and Federally Qualified Health Centers: Update rates for Specialist Professional services and California Children's Services paneled providers, effective July 1, 2024.
3. Professional Services and Community Clinics: Add language to operationalize a payment methodology to comply with the Department of Health Care Services mandatory targeted rate increases, effective January 1, 2024.
4. Federally Qualified Health Centers: Update rates to no less than other contracted providers for similar targeted rate increase-eligible services, per federal requirements.

Background and Discussion

Staff requests that the CalOptima Health Board of Directors (Board) authorize amending the Medi-Cal Fee-for-Service (FFS) Professional Services, Community Clinics, and Federally Qualified Health Centers (FQHC) contracts for specified services to reflect updated rates and to incorporate language requirements to provider contracts to comply with the Department of Health Care Services (DHCS) mandatory targeted rate increase (TRI), effective January 1, 2024.

Provider Rate Increase

The Board committed $210.5 million in rate increases for contracted health networks and eligible FFS providers for Fiscal Year (FY) 2024-25 at the May 2, 2024, meeting. This increase will ensure financial stability, network adequacy, and member access to care within the CalOptima Health delivery system for the next 30 months as follows:

- ABA-BH Providers: Increase from the current rate for select services by 21%.
- Specialist Services for Medi-Cal Classic Members: Increase from the current rate of 133% of the Medi-Cal Fee Schedule to a blended rate of 156% of the Medi-Cal Fee Schedule.

Back to Agenda

- California Children's Services Paneled Specialist Services: Increase from the current rate of 140% of the Medi-Cal Fee Schedule to a blended rate of 156% of the Medi-Cal Fee Schedule.

DHCS Targeted Rate Increase

The DHCS TRI is a set of payment increases applicable to eligible providers within the Medi-Cal FFS delivery system and Medi-Cal managed care plans for targeted services, which became effective January 2024 pursuant to the 2023 Budget Act and Assembly Bill 118 (Chapter 42, Statutes of 2023). Staff proposes including a single comprehensive provision in contracts supporting TRI implementation for all future provider types that DHCS identifies as eligible. CalOptima Health will institute a payment methodology to comply with requirements related to the TRI. Proposition 56 supplemental payments for physician services will be subsumed under the applicable TRI payments.

The DHCS draft All Plan Letter on Targeted Provider Rate Increases notes that FQHCs are not eligible providers for TRI payment rates. However, pursuant to the Social Security Act §1903(m)(2)(A)(ix), CalOptima Health is required to pay rates to FQHCs at no less than other contracted providers for similar eligible services.

Staff requests the Board approve the above recommended actions, allowing for the execution of these contract amendments, to comply with regulatory requirements and support continued member access to quality care for CalOptima Health members.

Fiscal Impact

Management has included expenses associated with the Medi-Cal FFS Professional Services, Community Clinics, and FQHC Contracts in the proposed FY 2024-25 Operating Budget, which is pending Board approval.

- TRI Implementation Period of July 1, 2024, through June 30, 2025: The aggregate annual fiscal impact of the proposed rate updates is approximately $57.8 million, with $32.7 million for the conversion of the Proposition 56 physician services supplemental payments and $25.2 million in additional funding to providers. The additional funding is for added procedure codes that were not formerly included under the Proposition 56 physician services supplemental payments, as well as to comply with federal requirements on compensating FQHCs with similar rates for like-services.

  TRI Implementation Period of January 1, 2024, through June 30, 2024: Staff will continue making Proposition 56 physician services supplemental payments until the scheduled conversion to TRI is completed. Proposition 56 physician services supplemental payments made for Calendar Year 2024 will be subsumed under the TRI. DHCS has included TRI funding in the Calendar Year 2024 rates. The aggregate fiscal impact of the proposed rate updates is approximately $28.9 million, with $16.3 million for the conversion of the Proposition 56 physician services supplemental payments and $12.6 million in additional funding to providers.

- Rate Increase (non-TRI related): The aggregate annual fiscal impact of the proposed rate updates is approximately $28.8 million. This amount is part of the $210.5 million commitment from unallocated reserves approved by the Board on May 2, 2024. As applicable, staff will continue to include updated expenses in future operating budgets.

Rationale for Recommendation

The above requested amendments serve to support CalOptima Health's delivery system, maintain compliance with the latest state requirements, and maintain a robust provider network.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Amendment to the Medi-Cal FFS Professional Services Contract for Physician Specialist services and CCS panel providers
2. Amendment to the Medi-Cal FFS Professional Services Contract for Applied Behavior Health - Behavioral Health services

/s/ Michael Hunn *05/31/2024*

Authorized Signature **Date**

AMENDMENT [XX] TO
ANCILLARY/PROFESSIONAL SERVICES CONTRACT

This Amendment [XX] to the [Ancillary/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 Health ("**CalOptima**"), and [add provider name] ("[**Professional/Provider]**"). CalOptima and [Professional/Provider] may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and [Professional/Provider] have entered into a [Ancillary/Professional] Services Contract, originally effective [insert date], ("**Contract**"), by which [Professional/Provider] has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and [Professional/Provider] desire to amend the Contract on the terms and conditions set forth herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Add the following new Section X.XX, *Targeted Rate Increase*, to Article 2, Definitions, to the Contract:

   X.XX "**Targeted Rate Increase**" or "**TRI**" means the set of provider rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) as implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. The first phase of TRIs are effective for dates of service beginning January 1, 2024. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment previously due to Provider. The TRI applies to both fee-for-service and other provider payment arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

2. Delete Section X.XX, *CalOptima QMI Program*, in its entirety and replace it with the following new Section X.XX, *QMI Program and Reporting*, to the Contract:

   X.XX CalOptima QMI Program and Reporting. 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 quality management and improvement ("QMI") program and that it shall participate in QMI program, as required by CalOptima. Such activities may include 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 cooperate with CalOptima and CalOptima's Regulators in any complaint, appeal, or other review of Covered Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Covered Services by CalOptima or such Regulators, as applicable, and as required under the applicable CalOptima Program.

      X.XX.X Provider agrees that CalOptima may use performance data for quality and reporting purposes, including quality improvement activities, public reporting to

AMENDMENT [XX] TO
PROFESSIONAL SERVICES CONTRACT

This Amendment [XX] to the Professional Services Contract ("**Amendment**") is effective as of July 01, 2024 ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and [add provider name] ("**Professional**"). CalOptima and Professional may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Professional have entered into a Professional Services Contract, originally effective [insert date], ("**Contract**"), by which Professional has agreed to provide or arrange for the provision of Covered Services to Members.

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

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Add the following new Section X.XX, *Targeted Rate Increase*, to the Article 2, Definitions:

[X.XX] "**Targeted Rate Increase**" or "**TRI**" means the set of provider rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) as implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. The first phase of TRIs are effective for dates of service beginning January 1, 2024. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment previously due to Provider. The TRI applies to both fee-for-service and other provider payment arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

2. Delete Section X.XX, *CalOptima QMI Program*, in its entirety and replace it with the following new Section X.XX, *QMI Program and Reporting*, to the Contract:

X.XX CalOptima QMI Program and Reporting. 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 quality management and improvement ("QMI") program and that it shall participate in QMI program, as required by CalOptima. Such activities may include 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 cooperate with CalOptima and CalOptima's Regulators in any complaint, appeal, or other review of Covered Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Covered Services by CalOptima or such Regulators, as applicable, and as required under the applicable CalOptima Program.

X.XX.X Provider agrees that CalOptima may use performance data for quality and reporting purposes, including quality improvement activities, public reporting to

consumers, and performance data reporting to Regulators, as identified in CalOptima Policies and required by Regulators and applicable laws.

X.XX.X Provider agrees that CalOptima may make publicly available, as frequently as CalOptima deems necessary, reports of Provider's compliance with the Contract's requirements and performance metrics, including Members' access to care, the quality of care received by Members, and Provider's other performance trends, as applicable to Provider's obligations hereunder.

X.XX.X As long as CalOptima's disclosures under this Section 2.12 otherwise comply with applicable laws, no CalOptima disclosure under this Section 2.12 shall constitute a breach of this Contract.

3. Delete Attachment [B], *Confidential Compensation Terms*, of the Contract in its entirety and replace it with the new Attachment [B], *Compensation*, attached to this Amendment and incorporated into the Contract by this reference.

4. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

5. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

(*signature page follows*)

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PROFESSIONAL:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ATTACHMENT B
COMPENSATION

Upon submission of a Clean Claim, CalOptima shall pay Professional pursuant to this Contract, CalOptima Policies, Government Contracts, and applicable laws, and Professional shall accept as payment in full from CalOptima, for services provided under this Contract the Amounts set forth in this Attachment B.

1. **Medi-Cal Program.**
    1. For Covered Services provided to referred Medi-Cal Members, CalOptima shall reimburse Professional the lesser of:
        1. Billed charges; or
        2. The rates outlined in Table 1: CalOptima ABA Fee Schedule Autism Related Services ("**Table 1**") below. the following amounts:

Table 1: CalOptima ABA Fee Schedule Autism Related Services

HCPCS Code	Procedure Description	Paraprofessional or Registered Behavior Technician Modifier Rates	Associate Behavioral Analyst (BCaBA), or Behavior Management Assistant Modifier Rates	Board Certified Behavior Analyst (BCBA), or Behavior Management Consultant/ Licensed Health Professional Modifier Rates	Board Certified Behavior Analyst (BCBA) Modifier Rates
H0031	Functional Behavioral Assessment by BCBA, per 15 min	N/A	N/A	N/A	HO [redacted]
H0032	Case oversight and management of treatment team, per 15 min	N/A	HN [redacted]	HO [redacted]	HO [redacted]
H2019	Direct Applied Behavior Analysis, per 15 min	HM [redacted]	HN [redacted]	HO [redacted]	HO [redacted]
S5110	Home care training, family, per 15 min	HM [redacted]	HN [redacted]	HO [redacted]	HO [redacted]
H2014	Social Skills group, per 15 min	HQ [redacted]	HQ [redacted]	HQ [redacted]	HQ [redacted]
H2014	Skills training and development, per 15 min	HM [redacted]	HN [redacted]	HO [redacted]	HO [redacted]
S5108	Home care training to home care, client, per 15 min	HM [redacted]	HN [redacted]	HO [redacted]	HO [redacted]

Modifier	Description
HO	Board Certified Behavior Analyst (BCBA or BCBA-D) or Licensed Health Professional, which is a Psychologist, Clinical Social Worker, Marriage and Family Therapist, or other licensed professional whose California licensure permits the design and/or implementation of behavior modification intervention services. Additionally, must have 12 twelve semester units in ABA, and 2 years experience designing and implementing behavior modification intervention services.
HN	Associate Behavioral Analyst (BCaBA), or Behavior Management Assistant
HM	Paraprofessional or Registered Behavior Technician
HQ	Group Setting

2. Claims Requirements.
    1. Reimbursement is based on the treating provider's licensure, certification, and CalOptima credentialing requirements for that discipline, and is not based on the provider's academic credentials alone.
    2. Rates include reimbursement for travel time and expense.
    3. CPT or HCPCS codes not contained Table 1 are not reimbursable.

4. Professional shall not be reimbursed for services provided to Member if there was no prior authorization received from CalOptima in accordance with Cal Optima Policies and Procedures.

5. The coding definitions (*e.g.*, CPT/HCPCS codes) assigned in this Contract shall be considered automatically updated based on revised codes and newly introduced codes consistent with guidance provided from the organization(s) responsible for code set updates (*e.g.*, DHCS, AMA, etc.), as applicable, and consistent with industry standards. If codes are changed by addition or deletion as stated in the current year's coding publications, the Parties agree that services will automatically revert to the new code(s) that best apply to the service.

3. Targeted Rate Increase Services. If applicable, for services subject to the TRI provided by a qualified professional, Professional will be reimbursed at the greater of the contracted rates, outlined above plus any applicable supplemental payments, or the Medi-Cal TRI fee schedule rate in effect for the date of service; provided, however, in no event will Professional be reimbursed at less than the Medi-Cal TRI fee schedule in effect for the date of service. Reimbursement for TRI services shall comply with DHCS Program requirements, applicable laws, and CalOptima Policies. This provision is retroactive to TRI services provided beginning January 1, 2024, or as otherwise specified by DHCS.

2. **Payment Procedures.**

1. Health Network. If a Health Network is financially responsible under its contract with CalOptima for the services a Professional rendered to a Member, Professional shall look solely to Health Network for payment for those services, and CalOptima and Member shall not be liable to Professional for those services.

2. Billing and Claims Submission. Professional shall submit to CalOptima an accurate, complete, descriptive, and timely Claim that includes the Member's name, and identification number, description of services and date(s) of service. Professional may not submit a Claim before the delivery of service. In accordance with CalOptima Policies, Professional shall submit all Claims electronically or by mail to CalOptima at Attention: Accounting Department, 505 City Parkway West, Orange, CA 92868. Professional is solely responsible for reimbursing its Contracted Providers for providing Covered Services for Professional under this Contract and shall ensure that all Contracted Providers agree to accept payment from Professional as payment in full for Covered Services provided to Members.

3. Payment Codes and Modifiers. Professional shall utilize current payment codes and modifiers for Medi-Cal or Medicare, as applicable, when billing CalOptima. CPT or HCPC codes not contained in the Medi-Cal fee schedule or Medicare fee schedule, as applicable, at the time of service are not reimbursable.

4. Claims Requiring Additional Justification. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification, and these will be handled on a case-by-case basis.

5. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.

6. Claims Deficiencies. CalOptima shall deny payment for any Claim that fails to meet requirements set forth in CalOptima Policies and applicable laws for Claims processing, and CalOptima shall notify Professional of any denial pursuant to CalOptima Policies and applicable laws.

7. Claims Auditing. Professional acknowledges CalOptima's right to conduct post-payment billing audits under this Contract. Professional and its Contracted Providers will cooperate with CalOptima's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting records and other related data. CalOptima will use established industry standards and federal and State guidelines to determine the appropriateness of the billing, coding, and payment. This section will survive any termination of the Contract.

8. Coordination of Benefits (COB). Professional acknowledges that Medi-Cal is the payor of last resort. Professional shall coordinate benefits with other programs or

entitlements recognizing where Other Health Coverage ("**OHC**") is primary coverage in accordance with CalOptima Program requirements.

9. Crossover Claims. The Medi-Cal reimbursement rates in this Contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims, CalOptima will reimburse Professional in accordance with CalOptima Policies, Government Contracts, Medi-Cal and Medicare program requirements, and state and federal laws and regulations. California law limits Medi-Cal program reimbursement for a Crossover Claim to an amount that, when combined with the Medicare or OHC payment, does not exceed Medi-Cal's maximum allowed for similar services as required by Welfare and Institutions Code § 14109.5. "**Crossover Claim(s)**" means claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or OHC is the primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's programs. "**Dual Eligible Members**" means members who are eligible for both Medicare or OHC and Medi-Cal benefits.

consumers, and performance data reporting to Regulators, as identified in CalOptima Policies and required by Regulators and applicable laws.

X.XX.X Provider agrees that CalOptima may make publicly available, as frequently as CalOptima deems necessary, reports of Provider's compliance with the Contract's requirements and performance metrics, including Members' access to care, the quality of care received by Members, and Provider's other performance trends, as applicable to Provider's obligations hereunder.

X.XX.X As long as CalOptima's disclosures under this Section 2.12 otherwise comply with applicable laws, no CalOptima disclosure under this Section 2.12 shall constitute a breach of this Contract.

3. (Optional) Delete Attachment X, *Compensation*, of the Contract in its entirety and replace it with the new Attachment X, *Compensation*, attached to this Amendment and incorporated into the Contract by this reference.

4. (Optional) Add to the Contract the new Attachment X, *Delegation Agreement*, which is attached hereto and incorporated into the Contract by this reference. This new Attachment X shall replace and terminate any other prior delegation agreements, including any *Delegation Acknowledgement and Acceptance Agreement*, between the Parties.

5. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

6. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR [PROFESSIONAL/PROVIDER]:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
23. Authorize Amendments to the CalOptima Health Medi-Cal Fee-for-Service Ancillary Services Contracts

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

Recommended Actions
Authorize the Chief Executive Officer to execute amendments to the CalOptima Health Medi-Cal Fee-for-Service Ancillary Services Contracts to:

1. Update rates for certain Ancillary Services Providers including, Ambulatory Surgery Centers, Home Health Agencies, Community Based Adult Services Centers, Free Standing Clinical Laboratories, Enhanced Care Management Providers, and Short-Stay Skilled Nursing Facilities, effective July 1, 2024.
2. Add language to operationalize a payment methodology to comply with the Department of Health Care Services mandatory targeted rate increases, effective January 1, 2024.
3. Add language to implement requirements in Department of Health Care Services All Plan Letter 23-004 for Skilled Nursing Facilities – Short Stays, and adjust payments, effective January 1, 2023, through June 30, 2024.

Background and Discussion
Staff requests that the CalOptima Health Board of Directors (Board) authorize amending the Medi-Cal Fee-for-Services (FFS) Ancillary Services Contracts for specific services to reflect updated rates and to incorporate language requirements to comply with the Department of Health Care Services (DHCS) mandatory targeted rate increases (TRI), effective January 1, 2024.

Provider Rate Increase
The Board committed $210.5 million in rate increases for contracted health networks and eligible FFS providers for Fiscal Year (FY) 2024-25 at the May 2, 2024, Board meeting. This increase will ensure financial stability, network adequacy, and member access to care within the CalOptima Health delivery system over the next 30 months, as follows:

- Ambulatory Surgery Centers: Increase from 90% of the Medicare rate to 100% of the Medicare rate.
- Home Health Agencies: Increase base to be no less than 120% of the Medi-Cal Fee Schedule.
- Community Based Adult Services Centers: Increase from 117% of the Medi-Cal Fee Schedule to 130% of the Medi-Cal Fee Schedule.
- Free-Standing Clinical Laboratories: Increase from 123% of the Medi-Cal Fee Schedule to 135% of the Medi-Cal Fee Schedule.

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- Enhanced Care Management Providers: Increase the current rates by 16% based on the updated DHCS assumptions calculated by CalOptima.
- Skilled Nursing Facilities – Short Stay: Update the payment structure to better align acuity with compensation. Changes include transitioning from an all-inclusive per diem payment to a Freestanding Skilled Nursing Facilities Level-B (FS/NF-B) rate plus a therapy per diem and a hard-to-place add-on for certain applicable conditions.

Implementation of DHCS APL 23-004
For the period January 1, 2023, through June 30, 2024, staff recommends implementing a revised rate schedule that reimburses each Skilled Nursing Facility – Short Stay at the skilled nursing facility rate minimally defined by DHCS, in alignment with Assembly Bill 186 (AB 186) (Chapter 46, Statutes of 2022). The statute reformed the financing methodology applicable to FS/NF-B and Adult Freestanding Subacute Facilities Level-B rates, effective January 1, 2023.

DHCS Targeted Rate Increase
The DHCS TRI is a set of payment increases applicable to eligible providers within the Medi-Cal FFS delivery system and Medi-Cal managed care plans for targeted services, which became effective January 2024 pursuant to 2023 Budget Act and Assembly Bill 118 (Chapter 42, Statutes of 2023). Staff proposes including a single comprehensive provision in contracts supporting the TRI implementation for all future provider types that DHCS identifies as eligible. CalOptima Health shall institute a payment methodology to comply with requirements related to the TRI. Proposition 56 supplemental payments for physician services will be subsumed under applicable the TRI payments.

Staff requests the Board approve the above recommended actions, allowing for the execution of these contract amendments to comply with regulatory requirements and support member access to quality care for CalOptima Health members.

Fiscal Impact
Provider Rate Increase: Management has included expenses associated with the Medi-Cal FFS Ancillary Services Contracts in the proposed FY 2024-25 Operating Budget, which is pending Board approval. The aggregate annual fiscal impact of the proposed rate updates to contracted Medi-Cal FFS ancillary providers is approximately $16.3 million. This amount is part of the $210.5 million commitment from unallocated reserves approved by the Board on May 2, 2024. As applicable, staff will continue to include updated expenses in future operating budgets.

Implementation of DHCS APL 23-004: The estimate fiscal impact to implement APL 23-004 for the period of January 1, 2023, through June 30, 2024, is not expected to exceed $10,000.

Rationale for Recommendation
The above requested amendments serve to support CalOptima Health's delivery system, maintain compliance with the latest State requirements, and maintain a robust provider network.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Amendment to the Ancillary Services Contract

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

AMENDMENT [XX] TO
ANCILLARY/PROFESSIONAL SERVICES CONTRACT

This Amendment [XX] to the [Ancillary/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 Health ("**CalOptima**"), and [add provider name] ("[**Professional/Provider]**"). CalOptima and [Professional/Provider] may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and [Professional/Provider] have entered into a [Ancillary/Professional] Services Contract, originally effective [insert date], ("**Contract**"), by which [Professional/Provider] has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and [Professional/Provider] desire to amend the Contract on the terms and conditions set forth herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Add the following new Section X.XX, *Targeted Rate Increase*, to Article 2, Definitions, to the Contract:

   X.XX "**Targeted Rate Increase**" or "**TRI**" means the set of provider rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) as implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. The first phase of TRIs are effective for dates of service beginning January 1, 2024. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment previously due to Provider. The TRI applies to both fee-for-service and other provider payment arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

2. Delete Section X.XX, *CalOptima QMI Program*, in its entirety and replace it with the following new Section X.XX, *QMI Program and Reporting*, to the Contract:

   X.XX CalOptima QMI Program and Reporting. 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 quality management and improvement ("QMI") program and that it shall participate in QMI program, as required by CalOptima. Such activities may include 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 cooperate with CalOptima and CalOptima's Regulators in any complaint, appeal, or other review of Covered Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Covered Services by CalOptima or such Regulators, as applicable, and as required under the applicable CalOptima Program.

      X.XX.X Provider agrees that CalOptima may use performance data for quality and reporting purposes, including quality improvement activities, public reporting to

consumers, and performance data reporting to Regulators, as identified in CalOptima Policies and required by Regulators and applicable laws.

X.XX.X Provider agrees that CalOptima may make publicly available, as frequently as CalOptima deems necessary, reports of Provider's compliance with the Contract's requirements and performance metrics, including Members' access to care, the quality of care received by Members, and Provider's other performance trends, as applicable to Provider's obligations hereunder.

X.XX.X As long as CalOptima's disclosures under this Section 2.12 otherwise comply with applicable laws, no CalOptima disclosure under this Section 2.12 shall constitute a breach of this Contract.

3. (Optional) Delete Attachment X, *Compensation*, of the Contract in its entirety and replace it with the new Attachment X, *Compensation*, attached to this Amendment and incorporated into the Contract by this reference.

4. (Optional) Add to the Contract the new Attachment X, *Delegation Agreement*, which is attached hereto and incorporated into the Contract by this reference. This new Attachment X shall replace and terminate any other prior delegation agreements, including any *Delegation Acknowledgement and Acceptance Agreement*, between the Parties.

5. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

6. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR [PROFESSIONAL/PROVIDER]:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

24. Approve Actions Related to AltaMed Health Services Medi-Cal Contract

Contacts

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

Recommended Actions

1. Authorize the transition of the current Medi-Cal health network risk arrangement for AltaMed Health Services (AltaMed) from a Shared Risk Group to a Health Maintenance Organization.
2. Authorize the Chief Executive Officer to execute a new HMO contract with AltaMed Health Network, Inc. for Medi-Cal, effective November 1, 2024, subject to approval by the Department of Managed Health Care.
3. Authorize unbudgeted expenditures in an amount up to $1.0 million from existing reserves to support the AltaMed Medi-Cal HMO contract for the period of November 1, 2024, through June 30, 2025.

Background and Discussion

CalOptima utilizes three (3) different contract risk models for delegated health networks: Shared Risk Group (SRG), Physician Hospital Consortia (PHC), and Health Maintenance Organization (HMO). In the SRG model, CalOptima delegates professional risk to a provider organization. Both the PHC and HMO models are full risk models. Under the PHC model, the physician group and hospital are separately contracted and are capitated only for the services delegated to them under their respective contracts. Under the HMO model, a single entity accepts risk for all delegated covered services. On May 5, 2022, the CalOptima Health board of directors (Board) approved the criteria and process for CalOptima Health to contract with a health network under the HMO model.

AltaMed is a SRG that serves 75,421 Medi-Cal and 971 OneCare members. Staff requests Board authorization to transition the AltaMed Medi-Cal health network from its current SRG risk contract to a HMO contract, and approval of a new HMO contract with AltaMed, subject to approval by the California Department of Managed Health Care (DMHC).

Currently, AltaMed is an approved, Knox Keene licensed, full-service health plan for Medi-Cal in Los Angeles County. AltaMed submitted a request to CalOptima Health to transition its SRG contract to a HMO contract and subsequently submitted a material modification to DMHC for approval to extend its current Knox Keene license service area for Medi-Cal in Orange County. CalOptima Health conducted an assessment pursuant to the Board-established criteria and found that AltaMed meets all requirements.

If approved by the Board, the fully executed HMO contract will be included in AltaMed's material modification filing with DMHC. If DMHC approves AltaMed's material modification, CalOptima Health anticipates implementing the transition to the HMO contract effective November 1, 2024.

Back to Agenda

Staff requests that the Board approve the recommended actions, allowing staff to implement the changes in support of the new HMO agreement between CalOptima Health and AltaMed, subject to final approval by DMHC. The new HMO agreement with AltaMed is in alignment with CalOptima Health's 5-year strategic plan and core strategies to remove barriers to health care access and increase equity for CalOptima Health members. The strategic plan also includes investing in provider workforce development initiatives and other educational investments to increase the supply of health care professionals, in support of CalOptima Health's mission to serve member health with excellence and dignity, respecting the value and needs of each person.

Fiscal Impact

The recommended action to transition AltaMed from the current SRG to an HMO Medi-Cal health network risk arrangement is an unbudgeted item. The estimated financial impact is $1.5 million annually or approximately $1.0 million for the period from November 1, 2024, through June 30, 2025. An appropriation of up to $1.0 million from existing reserves will fund this action in Fiscal Year 2024-25. Management will include updated medical expenses related to the AltaMed Medi-Cal HMO contract in future operating budgets.

Rationale for Recommendation

Approval of the recommended Board actions will allow CalOptima Health to proceed with implementation of the new risk arrangement agreed upon by CalOptima Health and AltaMed.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Proposed AltaMed Medi-Cal health network HMO Contract

Board Actions

N/A

/s/ Michael Hunn *05/31/2024*

Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Health Medi-Cal Health Networks: AltaMed				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

MEDI-CAL

HMO

CONTRACT FOR HEALTH CARE SERVICES

BETWEEN

CALOPTIMA

AND

ALTAMED HEALTH NETWORK, INC.

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F. CERTIFICATION REGARDING LOBBYING – 1 & 2

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CONTRACT FOR HEALTH CARE SERVICES

HMO

THIS CONTRACT FOR HEALTH CARE SERVICES ("Contract") is effective November 1, 2024 ("Effective Date") by and between Orange County Health Authority, a public agency dba CalOptima Health, ("CalOptima") and AltaMed Health Network, Inc. ("HMO"), with respect to the following facts:

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 No. 00-8, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State pursuant to which it is obligated to arrange and pay for the provision of services to Medi-Cal eligible beneficiaries residing in Orange County, California, who receive Covered Services.

C. HMO desires to provide or arrange for the provision of Covered Services to Members as defined herein.

D. HMO is a restricted health care service plan licensed under the California Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code § 1340 et seq.), as amended, that provides health care services to its enrolled Members.

E. CalOptima and HMO desire to effectuate this Contract to state the terms and condition(s) set forth herein. This Contract shall control and govern the relationship of the parties following the Effective Date with respect to the subject matter contained herein and upon obtaining all necessary regulatory approvals, including approval by DHCS.

F. CalOptima and HMO desire to enter into this Contract on the terms and condition(s) set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
Definitions

1.1 "Administrative Services" means those non-clinical functions that are the responsibility of the HMO and are required to discharge the obligations and meet the requirements set forth in this Contract, in CalOptima Policies and, in Memoranda of Understanding.

1.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

1.3 "Advance Directive" means a written instruction such as under the California Natural Death Act Declarations or durable power of attorney for health care, recognized under State law and relating to the provision of medical care when an individual is incapacitated.

1.4 "Aid Code" means the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.

1.5 "American Indian" means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes members in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purpose of eligibility for Indian health services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.6 "American Indian Health Care Provider" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)."

1.7 "American Indian Health Service Programs" means facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population with a defined geographic area, per Title 22, Section 55000."

1.8 INTENTIONALLY LEFT BLANK

1.9 "California Children's Services (CCS)" means those services authorized by the CCS Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.10 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Sections 41515.2 through 41518.9.

1.11 "California Children's Services (CCS) Program" means the 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.

1.12 "CCS Provider" or "CCS-Paneled Provider(s)" means any of the following providers when used to treat Members for a CCS Eligible Conditions:

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.

1.13 "CalOptima Board" or "Board" means the CalOptima Board of Directors.

1.14 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled with a Health Network or HMO.

1.15 "CalOptima Policy(s)" means CalOptima policies and procedures relevant to this Contract, as amended from time to time, at the sole discretion of CalOptima.

1.16 "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforces applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, HMO, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, Department of Managed Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designees, including DHCS' external quality review organization contractor.

1.17 "Capitation Payment" means the monthly amount paid to the HMO by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by HMO's monthly enrollment based upon Aid Code, age and gender.

1.18 "Capitation Rate" means the rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age and gender.

1.19 "Care Management Services" means:

1.19.1 Providing or approving all Covered Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services;

1.19.2 Coordinating Medically Necessary Covered Services with other Medi- Cal benefits not covered under this Contract;

1.19.3 Maintaining a Medical Record with documentation of referral services and follow-up as medically indicated;

1.19.4 Ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care;

1.19.5 Authorization of referred services;

1.19.6 Coordinating a Member's care with all external agencies that are required to be involved in addressing the Member's needs as addressed in MOUs and in CalOptima Policies;

1.19.7 Coordinating care for Members transitioning from CalOptima Direct to a Health Network or from one Health Network to another Health Network; and

1.19.8 Targeted services for Members with Special Health Care Needs to support compliance with Federal Medicaid contingencies, including but not limited to: identification of Members with Special Health Care Needs, assessment of Members with Special Health Care Needs, development of treatment plans, and monitoring the progress of adherence to treatment plans for Members with Special Health Care Needs.

1.19.9 Any of the services listed in this Section 1.19 as necessary to coordinate referrals and coordination of care for Members eligible for both Medicare and Medi-Cal services, as required by CalOptima's contracts with DHCS.

1.20 "Child Health and Disability Prevention" or "CHDP" means the California program, defined in the Health and Safety Code Section 12402.5 et seq. that covers certain pediatric preventive services for children eligible for Medi-Cal.

1.21 "Clean Claim" shall have the same meaning as "Complete Claim," as that term is defined in Title 28, CCR Section 1300.71(a)(2).

1.22 INTENTIONALLY LEFT BLANK

1.23 INTENTIONALLY LEFT BLANK

1.24 "Complex Case Management" means an approach to case management that meets differing needs of high and rising-risk Members, including both ongoing chronic care coordination for chronic conditions and interventions for episodic, temporary needs. Complex Case Management includes all services and requirements under Basic PHM.

1.25 "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 its Board members, employees, contractors and providers comply with applicable law and ethical standards.

1.26 "Comprehensive Perinatal Services Program" or "CPSP" means those services defined in Section 14134.5 of the Welfare and Institutions Code and Title 22, Sections 51179 and 51348 of the California Code of Regulations (CCR). For CalOptima Members, CPSP is incorporated into CalOptima's Perinatal Support Services (PSS).

1.27 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or by at least 1,500 such Members in two contiguous ZIP codes.

1.28 "Contract" means this written instrument between CalOptima and HMO. This Contract shall include, in addition to this document, any Memoranda of Understanding entered into by CalOptima which are binding on HMO, DHCS Medi-Cal Managed Care Policy Division Policy Letters and, Contract Interpretation.

1.29 "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 State 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 HMO shall begin Participating in the CalOptima Whole Child Model Program, 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."

1.30 "DHCS" means the State of California Department of Health Care Services.

1.31 "Derivative Aid Code" means an Aid Code, which is a subset of eligible beneficiaries derived from an original covered Aid Code.

1.32 "Disease Management" means a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions:

1.32.1 That supports the physician/patient relationship;

1.32.2 Emphasizes prevention of exacerbation and complications utilizing cost-effective evidence based practice guidelines and patient empowerment strategies such as self-management; and

1.32.3 Continuously evaluates clinical humanistic and economic outcomes with the goal of improving health.

1.33 "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive and preventive child health program for individuals under the age of twenty-one (21). EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

1.34 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.34.1 Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

1.34.2 Serious impairment to bodily functions; or

1.34.3 Serious dysfunction of any bodily organ or part.

1.35 "Emergency Services" means Covered Services furnished by a qualified Provider, which are needed to evaluate or Stabilize an Emergency Medical Condition that is found to exist using a prudent layperson standard.

1.36 "Encounter" means any unit of Covered Service provided to a Member by Health Network regardless of Health Network reimbursement methodology. These services include any and all services provided to a Member, regardless of the service location or provider, inclusive of out-of-network services, including sub-capitated and delegated Covered Services.

1.37 "Evaluation Services Provider" means a provider of custom wheelchair and seating systems assessment and evaluation services, whether provided in-home or in the provider's facility, designated and contracted to assess and evaluate a Member with Disabilities (MWD)'s needs for custom power wheelchairs and seating systems, or customized modifications to wheelchairs and seating systems.

1.38 "Facility" means any premises:

1.38.1 Owned, leased, used or operated directly or indirectly by or for the HMO for purposes related to this Contract; or

1.38.2 Maintained by a Subcontractor to provide Covered Services pursuant to an agreement with the HMO(s).

1.39 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes but is not limited to:

1.39.1 Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

1.39.2 Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

1.39.3 Patient visits for the purpose of Family Planning;

1.39.4 Family Planning counseling services provided during a regular patient visit;

1.39.5 IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

1.39.6 Tubal ligations;

1.39.7 Vasectomies;

1.39.8 Contraceptive drugs or devices;

1.39.9 Treatment for complications resulting from previous Family Planning procedures.

1.39.10 Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.40 "Federally Qualified Health Center" or "FQHC" means an entity as defined in 42 USC Section 1396d(l)(2)(B).

1.41 "Fee-for-Service" or "FFS" means the reimbursement paid to Providers on a non-capitated basis.

1.42 "Foster Care" means an out-of-home placement for a child either on a temporary or permanent basis.

1.43 "Health Education" means any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

1.44 "Health Maintenance Organization" or "HMO" means the health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, (commencing with Section 1340 of the California Health and Safety Code) ("Knox-Keene Act") and who is signatory to this Contract.

1.45 "Health Network" means a physician hospital consortium (PHC), physician group under a shared risk contract, or a health care service plan, such as an HMO, as defined in the Knox-Keene Act, and contracted by CalOptima to provide Covered Services to Members.

1.46 "Healthcare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

1.47 "HHS" means the United States Department of Health and Human Services.

1.48 "Hospital" means a general acute care hospital licensed under the laws of the State of California and accredited by the Joint Commission, or other Centers for Medicare and Medicaid Services (CMS) deemed accrediting body, and certified for participation under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act), which is owned or operated by HMO or with which HMO has a Subcontract to provide Covered Services under this Contract.

1.49 "Incontinence Supplies" means Medical Supplies used to manage bowel and/or bladder incontinence.

1.50 "Joint Commission" means the Joint Commission for the Accreditation of Health Care Organizations.

1.51 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services, or sub-acute care services.

1.52 "Management Services Organization" or "MSO" means any organization, firm, company or entity providing Administrative Services on behalf of HMO which impact CalOptima Members.

1.53 "Medi-Cal" is the name for the Medicaid program in the State of California, and "Medicaid" is the program authorized by Title XIX of the Social Security Act and the regulations promulgated thereunder.

1.54 "Medi-Cal Fee Schedule" means the Medi-Cal payment system for reimbursement for physician services in Title 22, CCR, Section 51503.

1.55 Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which DHCS conveys information or interpretation of changes in policy or procedure at the Federal or State levels. APLs and Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

1.56 "Medically Necessary" or "Medical Necessity" means reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, 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 Welfare and Institutions Code Section 14132(v).

1.57 "Medical Record" means any record kept or required to be kept by any Provider that documents all the medical services received by the Member, including without limitation inpatient, outpatient, emergency care, referral requests and authorizations.

1.58 "Medical Screening Examination" or "MSE" means an examination within HMO's capability (including ancillary services routinely available) to determine whether or not an Emergency Medical Condition exists.

1.59 "Medical Supplies" means items, which, due to their therapeutic or diagnostic characteristics, are essential to enable Members to effectively complete a physician ordered plan of care, excluding common household items and clothing.

1.60 "Medical Therapy Program (MTP)" means a special program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

1.61 "Medicare" means the federal health insurance program for: people sixty-five (65) years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called (ESRD) as defined in Title XVIII of the Federal Social Security Act.

1.62 "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHCS, or the United States Social Security Administration who is enrolled in the CalOptima Program and the HMO.

1.63 "Member with Special Health Care Needs" means a Member who meets at least one of the following criteria: (i) Medicare eligible; (ii) diagnosed with an emotional or physical disability; (iii) placed in the foster care system; (iv) Regional Center of Orange County (RCOC) program eligible; or (v) CCS Program eligible.

1.64 "Memorandum/Memoranda of Understanding" or "MOU", means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members, and contracts between CalOptima and the County of Orange that incorporate such agreements, including but not limited to the Coordination and Provision of Public Health Care Services Contract.

1.65 "Minimum Standards" means the minimum participation criteria established by CalOptima that must be satisfied in order for specified categories of Providers to submit claims and/or receive reimbursement from the CalOptima program (including Health Networks and CalOptima Direct) for items and/or services furnished to Members as described in CalOptima Policies.

1.66 "National Committee on Quality Assurance" or "NCQA" means the non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

1.67 "Other Member" means a Medi-Cal beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration who is enrolled by the State in a CalOptima Program but is not enrolled in the HMO.

1.68 "Out-of-Network Provider" means a Provider who is not obligated by a written contract with HMO to provide Covered Services to Members.

1.69 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

1.70 "Participating Provider" means a Provider who is obligated by a written contract to provide Covered Services to Members on behalf of HMO. All Participating Providers shall be considered Subcontractors.

1.71 "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 as specified in CalOptima's Compliance Program and CalOptima Policies.

1.72 "Pediatric Preventive Services" or "PPS" means well child services, which incorporate services covered under the Medi-Cal CHDP Program and the American Academy of Pediatrics Guidelines for Health Supervision.

1.73 "Perinatal Support Services" or "PSS" means obstetrical services enhanced with those perinatal services that are incorporated in CPSP services and perinatal Care Management for pregnant and post-partum Members.

1.74 "Person-Centered Planning" means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of basic and Complex Case Management and discharge planning.

1.75 "PHC" and "PHCs" means a physician-hospital consortium/consortia.

1.76 Not Applicable to this Contract.

1.77 "Physician Incentive Plan" means any compensation arrangement between HMO and a physician or physician group designed to motivate physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Members.

1.78 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) furnishing Covered Services under medical benefits, as described in CalOptima Policies.

1.79 "Primary Care Physician" or "PCP" means a physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD and CCS Members "Primary Care Physician" or "PCP" shall additionally mean any clinic or Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP, provided that clinic or Specialist Physician is qualified to treat the required range of conditions of the Member.

1.80 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution who furnishes health care items or services.

1.81 "Quality Indicators" means measurable variables relating to a specific clinical or health service delivery area, which are reviewed over a period of time to monitor the process or outcome of care delivered in that clinical area.

1.82 "Reinsurance" means coverage provided by CalOptima and any coverage secured by HMO, which limits the amount of risk or liability for the cost of providing Covered Services.

1.83 "Alcohol Misuse Screening and Counseling" or AMSC" (formerly referred to as "Screening, Brief Intervention, and Referral to Treatment" or "SBIRT") means services provided by a Primary Care HMO to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

1.84 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion and Human Immunodeficiency Virus testing.

1.85 Not Applicable to this Contract.

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1.86 "SPD Member" means Members in Seniors and Persons with Disabilities Aid Codes

1.87 "Specialist Physician" or "Specialist" means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

1.88 "Specialized Durable Medical Equipment" means durable medical equipment that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

1.89 "Specialty Mental Health Provider" means a person or entity who is licensed, certified or otherwise recognized or authorized under the State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include but are not limited to clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, therapists and registered nurses authorized to provide Specialty Mental Health Services.

1.90 "Specialty Mental Health Services" means:

1.90.1 Rehabilitative services which include mental health services, medication support services, day treatment intensive services, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services;

1.90.2 Psychiatric inpatient hospital services;

1.90.3 Targeted Care Management services;

1.90.4 Psychiatrist services;

1.90.5 Psychologist services; and

1.90.6 EPSDT supplemental specialty mental health services.

1.91 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and the placenta.

1.92 "State" means the State of California.

1.93 "State Contract" means the written agreement between CalOptima and the State pursuant to which CalOptima is obligated to arrange and pay for the provision of Covered Services to certain Medi-Cal beneficiaries in Orange County, California.

1.94 "Subcontract" means a written agreement entered into by the HMO with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for HMO specifically related to fulfilling HMO's obligations to CalOptima under the terms of this Contract.

1.95 "Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with HMO. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates. A delegate means an organization or person that subcontracts with HMO to perform any administrative function or service for HMO specifically related to fulfilling HMO's obligations to CalOptima under the terms of this Contract."

1.96 "Sub-delegation" means the process by which HMO expressly grants, by formal written agreement, to another entity the authority to carry out a function that would otherwise be required to be performed by HMO in order to meet its obligations under, and the intent of this Contract.

1.97 "Threshold Languages" means those languages as determined by State requirements per MMCD Policy Letter 99-03, or any update or revision thereof.

1.98 "Urgent Care Services" means Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury for which treatment cannot be delayed.

1.99 "Vaccines for Children" or "VFC" means the federal program, which provides free vaccines for eligible populations. Medi-Cal covered children, ages eighteen (18) years and younger, are eligible for free vaccines under this program.

1.100 "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.

1.101 Intentionally left blank.

1.102 Intentionally left blank.

1.103 Intentionally left blank.

1.104 Intentionally left blank.

1.105 "Basic Population Health Management" or "Basic PHM" means CalOptima's approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's risk tier, at the right time and in the right setting. Basic PHM includes federal requirements for care coordination and comply with all applicable federal and state requirements, and National Committee for Quality Assurance ("NCQA") standards.

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1.106 "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.

1.107 "ECM Care Team" means a team of staff employed or contracted by the HMO, as an ECM Provider, that provides ECM services to ECM Members.

1.108 "ECM Member" means a CalOptima Medi-Cal Member who meets inclusion criteria for one of the ECM Populations of Focus, authorized to receive ECM services, and assigned to the HMO.

1.109 "ECM Provider" means HMO when providing ECM services to ECM Members pursuant to this Contract.

1.110 "Community Supports means, 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 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).

1.111 "Lead Care Manager" means a Member's designated care manager for ECM, who works for the ECM Provider organization. The Lead Care Manager operates as part of the Member's ECM Care Team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

1
Obligations of HMO – Financial

2.1 Not Applicable to this Contract.

2.2 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, or any functions, duties or obligations of such party under this Contract. Neither termination of the 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.

2.3 INSURANCE REQUIREMENTS:

2.3.1 Professional/Medical Malpractice:
Each Participating Provider providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy for the specialty or type of service which the Participating Provider provides with minimum limits as follows:

PCP or Specialist Physician:
$1,000,000 per incident/$3,000,000 aggregate

Hospital providing covered services:
$5,000,000 per incident/$5,000,000 aggregate

2.3.2 Commercial General Liability/Commercial Automobile Liability:
HMO shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate

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

CalOptima must be named as an additional insured on HMO's Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:
HMO and each Participating Provider shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance:
$1,000,000 Bodily Injury by Accident - each accident
$1,000,000 Bodily Injury by Disease - policy limit
$1,000,000 Bodily Injury by Disease - each employee

2.3.4 Managed Care Errors and Omissions:
HMO shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

Managed Care Errors and Omissions:
$5,000,000 each claim/$5,000,000 aggregate

2.3.5 Cyber Liability:
HMO shall maintain cyber lability insurance with the minimum limits listed below covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion, and network security. Such

coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

Cyber Liability Insurance:

$5,000,000 each occurrence/claim and $5,000,000 aggregate

2.3.6 Insurer Ratings: Such insurance shall be provided by an insurer:

(a) Rated by A.M. Best with a rating of A V or better; and
(b) "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or is licensed as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code § 12180.7.

2.3.7 Captive Risk Retention Group/Self Insured: Where any of the Insurance(s) mentioned in this Section 2.3.7 are provided by a Captive Risk Retention Group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

2.3.8 Cancellation or Material Change: The HMO shall not of its own initiative cause such insurance as addressed in this Article to be cancelled or materially changed during the term of this Contract.

2.3.9 Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by HMO shall be provided to CalOptima prior to execution of the Contract and annually thereafter. HMO shall provide the Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by Participating Providers to CalOptima upon request.

2.3 REIMBURSEMENT FOR CERTAIN COVERED SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENT---HMO shall reimburse the Local Health Department (LHD) on a FFS basis, according to the current Medi-Cal Fee Schedule, for certain Covered Services provided to Members, in accordance with CalOptima Policy. This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.4 HMO FINANCIAL RESPONSIBILITY FOR MEDICAL SUPPLY ITEMS --- HMO shall be responsible for authorizing all injectable medications, or medications in an implantable dosage form which shall be reimbursed as set forth in Attachment A, Division of Financial Responsibility.

2.5.1 AS SET FORTH IN ATTACHMENT A, the Division of Financial Responsibilities, HMO shall also be financially responsible for authorizing and paying for Medical Supplies and durable medical equipment.

2.5.2 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.5 SKILLED NURSING FACILITY FINANCIAL RESPONSIBILITY --- HMO shall be financially responsible for Skilled Nursing Facility services daily rate when such services are determined by CalOptima to be in-lieu of acute hospitalization.

2.6 PAYMENTS TO PROVIDERS ---

2.7.1 Capitation Payments - HMO and/or Subcontractors shall distribute monthly capitation payments to capitated Participating Providers within fifteen (15) calendar days following the date on which HMO receives payment from CalOptima.

2.7.2 Claims Turnaround Time - HMO shall reimburse Complete Claims, or any portion of any Complete Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by HMO, unless the claim or portion thereof is reasonably contested by HMO, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by HMO in accordance with CalOptima Policy.

2.7.3 Claims Adjudication – Except as provided in this Section, HMO shall accept and adjudicate claims for Covered Services provided to Members in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

2.7.4 Dispute Resolution - HMO shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies.

2.7.5 Right Of Appeal - HMO shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to HMO's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from HMO's Date of Determination.

2.7.6 CalOptima Payment On Behalf Of HMO

2.7.6.1 If CalOptima receives a copy of an unpaid Complete Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies.

2.7.6.2 If HMO does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Complete Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of HMO, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation payment, in accordance with CalOptima Policy.

2.7.7 Assumption of Delegated Functions.

2.7.7.1 Assumption Of Claims Processing. In the event that HMO fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, either assume responsibility from HMO for claims payment, or terminate this Contract as provided for in Section 13.1 of this Contract. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that HMO has established an approved corrective action plan consistent with Section 1375.4 (b)(4) of the Health and Safety Code.

2.7.7.2 Assumption Of Dispute Resolution. In the event that HMO fails to resolve its Provider disputes in a timely manner, CalOptima may, at its sole discretion, assume responsibility from HMO for dispute resolution, or terminate this Contract as provided for in Section 13.1 of this Contract.

2.7.7.3 Recoupment Of Costs For Assumption Of Claims Processing And/Or Dispute Resolution. CalOptima, at its sole and absolute discretion, may reduce HMO Capitation Rate to recoup additional administrative costs for the assumption of the claims processing and/or dispute resolution responsibilities of HMO, as described in this Section, as well as any amounts, including interest due, on claims unpaid at the assumption of responsibilities by CalOptima.

2.7.8 Quarterly Claims Payment Performance Report.

2.7.8.1 HMO shall submit, in a format specified by CalOptima Policies, a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose HMO's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations.

2.7.8.2 HMO shall ensure that each Quarterly Claims Payment Performance Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of HMO, stating that the report is true and correct to the best knowledge and belief of the principal officer.

2.7.8.3 HMO's Quarterly Claims Payment Performance Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

2.7.9 Forwarding of Misdirected Claims

2.7.9.1 HMO shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the HMO group. HMO will receive misdirected claims per CalOptima Policy.

2.7.9.2 HMO shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within 10 working days of receipt of the claim. CalOptima shall receive these files per CalOptima Policy, and load them into their system to ensure timely claims processing.

2.7.10 FQHCs Payments - If FQHC, HMO shall reimburse the FQHC at a rate comparable to any other Subcontract arrangement for similar services

2.7.11 American Indian Health Service Payments - HMO shall reimburse American Indian Health Care Provider(s) for Covered Services provided to Members who are qualified to receive services from an American Indian Health Care Provider. HMO shall reimburse American Indian Health Care Provider at a rate comparable to any other Subcontract arrangement for similar services.

2.7.12 Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in HMO's provider network, HMO shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy.

2.7.13 Family Planning Provider Payments - HMO shall reimburse non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. HMO shall reimburse non-contracting family planning providers for services provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

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2.7.14 Sexually Transmitted Disease Treatment Payments - HMO shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. HMO may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to HMO along with billing information.

2.7.15 HIV Testing and Counseling Payments - HMO shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. HMO shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to HMO.

2.7.16 Information Disclosures To Participating Providers. HMO shall provide to all Participating Providers, initially upon contracting and annually thereafter on or before the Contract anniversary date, and at any time upon request from a Participating Provider, in an electronic format as defined and detailed in CalOptima Policies, the following:

2.7.16.1 A complete fee schedule.

2.7.16.2 Payment policies and nonstandard coding methodologies used to adjudicate claims.

2.7.17 Provider Payments-

2.7.17.1 HMO shall reimburse contracted Specialist Physician for Covered Services rendered to Members on an aggregate basis, at an amount equal to or greater than one hundred thirty-three percent (133%) of the Medi-Cal fee schedule except for those members specified below.

2.7.17.2 In addition to the requirements in this Contract, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall compensate CCS paneled physicians and surgeons providing CCS Services to CCS eligible Members at rates that are equal to or exceed the applicable Medi-Cal Program CCS fee-for-service rates, unless the physician or surgeon enters into an agreement on an alternative payment methodology mutually agreed to by HMO and the physician and surgeon.

2.7.17.3 For CCS neonatal intensive care units, HMO shall pay the CCS Provider either the equivalent of Medi-Cal fee-for-service rates, such as the All Patient Refined Diagnosis Related Group (APR-DRG) rates or other established rates, or HMO's negotiated rates, whichever is higher, for up to 12 months after the transition.

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2.7.18 DIRECTED PAYMENTS FOR QUALIFYING COVERED SERVICES --- Effective July 1, 2020, CalOptima and HMO shall administer directed payments that are relevant to this Contract in accordance with CalOptima Policy FF.2011, Directed Payments by HMO to eligible providers rendering qualifying Covered Services, reporting requirements related to directed payments, and reimbursement of directed payments by CalOptima to HMO.

2.7.19 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.8 THIRD PARTY TORT LIABILITY/ESTATE RECOVERY --- HMO shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. HMO shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

2.9 OTHER HEALTH COVERAGE (OHC) --- HMO shall cost avoid or make post-payment recovery for the reasonable value of Covered Services paid by HMO and rendered to Members whenever a Member's OHC covers the same Covered Services, either fully or partially. In no event shall HMO cost avoid or seek post-payment recovery for the reasonable value of Covered Services from a Third Party Tort Liability Action or make a claim against the estates of deceased Members. HMO shall coordinate benefits with other programs or entitlements recognizing OHC as primary coverage and Medi-Cal as the payor of last resort. HMO shall not undertake cost avoidance or post-payment recovery except on the basis of OHC reflected in an OHC code reflected in the Medi-Cal eligibility records.

2.9.1 Cost Avoidance - If HMO reimburses a Provider on a Fee-for-Service basis, HMO shall not pay claims for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code without proof that the Provider has first exhausted all benefits of other liable parties. Proof of third party billing is not required before payment for services provided to Members with OHC codes A or N.

2.9.2 Post-Payment Recovery - If HMO reimburses a Provider on a Fee-for-Service basis, HMO shall pay the Provider's claims and then seek to recover the cost of the claim by billing liable third parties for services provided to Members with OHC codes A or N; for services defined by DHCS as prenatal or PPS, or in child support enforcement cases. If HMO does not have sufficient information to determine whether or not OHC is the result of child support enforcement case, then HMO shall follow the procedure above for cost avoidance. If HMO does not reimburse a Provider on a Fee-for-Service basis, then HMO shall pay for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual Covered Services rendered.

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2.9.3 HMO shall have written policies implementing these requirements.

2.9.4 HMO shall submit monthly reports to CalOptima identifying OHC in accordance with CalOptima Policies.

2.9.5 HMO shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. Reports shall be made available upon CalOptima request.

2.9.6 HMO shall identify OHC unknown to DHCS within ten (10) days of discovery to CalOptima in accordance with CalOptima Policies.

2.9.7 HMO shall demonstrate to CalOptima that where HMO does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues HMO projects it would receive from such activity.

2.9.8 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination. This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.10 MEDICAL LOSS RATIO --- HMO shall maintain a minimum acceptable medical loss ratio as defined by CalOptima Policies of eighty-five percent (85%).

2.11 FINANCIAL VIABILITY STANDARDS AND REPORTING --- HMO shall maintain a cash-to-claims ratio of no less than .75 at all times during this Contract. HMO shall substantiate compliance with this requirement by submitting all applicable reports to the Department of Managed Health Care.

2.12 COOPERATION WITH DMHC --- HMO shall fully cooperate and comply with the Department of Managed Health Care's review and audit process, and permit DMHC to obtain and evaluate supplemental financial information related to HMO. HMO shall also fully cooperate and participate in DMHC's Corrective Action Plan (CAP) process.

2.13 Not Applicable to this Contract.

ARTICLE 3
Obligations of HMO - Administrative

3.1 STATUTORY REQUIREMENTS --- HMO shall retain at all times during the period of this Contract a valid restricted Knox-Keene license issued by the California Department of Managed Health Care (DMHC).

3.2 EQUAL OPPORTUNITY

3.2.1 HMO 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. HMO 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. HMO 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 HMO 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.

3.2.2 HMO and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of HMO 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.

3.2.3 HMO 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 HMO 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.

3.2.4 HMO 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.

3.2.5 HMO 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.

3.2.6 In the event of HMO 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 HMO 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.

3.2.7 HMO and its Subcontractors will include the provisions of Sections 3.2.1 through 3.2.7 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. HMO 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 HMO and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, HMO 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.

3.3 MARKETING GUIDELINES --- HMO shall comply with the marketing guidelines set forth in CalOptima Policies.

3.4 CALOPTIMA LOGO --- HMO shall not display the CalOptima logo on any of HMO's written communication to Members without prior written approval by CalOptima.

3.5 MEMBER INQUIRIES AND CALLS --- HMO shall establish and maintain a call center for receiving and responding to Member inquiries and calls. HMO's call center shall meet requirements established by CalOptima Policies. HMO shall equip and furnish call center

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including but not limited to appropriate telephone equipment and systems, so as to assure HMO shall supply reports of call center performance as required by CalOptima Policies.

3.6 WRITTEN MATERIALS --- Except as otherwise provided in this Contract, HMO shall ensure that all written Member information provided by HMO to Members is provided at a sixth grade reading level, or as determined appropriate through the CalOptima group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions. Written Member informing materials, shall be translated into the identified Threshold and Concentration Languages. Written Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested. HMO shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

3.7 COMPLAINTS AND GRIEVANCES ---

3.7.1 Member Grievance Procedures - Members or Members' authorized representative may file grievances about any aspect of service delivery provided or arranged by HMO. HMO shall implement and comply with CalOptima Policies relating to Member grievances. HMO shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

3.7.2 Provider Grievance Procedures - Providers may file grievances about any aspect of service delivery provided or arranged by HMO. HMO shall implement and comply with CalOptima Policies relating to Provider grievances.

3.8 SUB-DELEGATION AND SUBCONTRACTING OF ADMINISTRATIVE SERVICES. Except as otherwise limited by the State Contract, this Contract and/or CalOptima Policies and subject to CalOptima's prior written approval, HMO may sub-delegate to an MSO, medical group, and/or IPA administrative functions required of HMO but shall not absolve HMO of oversight responsibilities. All sub-delegation must be approved by CalOptima. HMO shall obtain approval of sub-delegation from CalOptima pursuant to the process detailed in CalOptima Policies. HMO's Sub-delegation to another entity does not alter HMO's ultimate obligation and responsibilities set forth in this Contract. HMO may give a sub-delegate the authority to act on behalf of HMO; but HMO retains oversight and accountability for the sub-delegated function. Accountability means that HMO cannot abdicate responsibility for the function being performed according to the requirements of this Contract, HMO's standards and those established by this Contract and CalOptima Policies. HMO is accountable for all functions performed in its purview whether by HMO, by any sub-delegate or by any sub-sub-delegate. If HMO chooses to sub-delegate a function, HMO must demonstrate that it has not compromised its ability to evaluate structures and processes and to achieve required performance across its Membership and provider network. At a minimum, HMO shall provide CalOptima no later than one hundred twenty (120) days prior to the proposed effective date of the sub-delegation, with written evidence of the sub-delegation including:

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3.8.1 A copy of the written agreement which meets the requirements of this Section and which describes the relationship between the HMO and the sub-delegate entity including the following information:

3.8.1.1 The sub-delegated functions;

3.8.1.2 The responsibilities of the HMO and the sub-delegate entity;

3.8.1.3 The frequency of the sub-delegate entity's performance;

3.8.1.4 The process by which the HMO evaluates the sub-delegate entity's performance; and

3.8.1.5 The HMO's remedies if the sub-delegate entity fails to fulfill its obligations including revocation of the sub-delegation.

3.8.2 A description of the HMO's process by which the sub-delegate entity was evaluated and selected to perform the sub-delegated functions, including the entity's score on a selection tool (if any).

3.8.3 A record of the HMO's ongoing oversight process, as requested by CalOptima including:

3.8.3.1 The HMO's annual evaluation of whether the entity is performing the sub-delegated functions in accordance with this Contract and NCQA standards;

3.8.3.2 The HMO's review of the sub-delegate entity's regular reports; and

3.8.3.3 Reports and data required to be submitted to CalOptima.

3.8.4 HMO shall terminate as soon as practical to meet the health care needs of Members, upon receiving written notification from CalOptima, any sub-delegation that fails to meet standards established by CalOptima and/or any of the requirements in this Contract or in CalOptima Policies.

3.8.5 HMO shall report to CalOptima in accordance with all requirements established in this Contract and in CalOptima Policies, data and information that includes and encompasses all of HMO's Members, including those receiving services from a sub-delegate of HMO.

3.8.6 HMO shall oversee and monitor its sub-delegates, and audit sub-delegates no less than once in any twelve- (12) month period. HMO shall establish standards and performance requirements for sub-delegate function(s) and requirements for sub-delegates shall require sub-delegate to meet or exceed all requirements of HMO in this Contract and in CalOptima Policies. HMO may be exempt from oversight, monitoring and auditing of sub-delegate if the sub-delegate is:

3.8.6.1 Contracted directly with CalOptima as a Health Network, or as a participant in a Health Network (i.e. a Shared Risk Group, PHC Physician Group, or PHC Hospital), or

3.8.6.2 NCQA accredited or certified for the function(s) sub-delegated by HMO to sub-delegate.

3.8.7 Sub-delegates failing to meet performance requirements shall be placed on a Corrective Action Plan (CAP). The CAP shall detail sub-delegate's deficiencies; list specific steps, tasks and activities to bring sub-delegate into compliance; and a timeline for completion of corrective action and to achieve compliance with performance requirements. HMO shall notify CalOptima of any sub-delegate providing services to CalOptima Members that is on a CAP. HMO shall provide CalOptima a copy of the CAP if requested.

3.9 SUBCONTRACTS --- HMO may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. HMO is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. HMO is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. HMO shall have policies and procedures addressing Subcontracts with any offshore individual or entity that receives, processes, transfers, handles, stores, or accesses CalOptima Member Protected Health Information (PHI) ("Offshore Subcontracts"), including policies that address security of such PHI and CMS requirements for reporting information about Offshore Subcontracts. HMO shall annually complete the CalOptima Offshore Attestation and make its Offshore Subcontract policies and list of such Offshore Subcontracts available to CalOptima upon request, including for audits by CalOptima and/or CalOptima's Regulators. Additionally, HMO shall require all Subcontracts contain the following:

3.9.1 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 an audit, inspection, evaluation, examination or copying in accordance with Sections 3.18 to 3.20 of this Contract;

3.9.2 An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Section 3.17 and 3.22 of this Contract;

3.9.3 Requirements for cultural and linguistic sensitivity and provision of interpreter services to be provided as set forth in Sections 3.33 and 3.34 of this Contract;

3.9.4 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Sections 7.2, 7.10, and 7.11 of this Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 3.21 and 3.21.1 of this Contract;

3.9.5 An agreement to maintain and make available to DHCS, CalOptima, and/or HMO, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 3.45 of this Contract;

3.9.6 An agreement requiring compliance with any MOU entered into by CalOptima, which are binding on the HMO;

3.9.7 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in a non-discriminatory manner;

3.9.8 An agreement to comply with all provisions of this Contract with respect to providing Emergency Services and State Contract (Exhibit A, Attachment 8, Provision 12) for those Subcontractors at risk for non-contracting Emergency Services;

3.9.9 An agreement that Subcontractors shall notify HMO of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent;

3.9.10 An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters; and (d) all applicable requirements specified in the State Contract and subsequent amendments, and federal and State laws and regulations;

3.9.11 An agreement that Participating Providers comply with the CalOptima Approved Drug List.

3.9.12 An agreement requiring Subcontractors to sign a Declaration of Confidentiality, which shall be signed and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;

3.9.13 An agreement to hold harmless the State, Members and CalOptima, in the event HMO 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 4.1.9 of this Contract;

3.9.14 An agreement to assist and cooperate with HMO and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract, Contract, or Subcontract, for any reason in accordance with Sections 8.2 and 8.2.1 of this Contract;

3.9.15 In the event that HMO implements and maintains a Physician Incentive Plan, it shall ensure that: (A) no specific payment is made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and (B) the stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR § 417.479, 42 CFR § 422.208, and 42 CFR § 422.210 are met by HMO.

3.9.16 Subcontractor shall comply with all monitoring provisions of this Contract and the State Contract and any monitoring requests by CalOptima and DHCS.

3.9.17 Services to be provided by the Subcontractor, term of the Subcontract (beginning and end 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;

3.9.18 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract;

3.9.19 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 14.10 of this Contract, and (b) to notify DHCS in a manner provided in Section 8.4 of the Contract in the event the Subcontract is amended or terminated;

3.9.20 An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if HMO delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract, including the Delegation Acknowledgement and Acceptance Agreement ("Delegation Agreement");

3.9.21 An agreement to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies, in accordance with Section 3.46 of this Contract, in instances where DHCS, CalOptima, and/or HMO determines that the Subcontractor has not performed satisfactorily;

3.9.22 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Sections 6.11.9 and 14.12 of the Contract;

3.9.23 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 10.10 of this Contract;

3.9.24 An agreement by the HMO to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 13.12 of the Contract; and

3.9.25 An agreement that Participating Providers are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program; and

3.9.26 Subcontractor's agreement to provide HMO with the disclosure statement set forth in 22 CCR Section 51000.35, prior to commencing services under the Subcontract, which shall be provided to CalOptima upon request.

3.10 HMO ORGANIZATION AND OPERATIONS STRUCTURE --- HMO shall comply with the organization and operations structure requirements of applicable laws and regulations. Without limiting the foregoing, HMO shall maintain a full time physician as Medical Director/Chief Medical Officer (CMO) whose responsibilities shall include, but not limited to, the following:

3.10.1 Ensuring that medical decision are: (i) rendered by qualified medical personnel, and (ii) are not unduly influenced by fiscal or administrative management considerations.

3.10.2 Ensuring that the medical care provided meets the standards for acceptable medical care.

3.10.3 Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.

3.10.4 Developing and implementing medical policy.

3.10.5 Resolving grievances related to medical quality of care.

3.10.6 Direct involvement in the implementation of Quality Improvement activities.

3.10.7 Actively participate in the functioning of the grievance and appeal procedures.

3.11 ENROLLMENT --- HMO shall accept as Members all persons indicated by CalOptima's information system and through regular transmission from CalOptima to HMO.

3.12 PCP ASSIGNMENT --- HMO shall assign Members who have been automatically assigned to HMO by CalOptima to a PCP within seven (7) days of the Member's assignment to HMO.

3.13 REQUIRED ENROLLMENT INFORMATION AND NOTICE --- HMO shall mail to a Member or Member's head of household a notice of enrollment and a HMO Member handbook or CalOptima approved supplement to the CalOptima Member handbook no later than seven (7) calendar days after receipt of notification that a Member has been enrolled with HMO. All member handbooks and supplements prepared by HMO shall be submitted to CalOptima for approval prior to printing. HMO shall not distribute to Members materials not approved by CalOptima. All materials shall be professionally produced and presented.

3.13.1 Should HMO choose to utilize the CalOptima Member handbook, HMO-specific information on each topic as defined by CalOptima Policies must be included in a CalOptima approved supplement to the CalOptima Member handbook given to all HMOs' CalOptima Members. CalOptima shall provide HMO with a template for the supplement to the CalOptima member handbook.

3.13.2 If HMO chooses to produce and use a Member handbook other than the CalOptima Member handbook, in addition to the requirements in this Contract, HMO's Member handbook shall contain all information included in the CalOptima Member handbook and HMO-specific information on each topic as defined by CalOptima Policies.

3.13.3 HMO shall provide Members with periodic updates, as needed, explaining changes in the above policies or services. CalOptima shall approve all updates prior to printing. HMO shall also provide one (1) copy of its enrollment information including its HMO Member handbook or supplement to every Participating Provider.

3.14 SPECIAL DISENROLLMENT --- HMO may request and CalOptima may approve according to CalOptima Policies disenrollment for specific Members.

3.15 VOLUNTARY DISENROLLMENT --- All Members have the right to disenroll from a Health Network. CalOptima shall process Member disenrollment in accordance with CalOptima Policies.

3.16 ADDITIONAL SERVICES --- HMO shall not solicit enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services, which have been approved by CalOptima.

3.17 MEDICAL AND ADMINISTRATIVE RECORDS --- HMO shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with 22 CCR Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All Medical Records shall meet the requirements of State Contract and applicable laws and regulations, including, but not limited to, 28 CCR Section 1300.80(b)(4) and 42 USC Section 1936a(w). Such records shall be available to health care providers at each encounter, in accordance with 28 CCR Section 1300.67.1(c). HMO shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Provider or Subcontractor site.

3.17.1 HMO and CalOptima agree to maintain the confidentiality of the Member's Medi-Cal status and information contained in the Member's Medical Records in accordance with federal and State law. HMO shall require that all Participating Providers and Subcontractors maintain the confidentiality of a Member's Medi-Cal status and information contained in a Member's Medical Records in accordance with federal and State Law.

3.17.2 Medical records under this Section shall reflect all aspects of patient care, including ancillary services, in accordance with CalOptima Policies, and shall, at a minimum, contain:

3.17.2.1 Member identification on each page; personal/biographical data in the record.

3.17.2.2 Initial Health Assessment within 120 days of enrollment.

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3.17.2.3 Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.

3.17.2.4 All entries dated and author identified; for member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the diagnosis and treatment plan.

3.17.2.5 The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.

3.17.2.6 Allergies and adverse reactions are prominently noted in the record.

3.17.2.7 All informed consent documentation, including the human sterilization consent procedures required by Sections 51305.1 through 51305.6 of Title 22 of the California Code of Regulations, if applicable.

3.17.2.8 Reports of emergency care provided (directly by a contracted provider or through a non-contracted emergency room) and the hospital discharge summaries for all hospital admissions.

3.17.2.9 Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.

3.17.2.10 For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive, such as a Durable Power of Attorney for Health Care.

3.17.2.11 Health education behavioral assessment and referrals to health education services.

3.17.3 It is understood that all Participating Provider's and Subcontractors' books and records pertaining to goods and services furnished under this Contract:

3.17.3.1 Shall be made available for inspection or copying at HMO's, Participating Providers' and/or Subcontractors' expense by CalOptima or authorized representative of State or federal government at all reasonable times at the HMO's, Participating Providers' or Subcontractors' place of business or at such other mutually agreeable location in California; and

3.17.3.2 Shall be maintained in accordance with the general standards applicable to such book or record keeping.

3.18 RECORDS RETENTION --- HMO and Subcontractors shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including claim forms and encounter data, for a period of not less than 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, with the exception

in which HMO or Subcontractor has been duly notified that DHCS, DHHS, the Department of Managed Health Care, the Department of Justice or Comptroller General of the United States, or their duly authorized representative have commenced an audit or investigation of the Contract or any Subcontract, until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Pediatric records for un-emancipated minor Members shall be maintained until the latter of the full retention period under this Section, or at least one (1) year after the Member has reached eighteen (18) years of age. 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.

3.18.1 HMO shall, upon request of CalOptima, transfer copies of such records to CalOptima's possession. No records shall be destroyed or otherwise disposed of prior to the retention period stated in Section 3.18without the prior written consent of CalOptima. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3.19 ACCESS TO PREMISES --- CalOptima and the State, through any authorized representatives, have the right at all reasonable times to monitor, inspect or otherwise evaluate the work performed or being performed hereunder, including subcontract supported activities and the premises in which it is being performed. If any monitoring, inspection or evaluation is made of the premises of HMO or Subcontractor, HMO shall provide, and shall require Subcontractors to provide, all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All monitoring, inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

3.19.1 Through the end of the records retention period specified in Section 3.18, HMO shall 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 audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 21: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the HMO's place of business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years.

3.19.2 Through the end of the records retention period specified in 3.18, HMO shall allow CalOptima and/or CalOptima's Regulators to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, Facilities, contracts, computers, or other electronic systems maintained by HMO and Subcontractors pertaining to these services at any time pursuant to 42 CFR section 438.3(h). Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract,

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including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.18, HMO shall furnish any record, or copy of it, to CalOptima, DHCS or any other CalOptima's Regulators, at HMO's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the HMO's Primary Care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations and Contract requirements. CalOptima and authorized State and Federal agencies will have the right to monitor all aspects of HMO's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of HMO, Subcontractor, and provider facilities, management systems and procedures, and books and records as CalOptima or DHCS deems appropriate, at any time 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, CalOptima, the State and their authorized representatives and designees will have the right to premises access, with or without notice to HMO. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima and authorized State agencies will have access to all security areas and HMO will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to the CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the HMO and/or the Subcontractor(s).

3.20 ACCESS TO AND AUDIT OF CONTRACT RECORDS --- Throughout the duration of the Contract and the retention period as specified in Section 3.18, HMO and Subcontractor shall provide duly authorized representatives of the State or federal government or CalOptima access to all records and material relating to HMO's provision of and reimbursement for activities contemplated under the Contract, and to HMO's financial condition and ability to bear risk under applicable state and federal laws. Such access shall include the right to inspect, audit and have available all such records and material and to verify reports furnished in compliance with the provisions of the Contract. All information so obtained shall be accorded confidential treatment as provided under applicable law. CalOptima employees shall sign HMO's statement of confidentiality prior to being admitted access to HMO's premises. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise. 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 HMO at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the HMO from participation in the Medi-Cal program; seek recovery of payments made to the HMO; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

3.21 RECORDS RELATED TO RECOVERY FOR LITIGATION --- Upon request by CalOptima, HMO 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

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privileges, in HMO's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If HMO asserts that any requested documents are covered by a privilege, HMO 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. HMO acknowledges that time may be of the essence in responding to such request. HMO shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by HMO or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

3.21.1 HMO further agrees to timely gather, preserve, and provide to DHCS any records in the HMO's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

3.22 MEMBER REQUEST FOR MEDICAL RECORDS --- HMO and Subcontractor shall furnish a copy of a Member's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider or an Out of Network Provider, at no cost to CalOptima or to the Member when:

3.22.1 Such a transfer of records facilitates the continuity of that Member's care; or

3.22.2 The Member is transferring from one Provider to another for treatment; or

3.22.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

3.23 DISCLOSURE OF OWNERSHIP --- HMO shall fully and accurately complete the disclosure form in Attachment B and submit the disclosure form to CalOptima prior to the Effective Date. HMO shall promptly notify CalOptima of any changes to the information contained in the disclosure form in Attachment B and submit an updated disclosure form to CalOptima within thirty (30) days of any such change.

3.23.1 If HMO is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, HMO 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.

3.24 FRAUD AND ABUSE REPORTING --- HMO 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 Participating Providers, Out of Network Providers, Members, or HMO's employees, within five (5) working days of the date when HMO first becomes aware of or is on notice of such activity.

3.24.1 HMO shall notify CalOptima, and CalOptima shall notify DHCS prior to HMO conducting any investigations. HMO shall conduct an investigation after notification has been given.

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3.24.2 HMO shall provide to CalOptima and/or CalOptima's regulators, upon request, written policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program.

3.24.3 HMO shall report all investigation results to CalOptima within two (2) working days of conclusion of any fraud and/or abuse investigation.

3.25 COMPLIANCE WITH APPLICABLE LAW --- HMO shall observe and comply with all federal and State law 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 HMO's performance under this Contract. This Contract shall be governed by and construed in accordance with applicable federal and State law and with the terms and obligations under the State Contract.

3.26 HMO COMPLIANCE PROGRAM --- HMO shall develop and implement a comprehensive and effective Compliance Program, including a Compliance Plan. Such Compliance Program shall include, but is not limited to, the implementation of the Office of Inspector General's (OIG) 7 Elements of an Effective Compliance Program: Standards & Procedures, Oversight, Education & Training, Auditing & Monitoring, Reporting, Enforcement and Discipline, and Response & Prevention. Compliance Programs shall be evaluated by the HMO annually to ensure that it remains effective. HMO shall make the Plan and related documents available to CalOptima upon request.

3.27 COMPLIANCE WITH CALOPTIMA'S COMPLIANCE PROGRAM --- HMO and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("HMO's Agents") shall comply with the requirements of CalOptima's Compliance Program, as may be amended from time to time, including the Code of Conduct and Compliance Plan. CalOptima shall make its Compliance Manual and Code of Conduct available to HMO and HMO shall make them available to HMO's Agents.

3.28 COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- HMO shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. HMO's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, as well as applicable requirements specified in the State Contract and subsequent amendments, and State and federal laws and regulations.

3.29 COMPLIANCE WITH POLICIES AND PROCEDURES --- HMO agrees to comply with and be bound by CalOptima Policies. CalOptima reserves the right to adopt, amend and/or discontinue CalOptima Policies at its sole discretion. HMO acknowledges and agrees that it shall implement CalOptima Policies applicable to its obligations under this Contract.

3.30 COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOU(s)) --- HMO agrees to comply with and be bound by any and all applicable MOUs

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entered into by CalOptima. HMO agrees to require Subcontractors to comply with applicable requirements of such MOUs.

3.31 COMPLIANCE WITH PARTICIPATION STATUS REQUIREMENTS ---HMO shall have policies and procedures to verify the Participation Status of HMO's Agents. HMO shall refer to the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (LEIE) (http://oig.hhs.gov), as well as the GSA Excluded Parties Lists Systems (EPLS) in the SAM System (https://www.sam.gov). In addition, HMO warrants and agrees as follows:

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

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

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

3.31.4 HMO shall include the obligations of this Section in its Subcontracts.

3.32 NON-DISCRIMINATION --- During the performance of this Contract, neither HMO nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. HMO and Subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. HMO and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, and et seq.) and the applicable regulations promulgated thereunder (CCR, Title 2, Section 7285.0, and 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. HMO and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. HMO shall include the non-discrimination and compliance provisions of this Section in all Subcontracts to perform work under this Contract.

3.32.1 HMO and all Subcontractors shall abide by 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

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IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the HMO nor Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons of 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); 45 CFR Part 84 (physical or mental handicap); 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, or as otherwise provided by law or regulation.

3.32.2 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service which is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating a Member differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions which individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

3.32.3 HMO shall take affirmative action to ensure that all Members are provided Covered Services without unlawful discrimination, except where medically indicated. 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.

3.32.4 HMO shall act upon all complaints alleging discrimination against Members in accordance, with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

3.32.5 HMO shall require all downstream providers to cooperate with CalOptima's Member Complaint Policy and time requirements to appeals within designated time frames.

3.33 LINGUISTIC AND CULTURAL SENSITIVITY --- CalOptima will provide cultural competency, sensitivity, and diversity training. HMO shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Contract and CalOptima Policies.

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3.33.1 HMO shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. HMO shall provide cultural competency, sensitivity, or diversity training for staff, providers and Subcontractors at key points of contact. HMO shall provide orientation and training on cultural competency to staff and providers serving Members. The training objectives shall include teaching participants an enhanced_awareness of cultural competency imperatives and issues related to improving access and quality of care for Members, as well as information on access to interpreters, and how to work with interpreters. HMO shall also, as appropriate, refer Members to culturally-appropriate community services programs.

3.33.2 Pursuant to CalOptima Policies, HMO shall provide translation of written member informing materials in the Threshold and Concentration Languages. HMO shall comply with the language assistance standards developed pursuant to California Health and Safety Code section 1367.04. Written member informing materials to be translated include, but are not limited to: 1) signage; 2) Evidence of Coverage and/or Member Services Guide; 3) disclosure forms; 4) provider listing or directories; 5) marketing materials; 6) form letters; 7) plan-generated preventive health reminders; 8) member surveys; and 9) newsletters. If a Member requests materials in a language not meeting the numeric Thresholds or Concentration Standards, HMO shall provide oral translation of the written materials utilizing bilingual staff or a telephonic interpreter service. HMO shall also make materials available to Members in alternate formats (e.g. Braille, audio, large print) upon request of the Member. HMO shall be responsible for ensuring the quality of translated materials at no cost to CalOptima or Member.

3.34 PROVISION OF INTERPRETERS --- HMO shall, at no cost to Members, provide linguistic interpreter services and interpreter services for the deaf or hard of hearing for all Members at all key points of contact, including telephone, advice and urgent care transactions, and outpatient encounters, and all sites utilized by HMO or any Subcontractors, as well as member services, orientations, appointment setting and similar administrative functions, as necessary, to ensure the availability of effective communication regarding treatment, diagnosis, medical history or health education. HMO shall have in place telephonic and face-to-face interpreter services and American Sign Language interpreter services contracts. HMO shall provide twenty-four (24) hour access to interpreter services for all Members, and shall implement policies and procedures to ensure compliance by subcontracted providers with these standards. Such access shall include access for users of Telecommunication Devices for the Deaf (TDD) or Telecommunications Relay Services (711 system). Upon a Member or Participating Provider request for interpreter services in a specific situation where care is needed, HMO shall make all reasonable efforts to provide a face-to-face interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services. If face-to-face interpretation is not feasible, HMO must ensure provision of telephonic interpreter services or interpretation through bilingual staff members. HMO shall routinely document the language needs of Members and the request or refusal of interpreter services in a Member's medical record. This documentation shall be available to CalOptima at CalOptima's request. HMO shall not require or suggest that a Member to use friends or family as interpreters. However, a family member or friend may be used when the

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use of the family member or friend: (i) is requested by the Member; (ii) will not compromise the effectiveness of service; (iii) will not violate Member's confidentiality; and (iv) the Member is advised that an interpreter is available at no cost to the Member. HMO shall ensure the linguistic capabilities and proficiency of individuals providing interpreter services.

3.35 MEMBER RIGHTS --- HMO shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed. HMO shall make Member Rights available to Member.

3.36 PARTICIPATING PROVIDER-MEMBER COMMUNICATION --- HMO shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from communicating with Members, and shall encourage its health care professionals to freely communicate the following to patients, regardless of benefit coverage:

3.36.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.36.2 Any information the Member needs in order to decide among all relevant treatment options.

3.36.3 The risks, benefits, and consequences of treatment or non-treatment.

3.36.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.37 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

3.37.1 HMO and CalOptima shall make any and all efforts and take any and all actions necessary to 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, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

3.37.2 HMO shall comply with HIPAA requirements as currently established in CalOptima Policies. HMO 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.

3.37.3 The parties agree to comply with the terms and conditions of the Health Network HIPAA Business Associates Agreement.

3.38 CONFIDENTIALITY OF INFORMATION

3.38.1 HMO 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 HMO, its employees, agents, or

Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. HMO and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out HMO's obligations under this Contract. HMO and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. HMO 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, Protected Health Information (PHI): names, geographical subdivisions smaller than a state, all elements of dates (except for year), phone and fax numbers, e-mail address, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, vehicle identifiers, device identifiers, web Universal Resource Locators (URLs), internet protocol address numbers, biometric identifiers, including finger and voice prints, full face photograph images, any other unique identifying number, characteristic or code.

3.38.2 Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 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 HMO from unauthorized disclosure. HMO may release Medical Records in accordance with applicable law pertaining to the release of this type of information. HMO 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 HMO or its Subcontractors, HMO:

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

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

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

3.38.2.4 will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the HMO by DHCS for this purpose.

3.39 REINSURANCE ---CalOptima arranges for the provision of reinsurance, as described more fully in CalOptima Policies. CCS Eligible Members with CCS Eligible Conditions shall be excluded from CalOptima's provision of reinsurance. HMO may, at its option and sole expense purchase supplemental Reinsurance from a source other than CalOptima. Additionally, HMO shall:

3.39.1 Identify a Reinsurance coordinator who shall serve as CalOptima's contact for all Reinsurance issues; and

3.39.2 Comply with CalOptima Policies for monitoring and monthly reporting of all Reinsurance claims activities.

3.39.3 In lieu of CalOptima-provided reinsurance, services for CCS Members shall be subject to interim reimbursement for catastrophic cases and retrospective risk corridors, as provided in Attachment E.

3.40 CLAIMS MANAGEMENT AND ADMINISTRATION --- HMO shall have a process for claims management and administration. HMO shall maintain a claim retrieval system that can, on request, identify the date of receipt, the action taken on all Provider claims (i.e., paid, denied, pended, other), and when action was taken. HMO shall date stamp all Provider claims upon receipt. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

3.41 TWENTY-FOUR (24) HOUR TELEPHONE COVERAGE--- HMO shall have one (1) California Statewide toll-free telephone number listed on the Automated Eligibility Verification System (AEVS) that Providers, Members or individuals acting on behalf of Members can call at anytime (twenty-four (24) hours/seven (7) days a week) to obtain authorization for all CalOptima Covered Services. Twenty-four (24) hour telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either:

3.41.1 Have authority to approve Covered Services; or

3.41.2 Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and

3.41.3 In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room; and

3.41.4 Respond to Provider's or Member's call within thirty (30) minutes. Failure to respond to such call within thirty (30) minutes shall result in the HMO being liable for the cost of subsequent Medically Necessary Covered Services related to that illness or injury whether or not that treatment has been authorized; and

3.41.5 Have the capability to coordinate continuous care and follow-up Covered Services, including referrals to Specialist Physicians, for all Members who have received MSE or Emergency Services and have been Stabilized.

3.41.6 All calls shall be logged in with time, date and any pertinent information related to persons involved, resolution and follow-up instructions. HMO shall notify CalOptima if the toll free telephone number changes no less than seven (7) working days prior to the change.

3.42 OBLIGATIONS UNDER PRIOR CONTRACT --- HMO acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). HMO shall perform all such obligations and duties. For purposes of this section, "Prior Contract" means the contract for health care services previously entered into between HMO and CalOptima pursuant to which HMO agreed to provide or arrange for the provision of Medi-Cal Covered Services Members.

3.43 EMPLOYEE EDUCATION ON FALSE CLAIMS ACT --- HMO shall comply with the requirements contained in 42 USC § 1396a(a)(68)(A)-(C) as a condition of receiving payment under this contract. HMO shall, upon request of CalOptima, demonstrate compliance with this provision, including providing CalOptima with copies of HMO's applicable written policies and procedures, any relevant employee handbook excerpts, and other educational materials used to meet this requirement.

3.44 MONITORING --- HMO shall comply with all monitoring provisions of this Contract and the State Contract, and any monitoring requests by CalOptima and DHCS.

3.45 HMO SUBCONTRACTS --- In addition to Section 3.9 of this Contract, HMO shall maintain and make available to CalOptima, DHCS, or other CalOptima's Regulators, upon their respective requests, copies of all Subcontracts. HMO shall ensure that all Subcontracts are in writing and require that the HMO and its Subcontractors:

3.45.1 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 and/or CalOptima's Regulators, or their designees.

3.45.2 Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the State Contract period or from the date of completion of any audit, whichever is later.

3.46 CALOPTIMA OVERSIGHT – HMO understands and agrees that CalOptima is responsible for the monitoring and oversight of all obligations of HMO under this Contract. In instances where DHCS or CalOptima determines that the HMO or any of the Subcontractors has not performed satisfactorily, CalOptima shall have the right to (a) amend or revoke the delegation of activities or obligations to the HMO, (b) require the HMO to amend or revoke the sub-delegation of activities or obligations to the Subcontractors, and/or (c) specify other remedies, including, but not limited to, those set forth in Sections 13.1 through 13.1.3.2. HMO shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with applicable laws and regulations, accreditation organization standards, and/or CalOptima Policies governing the obligations of HMO or the oversight of those obligations.

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3.47 Information and Cyber Security. HMO must have policies, procedures, and practices that address its information and cyber security measures, safeguards, and standards, including at least the following:

3.47.1 Access Controls. Access controls, including Multi-Factor Authentication, to limit access to HMO's information systems and any CalOptima information that HMO maintains or can access.

3.47.2 Encryption. Use of encryption to protect any CalOptima information, in transit and at rest, that HMO maintains or can access.

3.47.3 Security. Safeguards for the security of the information systems and CalOptima information that HMO maintains or can access, including hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

3.47.4 Software Maintenance. Software maintenance, support, updates, upgrades, third-party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable industry standards.

3.47.5 Network Security. Network security that conforms to generally recognized industry standards and best practices.

For the purpose of this Section 3.47, "**Multi-Factor Authentication**" means authentication through verification of at least two (2) of the following types of authentication factors: (i) knowledge factors, such as a password; (ii) possession factors, such as a token or text message on a mobile phone; (iii) inherence factors, such as a biometric characteristic; or (iv) any other industry standard and commercially accepted authentication factors.

ARTICLE 4
Obligations of HMO – Provision of Covered Services

4.1 PROVISION OF COVERED SERVICES TO MEMBERS --- HMO shall provide Covered Services to Members under this Contract in the same manner as those services are provided to other patients of HMO, but in no case less than the amount of such services provided under the Medi-Cal Fee-for-Service Program. Consistent with the concept that HMO is the medical home of the Member, where the Member receives the majority of the Member's care and where the Member's overall health status, need for care and services, and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained, HMO shall coordinate Members' needs for Covered Services and provide Care Management Services and other services to assure Members receive all necessary care and services without regard to the party financially responsible for care and services. HMO shall provide Covered Services to Members and HMO agrees as follows:

4.1.1 HMO shall provide and pay for, consistent with the terms and provision of this Contract and CalOptima Policies, the provision of all Covered Services to Members that are the financial responsibility of HMO as set forth in Attachment A, with the exception of certain Medical Supplies identified in Attachment C;

4.1.2 If HMO's network is unable to provide necessary medical services covered under this Contract to a particular Member, HMO must adequately and timely cover these services out of network for the Member, for as long as HMO is unable to provide them. HMO shall make prior arrangements with Out-of-Network Providers for the provision of such services, and shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and authorization of Out-of-Network Providers;

4.1.3 HMO shall be liable for the provision of and payment for all Covered Services notwithstanding a delay in payment of the Capitation Payment;

4.1.4 CalOptima may incorporate any change in Covered Services mandated by federal or State law or regulation into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the HMO thirty (30) calendar days' notice of any such change. CalOptima shall determine the effective date of the change in Covered Services;

4.1.5 The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians participating in the respective HMO as to the Medical Necessity of the service, except that HMO shall provide assessment and evaluation services ordered by a court or legal mandate;

4.1.6 HMO shall comply with Jackson v. Rank, U.S. District Court (E.D. Cal.), No. CIV 5-83-1451 LKK, June 9, 1986, and notify its Members when the HMO denies, modifies or defers a PCP's request for authorization or terminates a previously authorized service;

4.1.7 Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. HMO acknowledges that disputes between the respective HMO and Members about Medical Necessity can be appealed pursuant to CalOptima Policies;

4.1.8 HMO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. HMO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and

4.1.9 HMO shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay capitation payments pursuant to this Contract. In no event, including but not limited to, non-payment by CalOptima or HMO, CalOptima's or the HMO's insolvency, or breach of this Contract by the HMO or CalOptima, shall HMO or Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, a

Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Contract. This provision does not prohibit HMO or Subcontractors from collecting co-payments and deductibles, if any, as specifically provided for in this Contract or for recoveries related to other health coverage, as identified in Section 2.8 of this Contract. HMO or a Subcontractor may bill a Member and collect fees for non-Covered Services from the Member if the Member agrees to the fees 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. HMO further agrees:

4.1.9.1 That this Section shall survive the termination of this Contract for those Covered Services rendered 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 the Members;

4.1.9.2 That this Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the HMO and Participating Providers or Subcontractors;

4.1.9.3 That language to ensure the foregoing shall be included in all of the HMO's Subcontracts with Participating Providers;

4.1.9.4 That no change or amendment to this Section or to similar section(s) in Subcontracts between the HMO and Participating Providers shall be made without the prior written approval of CalOptima; and

4.1.9.5 HMO further agrees that, in the event of a violation of this Section by HMO or Subcontractor, including but not limited to, balance billing of Member for Covered Services provided under the Contract or Subcontract, CalOptima shall take appropriate remedial action against HMO or Subcontractor, including, but not limited to, repayment of any amounts collected, and appropriate Sanctions, as provided for in Section 13.1.

4.2 EMERGENCY CARE --- HMO shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 12). HMO is required to provide and pay for all Emergency Services, including Emergency Services provided by Out of Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week.

4.2.1 HMO shall reimburse or authorize reimbursement, as appropriate, for all Emergency Services without prior authorization, and in accordance with CalOptima Policy. Payment may be denied only if HMO reasonably determines that Emergency Services were never performed.

4.2.2 HMO shall reimburse or authorize reimbursement for facility changes for Emergency Services. HMO is required to reimburse hospital when necessary for all MSE. If the MSE indicates that the Member has an Emergency Medical Condition as defined in

Section 1.34, HMO must reimburse or authorize reimbursement, as appropriate for all Covered Services Medically Necessary to diagnose and Stabilize the Member.

4.2.3 HMO shall reimburse those physicians providing services in an Emergency Department with whom HMO has a contract according to the terms of that contract. HMO shall offer to enter into a contract with any physician group contracting with CalOptima for the provision of physician services in an Emergency Department on the same terms, conditions and rates as provided for in that CalOptima contract. HMO shall reimburse all other non-contracted physicians providing services in an Emergency Department in accordance with the Deficit Reduction Act of 2005, 42 USC 1396u-2(b)(2)(D), and CalOptima Policy.

4.2.4 HMO shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition as defined in Section 1.34, turned out to be non-emergency in nature.

4.2.5 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms. HMO shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have resulted in an outcome specified in Section 1.34. Further, HMO shall not deny payment for treatment obtained when HMO or a Participating Provider instructs the Member to seek Emergency Services.

4.2.6 HMO shall reimburse the County of Orange for Emergency Services and Urgent Care Services provided to Members at Orangewood Children's Home or while in Foster Care during periods of emergency foster placement or court-ordered stays. Payment shall be based on the prevailing Medi-Cal Fee Schedule.

4.2.7 If there is a disagreement between HMO or any Participating Provider and Out of Network Provider regarding Medically Necessary Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Member at the treating facility shall prevail. HMO may establish relationships with treating facility whereby the HMO may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider and Hospital under contract with HMO agree to accept the transfer of the Member after the Member has been Stabilized. The attending emergency physician, or the Provider actually treating the Member is responsible for determining when the Member is sufficiently Stabilized for transfer or discharge and that determination is binding on HMO.

4.2.8 Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). HMO is financially responsible for post-stabilization services obtained within or outside HMO's network that are pre-approved by a plan provider or other entity representative. HMO is financially responsible for post-stabilization care services obtained within or outside HMO's network that are not pre-approved by a plan provider or other HMO representative, but administered to maintain the Member's Stabilized condition within 1 hour of a request to HMO for pre-approval of further post-stabilization care services.

4.2.8.1 HMO is also financially responsible for post-stabilization care services obtained within or outside HMO's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the Member's Stabilized condition if HMO does not respond to a request for pre-approval within 30 minutes; HMO cannot be contacted; or HMO's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, HMO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.

4.2.8.2 HMO's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

4.2.8.3 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214 HMO is financially responsible for payment for post-stabilization services following an emergency admission at the hospital's Medi-Cal FFS payment amounts for general acute care inpatient services rendered by a non-contracting Medi-Cal certified hospital, unless a lower rate is agreed to in a writing signed by the hospital. For the purposes of this Section, the Medi-Cal FFS payment amounts for dates of service when the post-stabilization services were rendered shall be the Medi-Cal FFS payment amounts established in California Welfare and Institutions Code (W & I) Section 14166.245, which for the purposes of this Section shall apply to all general acute care hospitals, including hospitals contracting with the State under the Medi-Cal Selective Provider Contracting Program (W & I Section 14081 et. seq.), less any associated direct or indirect medical education payments to the extent applicable. Payment made by HMO to a hospital that accurately reflects the payment amounts required by this Section shall constitute payment in full under this Section, and shall not be subject to subsequent adjustments or reconciliations by HMO, except as provided by Medicaid and Medi-Cal law and regulations. A hospital's tentative and final cost settlement processes required by 22 CCR 51536 shall not have any effect on payments made by HMO pursuant to this Section.

4.2.8.4 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214, HMO is financially responsible for payment for post-stabilization services following an emergency admission. HMO shall reimburse those physicians providing post-stabilization services with whom HMO has a contract according to the terms of that contract. HMO shall reimburse all non-contracted physicians providing post-stabilization services in accordance with the Medi-Cal Fee Schedule as defined in CalOptima Policy.

4.3 NEWBORN SERVICES --- HMO shall provide all Covered Services to any newborn child born to a Member for the month of the birth and the following month.

4.4 FAMILY PLANNING --- HMO is solely responsible for developing policies and procedures to ensure that Member's Family Planning information and records are confidential as required by State law. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, HMO shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government or the Member's PCP to maintain consistency of the Member's Medical Record. HMO's Subcontracts with PCPs must include language regarding the confidentiality of Family Planning documents, information and records. Prior authorization for Family Planning services shall not be required.

4.4.1 HMO shall comply with OBRA 1987, Section 4113(c)(1)(B), which requires HMO to certify that it shall not restrict or prevent a Member from selecting a Participating Provider or an Out of Network Provider to deliver Family Planning Covered Services and supplies. This does not relieve HMO from financial responsibility for such services.

4.4.2 HMO shall not prevent Members from receiving Family Planning Covered Services from Out of Network Providers.

4.4.3 HMO shall provide information that clearly explains the rights of the Member regarding the choice of Family Planning Providers. HMO shall also provide similar information to all Providers who are either PCPs, obstetricians, gynecologists, or urologists. The intent of this information is to implement the specifications of this paragraph by arranging for the availability of consistent and accurate information from the Member's PCP, obstetrician, gynecologist, or urologist about the Member's rights to freedom of choice regarding Family Planning Providers.

4.4.4 HMO shall provide information to Members and Participating Providers about a Member's right to file a grievance or request a State hearing, in accordance with CalOptima Policies, for any reason including if the Member has reason to believe that the HMO has restricted, prevented, impaired or denied the Member's free choice of Family Planning Providers.

4.4.5 HMO shall incorporate specifications of this Section in its Subcontracts with its PCPs, obstetricians, gynecologists, and urologists.

4.5 ANCILLARY SERVICES FOR LONG TERM CARE --- HMO shall provide authorized Covered Services, including ancillary Covered Services for both emergent and routine laboratory tests and x-rays, not included in the facility day rate for all Members residing in Long Term Care Facilities.

4.6 ACCESS TO SERVICES TO WHICH HMO OR A SUBCONTRACTOR HAS A MORAL OBJECTION --- Unless prohibited by law, HMO shall arrange for the timely referral and coordination of Covered Services to which HMO or a Subcontractor has religious or ethical objections to perform or otherwise support and shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals.

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4.7 ALCOHOL MISUSE SCREENING AND COUNSELING --- HMO shall ensure the provision of AMSC services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond AMSC. HMO shall document AMSC services in Members Medical Records.

4.8 AMERICAN INDIAN HEALTH SERVICE PROGRAMS --- American Indian Health Service Programs can operate as a Primary Care Physician for American Indian Members, and as such can provide referrals directly to network physician without first requesting a referral from a network Primary Care Physician. HMO shall ensure timely access to American Indian Health Service Programs by including American Indian Health Service Programs within HMO's network for American Indian Members in accordance with 42 CFR 438.14(b).

4.9 PARTICIPATION IN CALOPTIMA WHOLE CHILD MODEL PROGRAM --- HMO acknowledges and agrees that its participation in CalOptima WCM is conditioned on transfer of CCS to CalOptima and meeting DHCS access and other requirements. Upon meeting those conditions, CalOptima shall notify HMO of the date upon which HMO will be considered to be "Participating in the CalOptima Whole Child Model Program" as this phrase is used in this Contract, and at which time HMO shall commence all CalOptima WCM obligations.

ARTICLE 5
Obligations of HMO – Access

5.1 TWENTY FOUR (24) HOUR PHYSICIAN COVERAGE --- HMO shall ensure that a physician Participating Provider or physician employed by HMO is available twenty-four (24) hours a day, seven (7) days a week for timely authorization including, but not limited to, authorizing Medically Necessary post-stabilization care, coordinating the transfer of Stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policies. In addition, HMO shall ensure disputed requests for authorizations are timely resolved in accordance with applicable law and regulations, as well as CalOptima Policies.

5.2 URGENT CARE SERVICES --- HMO shall make Covered Services available within twenty-four (24) hours or as appropriate for Urgent Care.

5.3 INITIAL HEALTH ASSESSMENT APPOINTMENT --- HMO shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment, and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under 21 years of age and include annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. HMO shall ensure that Members are referred to appropriate Medi-Cal

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dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. HMO's failure to perform at or in excess of minimum performance requirements shall subject HMO to sanctions in accordance with this Contract and CalOptima Policies. HMO shall ensure that health assessment information shall be recorded in the Member's Medical Record.

5.4 APPOINTMENT FOR PEDIATRIC PREVENTIVE COVERED SERVICES --- HMO shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule and/or DHCS requirements. Immunizations are to be provided according to the latest guidelines published by the AAP and the Advisory Committee on Immunization Practices (ACIP). If there are any conflicts in the recommendations, the higher standard shall be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force.

5.5 HOSPITAL GEOGRAPHIC DISTRIBUTION --- HMO agrees that each hospital participating in the HMO, shall be located within ten (10) miles or thirty (30) minutes of the PCPs designated service area with active medical staff privileges at each hospital.

5.6 DAYS TO APPOINTMENT---

5.6.1 Non-Emergency Covered Services - HMO shall ensure that appointments are scheduled with a PCP for non-emergency or non-urgent Covered Services within ten (10) business days of a Member's request. HMO shall also have a process in place for follow-up on Member missed appointments.

5.6.2 Specialist Services – HMO shall ensure that appointments are scheduled with Specialists within fifteen (15) business days of request of appointment. HMO shall arrange for the provision of specialty services from specialists outside the network if unavailable within HMO's network, when determined medically necessary.

5.6.3 Preventive Covered Services - HMO shall schedule health assessments and general physical examinations in advance consistent with professionally recognized standards of practice as determined by the treating Provider acting within the scope of his or her practice and in accordance with CalOptima Policies.

5.6.4 Maternity Covered Services - HMO shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request. Subsequent routine appointments shall be scheduled in advance in accordance with applicable Department of Managed Health Care regulations governing timely access to non-emergency health care services. HMO shall cover and ensure the provision of all Medically Necessary services for pregnant Members. HMO shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

5.6.5 Measurement - HMO shall periodically measure days to appointment.

5.6.6 The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with Professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

5.6.7 Members shall be offered appointments within the following timeframes:

5.6.7.1 Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;

5.6.7.2 Urgent appointment for services that do require prior authorization– within 96 hours of a request;

5.6.7.3 Non-urgent primary care appointments – within ten (10) business days of a request;

5.6.7.4 Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

5.6.8 In the event that a Provider, including a PCP, is terminated or leaves the HMO for any reason, HMO 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 in accordance with applicable CalOptima Policies and regulatory requirements.

5.7 OFFICE WAITING TIMES --- HMO shall periodically measure office waiting times to ensure compliance with CalOptima Policies, by its subcontracted Participating Providers, and shall take appropriate action to provide notice to Participating Providers if they are not meeting the wait time requirements that they may be sanctioned for such non-compliance up to and including termination of their Subcontract. HMO's failure to monitor and enforce Participating Provider office wait time requirements in accordance with the terms of this Contract may subject HMO to sanctions as set forth in this Contract and CalOptima Policies.

5.8 TIME LIMIT FOR DECISION ON REFERRALS --- HMO shall provide a decision on authorization requests for those Covered Services that are not Urgent Care Services or Emergency Services, including Specialty Physician referrals as set forth in CalOptima's utilization management program. These Covered Services shall be provided or made available to the Member within fifteen (15) calendar days after authorization is granted. HMO shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

5.9 CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES --- Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. HMO'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. HMO's proposal shall allow for timely notice to Members to allow them to change PCPs if desired, as provided in Section 5.10 of this Contract.

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5.10 NOTICES ABOUT PCP CHANGES --- HMO shall give Members thirty (30) calendar days' notice if their PCP withdraws from HMO. All notices sent to Members shall be submitted to CalOptima for prior approval before distribution to Members. Such notices must include instructions for selecting a new PCP should the Member not be satisfied with a new PCP assigned by HMO. With the exception of PCP terminations in which a provider is immediately terminated due to endangering the health and safety of patients, committing criminal or fraudulent acts or engaging in grossly unprofessional conduct, Members not receiving thirty (30) calendar days advance notice of PCP withdrawal shall be permitted to self-refer within HMO for up to sixty (60) calendar days or until a new PCP is chosen by Member.

5.11 CHOICE OF PCP --- HMO shall offer each Member the opportunity to choose a PCP affiliated with the HMO. A Member may elect to obtain primary care services from a contracted non-physician medical practitioner as long as there is a physician who has ultimate responsibility for the Member's Care Management Services. When HMO receives the Member's files from CalOptima and determines that the Member has not indicated a PCP choice, HMO shall assign the Member to a PCP and include information about this assignment with the required enrollment information sent to the Member within seven (7) calendar days of notification of a Member's enrollment in HMO. HMO shall permit Members to change PCPs at least monthly, and to change more often if assignment of a specific PCP would be harmful to the interest of the Member.

5.12. PROVIDERS ELIGIBLE FOR PARTICIPATION IN MEDI-CAL --- Except in emergency situations, HMO shall use only Providers who are eligible for participation in the Medicare and/or Medi-Cal program to provide the Covered Services required under this Contract. Providers shall: (i) not be suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs; (ii) have not ever been suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs based on a mandatory exclusion as defined in 42 U.S.C. § 1396a-7(a); and (iii) have not been convicted of any felony, or any misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years.

5.13 PROVIDER TO MEMBER STAFFING RATIOS ---

5.13.1 Provider to Member Ratios - As specified by the State, HMO shall ensure that PCP staffing ratios satisfy the following full-time equivalent provider to Member ratios:

5.13.1.1 Primary Care Physicians 1:2,000 Members;
5.13.1.2 Total physicians 1:1,200 Members; and
5.13.1.3 If Non-physician Medical Practitioners are included in HMO's Network, each individual Non-physician Medical Practitioner shall not exceed a full-time equivalent provider/Member caseload of one (1) provider per 1,000 Members.

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5.13.2 Supervising Physicians - HMO shall ensure that physicians who supervise non-physician mid-level staff are certified to supervise by the California Medical Board. As specified by the State, the ratio of physician supervisor to non-physician medical practitioner shall satisfy the requirement of a minimum of one (1) physician to:

5.13.2.1 Four (4) nurse practitioners; or
5.13.2.2 Four (4) physician assistants; or
5.13.2.3 Four (4) non-physician medical practitioners in any combination that does not include more than three (3) certified nurse midwives or two (2) physician assistants.

5.14 PCP GEOGRAPHIC DISTRIBUTION --- HMO shall maintain a network of PCPs, to make available to every Member a PCP whose office is located within thirty (30) minutes or ten (10) miles of Member's place of residence. Nothing in this provision shall be interpreted as preventing a Member from choosing a PCP beyond these geographic limits.

5.15 SPECIALIST GEOGRAPHIC DISTRIBUTION --- HMO shall make available to every Member, Specialists whose offices are located within fifteen (15) miles or thirty (30) minutes from the Member's place of residence as required in W & I Code Sections 14197(b) and (c). HMO shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles or thirty (30) minutes from Member's place of residence.

5.16 PHYSICAL ACCESS --- HMO'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.

5.17 ACCURACY OF PROVIDER DIRECTORY --- HMO shall notify CalOptima within five (5) business days when either of the following occur:

5.17.1 The Provider is not accepting new Members.
5.17.2 If the Provider had previously not accepted new Members, the Provider is currently accepting new Members.

ARTICLE 6
Obligations of HMO – Clinical Quality

6.1 LICENSURE --- HMO shall ensure that every physician providing Covered Services and employed or engaged by HMO or Subcontractor shall retain at all times during the period of this Contract a valid license to practice medicine issued by the Medical Board of the State of California, without restriction to practice in designated field of medicine.

6.2 HEALTH EDUCATION AND PREVENTION --- HMO shall inform Members of contributions which they can make to the maintenance of their own health and the proper use of health care services and have a program of health education and prevention (HEP) available in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. HMO shall:

6.2.1 Coordinate and integrate with CalOptima's QI Program;

6.2.2 Refer Members to appropriate HEP, based on the Member's needs;

6.2.3 Implement and utilize the Staying Healthy Assessment Tool as defined in CalOptima Policies; and,

6.2.4 Educate Providers and Members regarding Health Education services available to Members.

6.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS --- HMO 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.

6.4 QUALITY IMPROVEMENT PROGRAM --- HMO shall participate and cooperate in CalOptima's Quality Improvement Program. HMO shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. HMO shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set (HEDIS)). HMO shall submit reports related to Quality Improvement as required by CalOptima Reporting Policy or otherwise required by DHCS. HMO shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:

6.4.1 Well defined goals and objectives of the QI Program;

6.4.2 A well-defined scope of the QI Program that considers all different types and levels of care and service provided to Members; and

6.4.3 Clearly defined accountability and responsibility for the QI Program.

6.4.4 The Board of Directors of HMO or a multi-disciplinary QI Committee designated by the Board of Directors of HMO shall oversee the QI Program conducted by HMO. This committee shall be separate from the Utilization Review committee (though Members may be the same) and have a separate agenda. The QI Committee shall have adequate representation from HMO. The QI Committee shall meet at least on a quarterly basis. HMO shall maintain attendance records and meeting minutes related to the QI Program.

6.4.5 The QI Program activities shall be reported in writing to HMO's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

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6.4.6 The HMO's QI Program shall include involvement and participation in network-wide studies/projects initiated by CalOptima.

6.4.7 HMO shall develop an annual QI work plan, which includes the following:

6.4.7.1 Goals, scope and planned projects for the year;

6.4.7.2 Planned monitoring of identified issues and tracking these issues over time;

6.4.7.3 Planned studies/audits suggested by CalOptima or the HMO; and

6.4.7.4 An annual evaluation of the QI Program/Plan.

6.4.8 HMO shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

6.4.9 Requirements for the HMO's QI Program shall be established by the HMO's QI Committee and requirements may change based on changes in industry standards. CalOptima's QI Committee shall notify HMO of any additional changes in QI standards and requirements that shall be incorporated in HMO's QI Program. HMO shall not be required to change QI Program requirements more frequently than once per year.

6.4.10 HMO shall report findings and actions taken as a result of the quality improvement activities to CalOptima at least quarterly. In addition, HMO shall provide, upon request, summaries of QI Committee meetings, findings following review of specific cases and other reviews to CalOptima.

6.4.11 The HMO shall respond promptly to all of CalOptima's requests for: (a) Medical Records; or (b) written responses to quality of care issues or Member complaints.

6.4.12 HMO shall allow CalOptima to use performance data for various program purposes, but not limited to, quality improvement activities, public reporting to consumers, and cost sharing for quality improvement activities, as identified in CalOptima Policy.

6.5 CASE MANAGEMENT SERVICES --- HMO shall offer a comprehensive Case Management Services program that targets medically and socially complex Members in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. The Case Management Services program shall consider the Member as a whole individual taking into consideration not only his/her medical needs but also the individual in context of cultural values, age, disability and self-determination.

6.5.1 HMO shall develop and implement policies and procedures that outline processes to support Case Management Services including but not limited to:

6.5.1.1 Pro-active identification mechanisms of high risk Members;

6.5.1.2 Referral processes;

6.5.1.3 Triage mechanisms with appropriate time frames;

6.5.1.4 Comprehensive assessment processes and formats;

6.5.1.5 Care plan development and care plan implementation guidelines and format;

6.5.1.6 Carve-out service coordination;

6.5.1.7 Documentation and communications processes for all Case Management Services; and

6.5.1.8 Mechanism for evaluation of Case Management Program outcomes.

6.5.2 HMO Case Management Services shall demonstrate the ability to find, receive, and process referrals for Covered Services and Urgent Care Services of Members who meet one (1), or more of the following conditions:

6.5.2.1 Are medically complex, demonstrate an inability to manage their medical condition and are at risk of exacerbation without intervention;

6.5.2.2 Demonstrate high recidivism;

6.5.2.3 Are chronically ill;

6.5.2.4 Have a catastrophic diagnosis;

6.5.2.5 Have inadequate family/community support;

6.5.2.6 Are cost and/or length of stay outliers;

6.5.2.7 Are receiving six (6) or more chronic medications per month;

6.5.2.8 Are transitioning between Providers that may cause continuity of care concerns; and

6.5.2.9 Are Members with Special Health Care Needs.

6.5.3 CalOptima shall be entitled to periodically review HMO's Case Management Services program to determine compliance with Case Management Services standards. HMO shall furnish Case Management Services records and information to CalOptima upon request.

6.5.4 HMO Case Management shall collaborate with CalOptima on cases identified by CalOptima as needing care coordinator interventions.

6.5.5 As a component of the Case Management requirements in this Contract, HMO shall

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assure that HMO possesses adequate information management systems and capabilities to support Case Management functions and to meet guidelines established by CalOptima in CalOptima Policies.

6.6 OBLIGATION OF HMO UPON TERMINATION OF CONTRACTED PROVIDERS --- HMO shall ensure continuity and coordination of care by notifying Members affected by the termination of a Provider or practice site and assisting them in selecting a new PCP or PCP site. HMO shall notify Members affected by the termination of a PCP or PCP site at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a new PCP or PCP site. HMO shall notify Members being seen regularly by a specialist or specialty group whose contract is terminated at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a different Provider or site. HMO shall obtain the prior written approval of CalOptima before furnishing such notice, as CalOptima must obtain written approval of DHCS as to form and content. When a Provider's contract is discontinued, and either the Provider or HMO decides to terminate the contract for reasons other than professional review actions; or the Member is seeing one (1) Provider within a group and that Provider discontinues with HMO, but the rest of the group continues its contract with HMO, then HMO shall allow Members to have continued access to that Provider under the following circumstances:

6.6.1 Members undergoing active treatment for a chronic or acute medical condition (in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes) have access to their discontinued Provider through the current period of active treatment or for up to ninety (90) calendar days, whichever is shorter; and

6.6.2 Members in their second (2nd) or third (3rd) trimester of pregnancy have access to their discontinued Provider through the postpartum period.

6.7 WHOLE CHILD MODEL PROGRAM ---

6.7.1 WHOLE CHILD MODEL PROGRAM COMPLIANCE --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9 and agrees to implement the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

6.7.1.1 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

6.7.1.2 To ensure consistency in the provision of CCS Covered Services, HMO shall use all current and applicable CCS Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS

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numbered letters in developing criteria for use by HMO's Medical Director or equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, HMO shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS Eligible Condition.

The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to Members eligible for CCS:

http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

6.7.1.3 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall be responsible for all available Medically Necessary Medi-Cal services that are Covered Services under the CalOptima Medi-Cal Program. Any Medically Necessary CCS Services not available as a CalOptima Medi-Cal Covered Service shall remain the responsibility of the State and the county.

6.7.2 CCS PROVIDER NETWORK --- HMO shall utilize only CCS-Paneled Providers to treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment, HMO shall include in their network an adequate number of CCS Providers able to serve the needs of Members with CCS Eligible Conditions and receive timely access. HMO's network shall include an adequate number of CCS-Paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty conditions and an adequate number of hospitals and/or facilities that include neonatal intensive care units, CCS-approved pediatric intensive care units, CCS-approved inpatient facilities and special care centers approved by the CCS Program to treat a CCS Eligible Condition. However, Members cannot be limited to a single delegated entity's provider network. HMO must ensure Members have access to all Medically Necessary CCS-Paneled Providers within CalOptima's provider network. In addition, HMO may use an out-of-state Provider, in accordance with APL 17-019, if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition. If no in-network CCS-Paneled Provider possesses the clinical expertise to appropriately treat a Member's CCS condition, then CCS delegated HMO shall arrange and pay for, and coordinate the provision of, the Medically Necessary Covered Services to the Member by one or more out-of-network CCS-Paneled Providers who possess the appropriate knowledge and clinical experience. CCS delegated HMO shall implement procedures to identify individuals who may need or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management.

6.7.3 CCS PROVIDER CREDENTIALING --- HMO shall credential CCS Providers in accordance with the existing credentialing requirements along with the requirements of APL 18-011. DHCS will retain responsibility for paneling CCS specialists. In addition, CCS Providers shall be able to utilize CalOptima's provider grievance process.

6.7.4 COVERED CCS SERVICES --- In addition to other services required to be provided to Members under this Contract, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall cover CCS Services for Members determined to be eligible in accordance with the CCS Program medical eligibility regulations. Upon diagnostic evidence that a Member under 21 years of age may have a CCS Eligible Condition, HMO shall refer the Member to the county CCS office for eligibility determination.

6.7.4.1 HMO shall ensure assessment and care coordination for the transition of Members who are eligible for CCS Services and receiving services through the CCS Program at the time of the transition.

6.7.4.2 For the identification of Members eligible for CCS Services, HMO shall ensure the following:

6.7.4.2.1 Participating Providers shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS Eligible Condition.

6.7.4.2.2 Initial referrals of Members with CCS Eligible Conditions shall be made to CalOptima by telephone, same day mail, or fax or other secure electronic system, and CalOptima will submit the referral and medical documentation to the County CCS Program for eligibility determination. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS Program.

6.7.4.2.3 HMO shall provide all Medically Necessary CCS Services for the Member's CCS Eligible Condition(s).

6.7.4.2.4 If the County denies CCS Program eligibility for a Member referred by HMO, HMO remains responsible for the provision of all Medically Necessary Covered Services to the Member, including EPSDT services.

6.7.5 CONTINUITY OF CARE --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with Welfare and Institution Code Sections 14094.13, Health and Safety Code Section 1373.96, APL 18-011, and as follows:

6.7.5.1 In accordance with Welfare and Institutions Code, Section 14094.13(a)-(d), HMO must allow for continuity of care between Members eligible for CCS Services and CCS Providers, and Providers of Specialized Durable Medical Equipment, with whom there is an existing relationship for up to 12 months after the transition. At its discretion, HMO may extend the continuity of care period beyond the 12 months specified in this Section.

6.7.5.2 For out-of-Network CCS Providers and Providers of Specialized Durable Medical Equipment, HMO must allow for continuity of care under the following conditions:

6.7.5.2.1 The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to CalOptima's Whole Child Model Program, or the Member has previously received Specialized Durable Medical Equipment from a DME provider.

6.7.5.2.2 The CCS Provider or Provider of Specialized Durable Medical Equipment accepts HMO's rate for the service, or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by HMO and the CCS Provider.

6.7.5.2.3 HMO confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

6.7.5.2.4 The CCS Provider or Provider of Specialized Durable Medical Equipment makes treatment information available to HMO, to the extent authorized by the State and federal patient privacy provisions.

6.7.5.3 Ensure that the continuity of care requirements for pharmaceutical services and provision of prescribed drugs are applied to Members who are eligible for the CCS Program at the time of the transition to the Whole Child Model Program. Before the previously prescribed drug is discontinued, HMO and the Member's prescribing CCS Provider shall complete the necessary evaluation and treatments and must both agree that the previously prescribed drug is no longer Medically Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

6.7.6 EPSDT SERVICES --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, for CCS-eligible Members, HMO shall provide all Medically Necessary Covered Services, including EPSDT services when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, HMO shall apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

6.7.7 CASE MANAGEMENT AND COORDINATION OF CARE --- Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide service authorization, case management, and care coordination for CCS Services by an employee or Subcontractor with knowledge or adequate training on the CCS Program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

6.7.7.1 Once a Member's eligibility for the CCS Program is established, CalOptima shall complete the risk level and needs assessment required under APL 18-011. HMO shall provide Complex Case Management services to all Members eligible for CCS Services and coordinate care between the Primary Care Provider, CCS specialty services, and if applicable Outpatient Mental Health Services and regional center services across all settings. The provision of Complex Case Management shall include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS and behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.2 HMO shall also arrange referral to Specialty Mental Health, and Drug Medi-Cal services as appropriate through the county substance use disorder program if determined necessary through CalOptima's assessment. To arrange services with a regional center, HMO shall:

6.7.7.2.1 Coordinate with Members eligible for CCS Services and their parents, custodial parents, legal guardians, or other authorized representatives, in understanding and accessing services; and

6.7.7.2.2 Operate as a central point of contact for questions regarding access, care, and problem resolution.

6.7.7.3 HMO shall create an individual care plan (ICP) for CCS-eligible Members who have been determined high risk through the CalOptima risk stratification process, incorporate the required elements stated in Welfare and Institutions Code, Section 14094.11(c) and APL 18-011, be specific to individual Member needs, and update the ICP at least annually.

6.7.7.4 Provide Person-Centered Planning, case management and coordination of care, to Members eligible for CCS Services and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.5 Provide information to Members eligible for CCS Services on how to access local family resource centers or family empowerment centers.

6.7.7.6 Allow a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request continuing case management and care coordination from their public health nurse within 90 days of transitioning to the Whole Child Model Program, in accordance with Welfare and Institutions Code, Section 14094.13(e). If the county public health nurse leaves the CCS Program or is no longer available to provide case management and care coordination, HMO shall transition those services to one of its case managers who has received adequate training on the CCS Program and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

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6.7.8 RIGHTS FOR MEMBERS ELIGIBLE FOR CCS ---

6.7.8.1 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall provide a mechanism for a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

6.7.8.2 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, for Members receiving continuity of care, HMO shall send a written notice 60 days prior to the end of the authorized continuity of care period. The notice shall explain the right to petition HMO for an extension of the continuity of care period, the criteria used to evaluate the petition, and the appeals process if HMO denies the petition.

6.7.8.3 In addition to the Member's right to file a Grievance or request an appeal or State Fair Hearing, effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall also ensure that Members who are eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, may appeal the continuity of care limitations, or the extension of a continuity of care period in accordance with Welfare and Institutions Code, Section 14094.13(i)(1).

6.7.8.4 Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, HMO shall also ensure that CCS-eligible Members, or the Members' parents, custodial parents, legal guardians, or other authorized representatives, retain the right to request an Appeal and State Fair Hearing for adverse benefit determinations that involve delay, modification, denial, or discontinuation of CCS Services in accordance with CalOptima Policy.

6.7.8.5 HMO must ensure Members are provided information on grievances, appeals and State Fair Hearing processes as provided under CalOptima Policies. Effective July 1, 2019, or such later date as HMO shall begin Participating in the CalOptima Whole Child Model Program, CCS-Eligible Members enrolled in managed care are provided the same grievance, appeal and State Fair Hearing rights as provided under APL 18-001, and State and Federal law.

6.8 CREDENTIALING REQUIREMENTS --- HMO acknowledges and agrees that CalOptima has delegated credentialing and recredentialing obligations to HMO. HMO shall have an ongoing credentialing and recredentialing program covering Participating Providers (e.g. Practitioners, organizational providers and licensed independent practitioners) consistent with CalOptima Policies and in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. HMO shall comply with all credentialing and recredentialing obligations as specified in this Contract and CalOptima Policies.

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6.8.1 HMO shall have a mechanism in place to ensure confidentiality of information collected during the credentialing and recredentialing process.

6.8.2 HMO shall ensure that all Participating Providers who furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's credentialing and recredentialing requirements as specified in CalOptima's Credentialing and Recredentialing Policy. HMO shall ensure that any Participating Provider who is required to meet credentialing and recredentialing requirements, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to Members. HMO shall ensure that all contracts with Participating Providers who are subject to these requirements allow for termination of the Participating Provider's right to furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.8.3 HMO shall provide to CalOptima or have available for CalOptima review upon request the following:

6.8.3.1 An accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHS-6216 (07/05), or such other disclosure form as DHCS may otherwise provide to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

6.8.3.2 A signed attestation that all Participating Providers who are required to meet CalOptima Minimum Standards in order to furnish, submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's Minimum Standards as specified in CalOptima Policies.

6.8.3.3 An annual signed attestation that all Participating Providers are credentialed to the standards set forth by CalOptima and DHCS.

6.8.3.4 Monthly summary of all credentialing and recredentialing activity including the name of Participating Provider, date of facility site review (if applicable) and decision date.

6.8.3.5 Concurrent reporting of any adverse action toward a Participating Provider, including adverse actions reported to a governmental or other regulatory agency.

6.8.3.6 If applicable, Quarterly Summaries and copies of facility site reviews performed for PCPs.

6.9 BOARD CERTIFICATION --- HMO shall ensure that all Practitioners furnishing Covered Services to Members meet those requirements identified in CalOptima Policy regarding Board Certification.

6.9.1 HMO shall ensure that any Practitioner who is required to meet the requirements set forth above, but fails to do so, does not furnish items and/or services to Members, submit claims and/or receive reimbursement for any Covered Services furnished to

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Members. HMO shall ensure that all contracts with Practitioners who are subject to these requirements allow for termination of the Practitioners' right to furnish items and/or services, submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.9.2 HMO acknowledges that these requirements apply to each individual Practitioner that is affiliated with and/or part of any medical group, independent physician associations (IPA) and/or other organization or entity that contracts with HMO to furnish Covered Services to Members.

6.10 FACILITY SITE/MEDICAL RECORDS REVIEW --- HMO shall participate in collaborative PCP site reviews for shared PCPs in accordance with MMCD Policy Letter specifications and other requirements of DHCS. HMO shall comply with CalOptima Policies related to PCP site reviews including those addressing collaborative programs.

6.11 COORDINATION AND CONTINUATION OF CARE --- HMO shall have systems in place to ensure managed patient care, including at a minimum:

6.11.1 Management and integration of health care, including Covered Services, through a PCP.

6.11.2 Referrals for Medically Necessary specialty, secondary and tertiary Covered Services.

6.11.3 HMO shall clearly specify referral requirements to Participating Providers and Subcontractors and establish a system to track and monitor services requiring prior authorizations through the HMO.

6.11.4 HMO shall have a utilization management program that meets guidelines as set forth in CalOptima Policies and is in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.11.5 Systems to assure provision of care in emergency situations, including an education process to help assure that Members know where and how to obtain Medically Necessary Covered Services in emergency situations.

6.11.6 The provision of Case Management Services as set forth in this Contract, CalOptima Policies and in coordination with CalOptima's Case Management program.

6.11.7 Systems for the consideration and approval of standing referrals, in accordance with CalOptima Policy.

6.11.8 HMO shall be responsible for coordinating care of certain services including:

6.11.8.1 HMO's Participating Providers providing Pediatric Preventive Services (CHDP) shall document such services on the CMS-1500, UB-04 claim form or electronic equivalent.

6.11.8.2 Participating Providers providing CHDP agree to coordinate with the Orange County CHDP Program as set forth in the CHDP Program pursuant to CalOptima's Pediatric Preventative Services Policy;

6.11.8.3 HMO shall promote education and support systems that increase compliance with the standards for periodicity and content of pediatric health assessments;

6.11.8.4 HMO shall make referrals to the Women, Infants and Children Food Supplementation Program (WIC) in accordance with WIC policies and procedures;

6.11.8.5 HMO shall make referrals for perinatal Members to the PSS program pursuant to CalOptima Policy;

6.11.8.6 HMO shall make referrals to the Regional Center of Orange County (RCOC), as set forth in the RCOC MOU;

6.11.8.7 All Members between the ages of three (3) and twenty-one (21) shall be referred to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment;

6.11.8.8 HMO shall be responsible for Covered Services that are related to dental services but are not provided by a dentist or dental anesthetists. Covered Services required for a dental procedure include but are not limited to: laboratory services, pre-admission physical examinations required for admission to inpatient and outpatient Facility, anesthesia services, and inpatient surgical services and inpatient hospitalization services as provided in CalOptima Policy. HMO shall develop referral and prior authorization policies and procedures to implement the above requirements. HMO shall submit these policies to CalOptima for review and approval;

6.11.8.9 HMO shall provide outpatient mental health services within the PCP's scope of practice. HMO shall refer Members requiring inpatient mental health services to the Orange County Health Care Agency (HCA) Behavioral Health Services. HMO shall retain financial responsibility for initial physical health assessment for any Member admitted to an inpatient facility. This assessment shall be performed by a facility physician or by the Member's PCP. HMO shall also maintain financial responsibility for any Covered Services that are Medically Necessary while Members are receiving inpatient care including but not limited to laboratory and/or x-ray services.

6.11.8.10 Mental Health Services. HMO shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. This would include the coordination and responsibility for non-mental health services for Members undergoing inpatient psychiatric treatment. CalOptima shall

retain financial responsibility for certain mental health psychotherapeutic drugs. HMO shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. HMO shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU.

6.11.8.11 For Outpatient Mental Health Services, HMO shall refer Members to the CalOptima Behavioral Health for mild to moderate mental health conditions and the Administrative Service Organization (ASO) for Specialty Mental Health services.

6.11.8.11.1 To access mild to moderate Outpatient Mental Health Services that are outside the PCP's scope of practice, HMO shall refer Members to CalOptima's mental health contracted provider through CalOptima Behavioral Health. Members requiring alcohol and or substance use disorder treatment should be referred to the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS).

6.11.8.12 For outpatient Specialty Mental Health Services, HMO shall refer Members to the Administrative Service Organization (ASO) contracted by Orange County to provide assessment, referral and authorization services for Specialty Mental Health Services.

6.11.8.12.1 HMO shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. DHCS retains financial responsibility for certain mental health psychotherapeutic drugs. HMO shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. HMO shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU; and

6.11.8.12.2 HMO shall arrange and coordinate Medically Necessary Covered Services, including referral of Members requiring alcohol and drug treatment to Orange County DMC-ODS. Members requiring outpatient heroin detoxification shall be referred to appropriate Providers.

6.11.9 To the extent that the HMO is responsible for the coordination of care for Members, CalOptima shall share with HMO, in accordance with Section 14.12, any utilization data that DHCS has provided to CalOptima, and HMO shall receive the utilization data provided by CalOptima and use it as the HMO is able for the purpose of Member care coordination.

6.12 VACCINES --- HMOs shall assure, at a minimum, all routine pediatric vaccinations currently recommended by the AAP/ACIP and the United States Preventative Task Force and additional routine immunizations are provided to Members consistent with HMO's immunization policy. CalOptima shall not reimburse HMO for the cost of vaccines that are available under the Vaccines for Children (VFC) program. Providers administering pediatric immunizations shall maintain an appropriate supply of vaccines from the VFC program. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

6.13 PHARMACY APPROVED DRUG LIST COMPLIANCE --- Participating Providers shall comply with the CalOptima Approved Drug List and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the Approved Drug List shall require prior authorization by CalOptima. The prescribing physician shall be responsible for submitting prior authorization requests and responding to requests for additional information in accordance with regulatory timeframes. The prescribing physician shall provide CalOptima all information necessary to process prior authorization requests.

6.13.1 HMO may be subject to sanctions for Participating Provider's failure to comply with the prior authorization process.

6.13.2 Participating Providers shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

6.14 RESEARCH --- HMO agrees to participate in and make data available for research projects initiated or approved by CalOptima.

6.15 FUNCTIONS AND DUTIES OF HMO FOR SPD --- HMO shall provide the following for SPD Members:

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6.15.2 HMO shall refer all SPD Members, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system, to a contracted Evaluation Services Provider, and provide appropriate Covered Services in accordance with the resulting evaluation, pursuant to CalOptima Policy;

6.15.3 HMO shall make available Incontinence Supplies to SPD Members when such supplies are Medically Necessary to treat incontinence. HMO shall not restrict the Incontinence Supplies by brand name as long as the supplies do not exceed the rate paid for comparable supplies under the DHCS Medi-Cal Fee-for-Service program;

6.15.4 HMO shall authorize Medical Supplies for six (6) month periods for SPD Members under the following conditions: (a) the PCP determines that the SPD Member requires ongoing Medical Supplies; (b) HMO determines that the Medical Supplies are Medically Necessary based upon the prescribing PCP's assessment; and (c) the PCP projects that the SPD Member's need for the Medical Supplies will remain stable over the six (6) month period;

6.15.5 HMO or Subcontractor shall dispense Medical Supplies in no greater than thirty (30) calendar day amounts, even when such Medical Supplies are authorized for six (6) month periods. HMO shall approve re-authorization of Medical Supplies at consecutive six (6) month intervals unless a PCP determines that a change in the SPD Member's medical condition warrants additional assessment, and/or adjustments to the prescription for Medical Supplies. Notwithstanding a six (6) month authorization, HMO shall not be responsible for providing Medical Supplies when the SPD Member's Medi-Cal eligibility ceases or when the Member is no longer enrolled with the HMO;

6.15.6 HMO shall permit SPD Members to select as a PCP any Participating Specialist Provider willing to perform the role of the PCP. HMO shall provide to all SPD Members upon enrollment HMO and at any time thereafter, upon the SPD Member's request a list of all Participating Specialist Providers willing and available to perform duties/functions of the PCP;

6.15.7 Within one-hundred twenty (120) days upon enrollment in the HMO of an SPD Member, HMO shall complete a plan of care pursuant to CalOptima Policies. HMO shall update this plan as appropriate and/or annually. HMO shall consult the SPD Member and/or Member's representative as appropriate in completing and updating the plan of care;

6.15.8 Upon request, and as Medically Necessary, for any qualifying SPD Member as defined in CalOptima Policies, HMO shall conduct and provide, when appropriate, a home assessment to assess the SPD Member's needs for appropriate referrals to Participating Providers and/or community based organizations and providers;

6.15.9 HMO shall provide SPD Members with standing referrals pursuant to CalOptima Policies, to specialists necessary for conditions requiring ongoing treatment or ongoing supply, equipment or DME service needs. These referrals can be renewed semi-annually; and

6.15.10 HMO shall have Participating Providers with facilities and/or sites that are capable of accommodating SPD Members with special medical care needs as defined in CalOptima Policies. Facility requirements to meet the needs of SPD Members with special medical care needs include, but are not limited to, office or clinic equipment to facilitate the appropriate and safe examination of SPD Members and the capacity to provide specific Covered Services to SPD Members, such as the provision of dental procedures under general anesthesia.

6.15.11 If HMO's network is unable to provide necessary medical services covered under the Contract to a particular SPD Member, HMO must adequately and timely cover these services out-of- network for the Member, for as long as the entity is unable to provide them. HMO acknowledges that out-of-network providers must coordinate with HMO with respect to payment, and HMO shall ensure that such out-of-network providers understand this requirement. HMO must ensure that cost to the Member is not greater than it would be if the services were furnished within the network. HMO shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member, in accordance with the continuity

of care requirements in Health and Safety Code Section 1373.96. For newly-enrolled SPD Members, HMO shall provide continued access for up to twelve (12) months to an out-of-network provider with whom the Member has an ongoing relationship (i.e. an existing provider from whom they are receiving services), if the provider will accept HMO or Medi-Cal FFS rates, whichever is higher per W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by identifying a link between the newly-enrolled SPD Member and an out-of-network provider using FFS utilization data provided by DHCS.

6.15.12 For SPD Members, HMO shall report all grievances related to those listed in Title 28, CCF, Section 1300.68(f)(2)(D), including, but not be limited to, timely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network requests.

6.15.13 HMO and Participating Providers and all staff who interact with SPD Members, as well as those who may potentially interact with SPD Members, or any other staff deemed appropriate by CalOptima or DHCS shall receive sensitivity training as provided by CalOptima or DHCS, or by HMO pursuant to DHCS requirements and CalOptima Policies.

6.15.14 Personal Care Coordinator (PCC) Programs for CCS and SPD Members Definitions.

6.15.14.1 Care Management Monthly Profile (Profile)" is a monthly report generated by CalOptima which provides the healthcare risk outcomes for CCS and SPD Members.

6.15.14.2 "Individual Care Plan" is a plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.

6.15.14.3 "Personal Care Coordinator or PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an CCS Eligible Condition as determined by the local CCS Program, or SPD aid code, supervised by a licensed person, and funded by CalOptima.

6.15.14.4 HMO shall employ PCCs, and participate in all PCC Program requirements as defined in CalOptima Policy and the Profile. HMO shall staff one PCC per six hundred (600) CCS or SPD Members assigned to HMO. PCC responsibilities include but are not limited to: Assisting Members and Member's PCPs in the development of an Individual Care Plan (ICP); communicating the ICP with the Member, Member's PCP and Member's care team; and assisting Members receiving care as outlined in the ICP. HMO shall submit required reports and documents to CalOptima. These include but are not limited to ICPs, PCC staffing levels, and PCC and professional staff descriptions to demonstrate adherence CalOptima Policy requirements.

6.15.14.5 CalOptima shall provide HMO with Profile requirements. Changes to the Profile which may impact PCC supplemental capitation, will be communicated to HMO thirty (30) days prior to the effective date of such change. If HMO is unable to agree to the requirements stipulated in the Profile, and no resolution is reached in the thirty (30) day period, further action may be taken including but not limited to recoupment of PCC supplemental funds that have been paid to HMO and termination of the Contract.

6.16 ADVANCE DIRECTIVES --- HMO shall maintain written policies and procedures related to Advanced Directives in compliance with current State law. HMO shall not discriminate against any Member on the basis of that Member's Advance Directive status.

6.17 SECOND OPINIONS --- HMO shall provide, at its sole cost and expense second opinions and provide to Members all required notification, documentation, forms and information regarding obtaining second opinions as prescribed by CalOptima Policies.

6.18 DISEASE MANAGEMENT --- HMO shall assist CalOptima in implementation of a disease management program in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.19 MEMBERS WITH SPECIAL HEALTH CARE NEEDS --- HMO shall identify, assess and implement care plans as appropriate for Members with Special Health Care Needs. HMO shall have processes for monitoring and tracking Members with Special Health Care Needs and the provision of services under the implemented plan of care.

6.20 MEMBER VISITS --- HMO shall ensure that Subcontracting health facilities licensed pursuant to Health and Safety Code Section 1250 permit a Member at Member's choice to be visited by a Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children. HMO shall include the requirement of this Section in its Subcontracts with such health facilities.

6.21 DHCS DIRECTIONS --- If required by DHCS, HMO 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.

6.22 Intentionally left blank.

6.23 ENHANCED CARE MANAGEMENT

6.23.1 HMO Participation in CalOptima ECM – HMO shall begin participating as an ECM Provider in CalOptima Enhanced Care Management, as set forth below, for CalOptima Members who meet the DHCS-defined criteria for one of the following Populations of Focus ("ECM Populations of Focus"):

6.23.1.1 For CalOptima adult Members who meet the DHCS-defined criteria for one of the following: (i) Individuals Experiencing Homelessness; (ii)

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"Individuals At Risk for Avoidable Hospital or ED Utilization (formerly known as "High utilizer"); (iii) Individuals with Serious Mental Illness ("SMI") and/or Substance Use Disorder ("SUD") Needs; (iv) Individuals Transitioning from Incarceration; (v) Individuals with Intellectual or Developmental Disabilities ("I/DD"); or (vi) Pregnancy, Postpartum, and Birth Equity Population of Focus.

6.23.1.2 Effective January 1, 2023, or such later date as determined by DHCS, for CalOptima Members who meet the DHCS-defined criteria for one of the following: (i) Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization; or (ii) Adult Nursing Facility Residents Transitioning to the Community.

6.23.1.3 Effective July 1, 2023, or such later date as determined by DHCS, for other CalOptima children and youth who meet the DHCS-defined criteria for one of the following: (i) Individuals Experiencing Homelessness; (ii) "Individuals At Risk for Avoidable Hospital or ED Utilization (formerly known as "High utilizer"); (iii) Individuals with SMI and/or SUD Needs; (iv) Individuals Transitioning from Incarceration; (v) Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition; (vi) Children and Youth Involved in Child Welfare (including foster care up to age 26); or (vii) Pregnancy, Postpartum, and Birth Equity Population of Focus.

6.23.1.4 Effective January 1, 2024, or such later date as determined by DHCS, for Members who meet the DHCS-defined criteria for one of the following: (i) Pregnancy, Postpartum, and Birth Equity Population of Focus (who are subject to racial and ethnic disparities).

6.23.2 HMO as an ECM Provider – HMO shall be responsible for providing ECM services as the Member's ECM Provider. ECM Provider shall ensure its systems and infrastructure are in place to provide ECM services to ECM Members. ECM Provider shall implement ECM in compliance with this Contract and CalOptima Policies.

6.23.3 ECM Provider Requirements – HMO, as an ECM Provider, shall satisfy the ECM Provider requirements as set forth in CalOptima Policies and as follows:

6.23.3.1 ECM Provider shall be experienced in serving the ECM Population(s) of Focus it will serve and shall have experience and expertise with the services it will provide.

6.23.3.2 ECM Provider shall comply with all applicable State and federal laws and regulations and all ECM requirements in the DHCS-CalOptima ECM and Community Supports Contract and associated guidance.

6.23.3.3 ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Members to critical appointments when necessary. ECM Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways.

6.23.3.4 ECM Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including Community Supports Providers, to coordinate care as appropriate to each Member.

6.23.3.5 ECM Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of an ECM Member care plan that can be shared with other Providers and organizations involved in each ECM Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

6.23.3.6 If a State-level enrollment pathway exists, ECM Provider shall enroll as a Medi-Cal Provider, pursuant to relevant DHCS APLs including APL 19-004: Provider Credentialing/ Recredentialing and Screening/Enrollment. If APL 19-004 does not apply to an ECM Provider, the ECM Provider shall comply with CalOptima's process for vetting the ECM Provider, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.

6.23.4 Identifying Members for ECM – HMO, which also serves as the ECM Provider, shall proactively identify Members who would benefit from ECM and determine on a case by case basis whether identified Members are eligible for ECM in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach.

6.23.5 Member Assignment to ECM Provider

6.23.5.1 CalOptima shall be responsible for making ECM authorization determinations for HMO's enrolled Members in accordance with applicable CalOptima Policies.

6.23.5.2 HMO shall serve as the ECM Provider for all ECM Members enrolled in the HMO, except as otherwise provided in Section 6.23.5.3 of this Contract.

6.23.5.3 HMO acknowledges and agrees that the County of Orange shall serve as the ECM provider for certain ECM Members as specified in CalOptima Policy GG.1356: Enhanced Care Management Administration. HMO shall fully cooperate and coordinate with CalOptima and with the County of Orange, serving as the ECM provider for such ECM Members, in accordance with applicable CalOptima Policies and/or as required by CalOptima to ensure compliance with DHCS requirements for ECM.

6.23.6 ECM Provider Staffing – At all times, ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each assigned ECM Member consistent with this Contract, CalOptima Policies, DHCS ECM Provider Standard Terms and Conditions, the DHCS-CalOptima ECM and Community Supports Contract and any other related DHCS guidance.

6.23.7 ECM Provider Outreach and Member Engagement – ECM Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach. ECM Provider shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.

6.23.7.1 ECM Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate, with the Member's consent, and in compliance with CalOptima Policies. ECM Provider shall use the following modalities, as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences: (i) Mail; (ii) Email; (iii) Texts; (iv) Telephone calls; and (v) Telehealth.

6.23.7.2 ECM Provider shall comply with non-discrimination requirements set forth in State and federal law and this Contract.

6.23.7.3 CalOptima and ECM Provider will coordinate to ensure that Members who meet exclusionary criteria as defined in CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach do not receive ECM services.

6.23.8. Initiating Delivery of ECM – ECM Provider shall obtain, document, and manage Member authorization for the sharing of personally identifiable information between CalOptima and ECM, Community Supports, and other Providers involved in the provision of Member care to the extent required by federal law.

6.23.8.1 Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law. When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to CalOptima.

6.23.8.2 ECM Provider shall notify CalOptima to discontinue ECM under the following circumstances: (i) The Member has met their care plan goals for ECM; (ii) The Member is ready to transition to a lower level of care; (iii) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or (iv) ECM Provider has not had any contact with the Member after three (3) attempts.

6.23.8.3 When ECM is discontinued, or will be discontinued for the Member, Provider is responsible for sending a notice of action notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is

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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 PHM, etc.).

6.23.9 ECM Requirements and Core Service Components of ECM – ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members assigned to the HMO. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.

6.23.9.1 Subject to all applicable requirements set forth in this Contract (including, but not limited to, subcontracting requirements), if the ECM Provider subcontracts with other entities to administer ECM functions, the ECM Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth in Section 6.23 of this Contract and CalOptima Policies and that its Subcontractors comply with all requirements in DHCS ECM Provider Standard Terms and Conditions and the DHCS-CalOptima ECM and Community Supports Contract. Notwithstanding any subcontracting arrangements, ECM Provider shall remain responsible and accountable for any subcontracted ECM functions.

6.23.9.2 ECM Provider shall: (i) Ensure each Member receiving ECM has a Lead Care Manager; (ii) Coordinate across all sources of care management in the event that an ECM Member is receiving care management from multiple sources; (iii) Notify CalOptima to ensure non-duplication of services in the event that an ECM Member is receiving care management or duplication of services from multiple sources; and (iv) Follow CalOptima's instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

6.23.9.3 ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and other associated entities, such as Community Supports Providers, as appropriate, to coordinate Member care for ECM.

6.23.9.4 ECM Provider shall provide the following core service components of ECM to each assigned ECM Member in compliance with CalOptima Policies GG.1354: Enhanced Care Management – Eligibility and Outreach and GG.1353: Enhanced Care Management Service Delivery: (i) Outreach and engagement of Members into ECM (ii) Comprehensive assessment and care management plan; (iii) Enhanced coordination of care; (iv) Health promotion; (v) Comprehensive transitional care; (vi) Member and family supports; and (vii) Coordination of and referral to community and social support services.

6.23.9.5 ECM Provider shall ensure the establishment of an ECM Care Team and a communication process between Members' ECM Care Team participants related to services being rendered, in accordance with the requirements set forth in CalOptima Policies.

6.23.9.6 ECM Provider shall complete a health needs assessment and develop a comprehensive, individualized, person-centered care plan for each ECM Member. ECM Provider shall ensure case conferences are conducted by the ECM Care Team and the ECM Member's health needs assessment and care plan are updated as necessary.

6.23.10 Training – ECM Provider shall participate in all mandatory, Provider-focused ECM training and technical assistance provided by CalOptima, including in-person sessions, webinars, and/or calls, as necessary. ECM Provider shall ensure that its staff who will be delivering ECM services complete training required by CalOptima and DHCS prior to participating in the administration of the ECM services.

6.23.11 Data Sharing to Support ECM - CalOptima and ECM Provider agree to exchange available information and data as required by DHCS guidance and CalOptima Policies, including but not limited to notification of hospital emergency department visits, inpatient admissions and discharges, and health history of ECM Members. CalOptima and ECM Provider shall conduct such information and data sharing in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements (including applying the minimum necessary standard when applicable), and other federal and California state laws and regulations. Further, ECM Provider shall establish and maintain a data-sharing agreement with other Providers that is compliant with all federal and California state laws and regulations as necessary. If applicable laws and/or regulations require an ECM Member's valid authorization for release of health information and a legal exception does not apply, ECM Provider may not release such information without the ECM Member's valid authorization.

6.23.11.1 CalOptima will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable: (i) Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider; (ii) Non-duplicative Encounter and/or claims data, as appropriate; (iii) Non-duplicative physical, behavioral, administrative and social determinants of health data (e.g., Homeless Management Information System (HMIS data)) for all assigned Members, as available; and (iv) Reports of performance on quality measures and/or metrics, as requested.

6.23.12 Claims Submission and Reporting – ECM Provider shall submit claims for the provision of ECM-related services to CalOptima using the national standard specifications and code sets to be defined by DHCS. In the event ECM Provider is unable to submit claims to CalOptima for ECM-related services using the national standard specifications and DHCS-defined code sets, ECM Provider shall submit an invoice to CalOptima with a minimum set of data elements (to be defined by DHCS) necessary for CalOptima to convert the invoice to an encounter for submission to DHCS.

6.23.13 Quality and Oversight – ECM Provider acknowledges that CalOptima will conduct oversight of ECM Provider's participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include audits and/or corrective actions. ECM Provider shall respond to all requests from CalOptima for information and documentation to permit ongoing monitoring of ECM.

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6.23.14 ECM Data and Reports. HMO shall submit to CalOptima complete, accurate, and timely ECM data and reports in the manner and form acceptable to CalOptima as required by CalOptima Policies or otherwise required by DHCS in order for CalOptima to monitor and meet the following: (i) performance targets; and (ii) its data reporting requirements to DHCS.

6.23.15 ECM Provider's Agent Qualifications - ECM Provider shall verify that the qualifications of all agents (including ECM Provider staff) providing ECM services under this Contract comply with the requirements of this Contract, CalOptima Policies, and DHCS guidance. In addition, for agents that enter into Members' homes or have face-to-face interactions with Members, ECM Provider shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. ECM Provider shall comply with all applicable laws in conducting background investigations and shall exclude unqualified agents from providing services under this Contract.

ARTICLE 7
Obligations of HMO – Reporting

7.1 DATA REPORTING REQUIREMENTS --- HMO shall comply with the data reporting requirements set forth in this Contract, including but not limited to the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and Guidelines referred to as the Timely and Appropriate Submission Requirements. HMO shall provide such additional data and modify the form, content, instructions and timetables for the collection and reporting of data as may be required by CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.2 ENCOUNTER REPORTING --- HMO shall submit to CalOptima complete, accurate, reasonable and timely encounter data (a) needed by CalOptima in order for CalOptima to meet its encounter data reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's regulators as provided in this Contract and in CalOptima Policies. HMO shall submit encounter data pursuant to standards defined by CalOptima Policies. Upon first receiving member assignments; or changing management companies, business systems, clearinghouse vendors, and/or contractual model; HMO shall begin encounter data file testing within sixty (60) days and complete testing within ninety (90) days. HMO shall be subject to financial penalties and/or sanctions if CalOptima determines that HMO is reporting to CalOptima less than all professional and facility encounters in the CalOptima required format and timelines. HMO shall have twelve (12) calendar days, upon notification by CalOptima, to correct encounters rejected by CalOptima's regulatory agencies, including the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS). Financial penalties or sanctions shall be assessed upon HMO should CalOptima determine that HMO is not meeting the standards as defined in CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.3 ANNUAL AUDIT AND FINANCIAL REPORTING REQUIREMENTS --- HMO agrees to provide the results of its annual audited financial statements, including "Letters to

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Management", if requested, for the prior calendar or fiscal year within one hundred-twenty (120) calendar days of the completion of that year. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of HMO as related to Members. HMO shall allow representatives of CalOptima, upon written request, to verify the financial report.

7.4 FINANCIAL REPORTING --- If HMO is required to file monthly Financial Statements with the DMHC, HMO shall simultaneously file monthly Financial Statements with DHCS. HMO shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections are requested, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. HMO shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

7.5 PARTICIPATING PROVIDER NETWORK CHANGES --- HMO shall report in compliance with CalOptima Policies, any changes, including but not limited to additions, deletions and location changes of Providers constituting HMO's provider network.

7.6 HMO ORGANIZATION PROFILE --- HMO shall report in compliance with CalOptima Policies, a profile of the HMO's organization, including, but not limited to, HMO's significant administrative and Provider network contractual relationships.

7.7 PARTICIPATING PROVIDER CONTRACTS --- HMO shall provide to CalOptima copies of all contract templates utilized with Participating Providers. Upon modification, change or replacement by HMO, HMO shall provide CalOptima with copies of current contract templates. In addition, upon request from CalOptima or DHCS, HMO shall provide copies of any Subcontract entered into or amended for purposes of fulfilling HMO's obligations under this Contract.

7.8 DISCLOSURE --- HMO and any Subcontractors shall make available to CalOptima, CalOptima's authorized agents, and appropriate representatives of the State and federal government any of HMO's or Subcontractor's financial records related to HMO's capacity to bear the risk of potential financial losses, or to the Covered Services performed and amounts paid or payable under this Contract. CalOptima recognizes the proprietary nature of this information and shall make all assurances to maintain its confidentiality in accordance with the California Public Records Act.

7.9 REPORTING UNAUTHORIZED DISCLOSURE OF PRIVATE MEMBER INFORMATION --- In the event that HMO, or any of its officers, employees, agents, or Subcontractors, becomes aware of the unauthorized disclosure of confidential Member information, as described in California Welfare and Institutions Code Section 14100.2, or of "personal information," within the meaning of California Civil Code Section 1798.3, HMO shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this Section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not HMO had reasonable control to avoid the disclosure.

7.10 PROVIDER DATA – HMO shall submit to CalOptima complete, accurate, reasonable, and timely provider data and other data and reports (a) needed by CalOptima in order for CalOptima to meets its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies.

7.11 REPORTS AND DATA --- In addition to any reporting obligations under this Contract, HMO shall submit reports and data relating to services covered under this Contract as required by CalOptima, in a form and manner specified by CalOptima, including, without limitations, for purposes of complying with requests for reports and data from CalOptima's Regulators to CalOptima.

7.12 CERTIFICATION OF DOCUMENT AND DATA SUBMISSIONS --- All data, information, and documentation provided by HMO 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 HMO's letterhead signed by the HMO's Chief Executive Office 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.

ARTICLE 8
Obligations of HMO – Termination

8.1 OBLIGATION UPON TERMINATION --- Upon termination of this Contract, it is understood and agreed that HMO shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of HMO 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. For Covered Services provided following the month in which HMO received Capitation Payment and termination occurred, HMO shall be paid according to the Medi-Cal Fee Schedule, as defined in CalOptima Policy applicable to such services in effect on the date the services are provided.

8.2 TERMINATION AND TRANSFER OF CARE --- Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State 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 State contractor, the HMO 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.

8.2.1 HMO agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason. Costs of reproduction shall be borne by HMO.

8.3 TERMINATION PLANS --- HMO shall have a plan for the orderly termination of services under this Contract. HMO shall submit a plan regarding coordination of care and payment of

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claims to CalOptima at least 60 days prior to expiration or termination of this Contract. The termination plan shall require the written approval of CalOptima.

8.4 APPROVAL BY AND NOTICE TO DHCS --- HMO acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of DHCS. CalOptima and HMO shall notify DHCS of amendments to, or termination of, this Contract. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. HMO acknowledges and agrees that any amendments or modifications shall be consistent with the requirements relating to submission to DHCS for approval.

8.4.1 NOTICE TO THE DEPARTMENT OF MANAGED HEALTH CARE -- In addition, HMO shall notify the Department of Managed Health Care in the event that this Contract is amended or terminated.

ARTICLE 9
Obligations of CalOptima – Financial

9.1 PAYMENT OF CAPITATION ---

9.1.1 Capitation Payment - CalOptima shall withhold from HMO an amount equal to twenty-five percent (25%) of one (1) month's Capitation Payment (Withhold). CalOptima may adjust HMO's Capitation Payment in accordance with Policy FF.3002.

9.1.2 Capitation Payment Schedule - CalOptima agrees to pay Capitation Payment to HMO on or about the fifteenth (15th) of the month for enrolled Member. Capitation Rates shall be daily pro-rated basis based upon the Member's effective date of enrollment with HMO.

9.1.3 Capitation Payment Withhold - CalOptima shall withhold from HMO an amount equal to twenty-five percent (25%) of one (1) month's Capitation Payment (Withhold). CalOptima may adjust HMO's Capitation Payment in accordance with Policy FF.3002.

9.2 CAPITATION RATE ADJUSTMENTS --- The Capitation Rates may be adjusted by CalOptima during the Contract term to reflect implementation of State or federal laws or regulations, changes in the State budget, the State Contract or DHCS policy, and/or changes in Covered Services. Reimbursement is subject to the DHCS providing funds for the purposes of this Contract. Payment adjustments made by DHCS and/or CMS may be reflected in payments to the HMO. If the State has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to HMO as soon as practicable. Capitation may also be adjusted in the event of de-delegation of any function delegated under this Contract or Delegation Agreement.

9.3 PAYMENTS FOR PERSONS WITH AIDS --- CalOptima shall pay a supplemental capitation rate, and HMO shall provide services to Members with a confirmed diagnosis of Acquired Immune Deficiency Syndrome (AIDS) in accordance with CalOptima Policy.

9.4 CALOPTIMA RIGHT TO RECOVER

9.4.1 Overpayments. HMO 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 HMO, CalOptima shall have the right to recover such amounts from HMO by recoupment or offset from current or future amounts due from CalOptima to HMO under this Contract or any other agreement between the parties, after giving HMO notice and an opportunity to return/pay such amounts.

9.4.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of HMO paid by CalOptima against any funds owed to HMO by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

9.4.3 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that HMO (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to HMO, from any current or future amounts owed by CalOptima to HMO under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to HMO that payment for such FFP amounts are due to CalOptima within thirty (30) days of HMO's receipt of the CalOptima invoice.

9.4.4 Dispute Resolution. HMO may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

9.4.5 Survival. This Section 9.4 shall survive the termination or expiration of the Contract.

9.5 ADDITIONAL PAYMENT --- CalOptima reserves the right to pay Providers or HMO additional sums in any manner that CalOptima deems at its discretion to be beneficial for CalOptima's Members.

9.6 LIMITATION ON CALOPTIMA'S PAYMENT OBLIGATIONS --- Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay HMO any Capitation Payment shall be subject to CalOptima's receipt of funding from the State.

9.7 DISPUTES --- Any and all disputes related to payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance by HMO.

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9.8 BONE MARROW AND ORGAN TRANSPLANTATION --- In the event that a Member assigned to HMO is actively listed on a DHCS-certified transplant provider list, then the Member will be disenrolled with HMO and enrolled in CalOptima Direct pursuant to CalOptima Policy. For Bone Marrow transplants, Members will be enrolled in CalOptima Direct upon referral to a designated transplant center for a qualifying diagnosis pursuant to CalOptima Policy. Except as provided herein, HMO is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.9 PAYMENT FOR TRANSPLANT EVALUATION --- For Members receiving transplant evaluation services, at a designated DHCS-approved transplant center for the specific transplant type being requested, payment or reimbursement shall be in accordance with CalOptima Policy.

9.10 ADULT MEMBERS DIAGNOSED WITH HEMOPHILIA --- In the event that an adult (age 21+ years) Member assigned to HMO is actively diagnosed as a hemophilia patient, then on the first of the month following diagnosis and notification of CalOptima the adult Member will be disenrolled with HMO and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, HMO is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.11 ADULT MEMBERS DIAGNOSED WITH END STAGE RENAL DISEASE (ESRD) --- In the event that an adult (age 21+ years) Member assigned to HMO is actively diagnosed as an ESRD patient then on first of the month following submission and acceptance of the CMS-2728 – US to the CalOptima Finance Department the adult member will be disenrolled with HMO and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, HMO is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.12 FALSE CLAIMS ACT POLICY – Providers receiving more than five (5) million dollars in a year are required to have a policy to educate employees about the False Claims Act and other State and Federal laws.

ARTICLE 10
Obligations of CalOptima – Administrative

10.1 Not Applicable to this Contract.

10.2 COMPREHENSIVE HMO AUDIT --- CalOptima shall conduct and HMO shall agree to a full comprehensive compliance audit to be conducted at HMO administrative offices and/or Facilities and/or via desktop/virtual review annually, or as deemed necessary, by CalOptima. CalOptima shall submit results of the HMO audit in writing to the HMO. HMO may rebut and dispute audit findings pursuant to CalOptima Policies. HMO is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. HMO acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from HMO.

10.3 ENCOUNTER DATA AUDIT --- On an annual basis, CalOptima shall conduct an Encounter audit. The audit shall consist of CalOptima requesting a percentage of each HMO's Member

Medical Records. These records shall be reviewed for services provided. These services shall then be compared to reported Encounters to determine if the HMO accurately reported all Encounters.

10.4 INTENTIONALLY LEFT BLANK

10.5 INTENTIONALLY LEFT BLANK

10.6 POLICIES AND PROCEDURES AVAILABILITY--- CalOptima shall provide or make available for HMO copies of current CalOptima Policies relevant to the provisions of this Contract. Copies of current CalOptima Policies relevant to the provisions of this Contract may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.7 MOU AVAILABILITY--- CalOptima shall provide or make available for HMO copies of current MOUs entered into by CalOptima that are binding on HMO within seven (7) working days of execution. Copies of current MOUs entered into by CalOptima that are binding on HMO may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.8 INTERPRETATION OF MOUs --- CalOptima shall provide or make available for HMO interpretation of MOUs entered into by CalOptima that are binding on HMO. Interpretation of MOUs will identify duties, obligation and responsibilities of HMO.

10.9 RELEASE OF PERFORMANCE INFORMATION AND DATA --- HMO acknowledges and agrees that CalOptima may release to Providers, Members and others without further notice to HMO, information and data relating to the performance of HMO that CalOptima determines among other things would contribute to Providers', Members' and others' evaluation of options and alternatives and/or making informed selections and decisions regarding health care and the provision of Covered Services.

10.10 PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider and HMO shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policy related to CalOptima Medi-Cal Program. HMO complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system.

10.11 RISK ARRANGEMENTS DISCLOSURE --- CalOptima shall provide timely notice regarding those items provided for under Subsections (a)(1) through (a)(3) of Section 1300.75.4.1 of Title 28 of the California Code of Regulations.

10.12 DISCLOSURES ---

10.12.1 ANNUAL FINANCIAL RISK DISCLOSURE – On the Contract anniversary date each year, CalOptima shall disclose to HMO the financial risk assumed under the Contract by providing to HMO the following information for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under this

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Contract:

10.12.1.1 A division of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to HMO, a hospital(s) or CalOptima under the Risk Arrangement.

10.12.1.2 Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, PCP, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

10.12.1.3 All factors used to adjust payments or risk-sharing targets, including, but not limited to, the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

10.12.1.4 The amount of payment for each and every service to be provided under the Contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the fee schedule shall be incorporated into the Contract by reference, and shall specify Medicare resource-based relative value scale ("RBRVS") year if RBRVS is the methodology for the fee schedule development. For any proprietary fee schedule, the Contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

10.12.2 ANNUAL DISCLOSURE OF CAPITATION PAYMENTS – On the Contract anniversary date each year, CalOptima shall disclose to HMO the amount of capitation payments to be paid per member per month.

10.12.3 CAPITATION DEDUCTION DETAIL – CalOptima shall provide to HMO sufficient details to allow HMO to verify the accuracy and appropriateness of any deductions from capitation payments made by CalOptima including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

ARTICLE 11
Obligations of CalOptima – Termination

11.1 MEMBER AND PROVIDER COMMUNICATION --- CalOptima shall approve all HMO, Member and provider communications relating to termination of this Contract, prior to distribution.

11.2 APPROVAL OF HMO TERMINATION PLANS --- CalOptima shall review and approve HMO termination plans at intervals and frequencies established by CalOptima Policies.

11.3 RELEASE OF WITHHOLD --- CalOptima shall release HMO's capitation withhold to HMO upon the latter of nine (9) months following the termination, or upon CalOptima's validation of completion by HMO of all post-termination requirements contained in this Contract and CalOptima Policy. In the event that all post-termination requirements have not been met within nine (9) months following termination, CalOptima may, at its sole discretion, apply HMO's capitation withhold funds to satisfy unmet post-termination requirements.

11.4 Not Applicable to this Contract.

ARTICLE 12
Health Care Delivery System

12.1 OUT-OF-COUNTY SERVICES --- HMO may contract with out-of-county facilities for Covered Services for CalOptima Members provided that the HMO ensures that it coordinates the Member's care and complies with all access, quality and other CalOptima requirements.

ARTICLE 13
Termination and Modification of Contract Terms

13.1 SANCTIONS AND TERMINATIONS FOR CAUSE --- If HMO fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the HMO by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (vii) failure to ensure that all Minimum Standards are met; (viii) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (ix) not having the required amounts and types of financial reserves; (x) failure of Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xi) failure to meet Medical Loss Ratio requirements; (xii) failure to meet minimum enrollment requirements; (xiii) failure to meet quality and/or performance requirements; (xiv) failure to comply with organization structure requirements as set forth in Section 3.10 of this Contract; (xv) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvi) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xvii) a violation of the Department of Managed Health Care's Risk Bearing Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations. CalOptima may take any of the actions described below:

13.1.1 Corrective Action Plan (CAP) - CalOptima may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the HMO or any Subcontractor(s) is not in compliance with any provision of this Contract or other Medi-Cal program requirement. A CAP shall be required if CalOptima receives a

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substantiated complaint or grievance related to the standard of care provided by the HMO or any Subcontractors. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within fourteen (14) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP.

13.1.2 General Sanctions - Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the HMO is not in compliance with the provisions of this Contract, CalOptima Policies and minimum performance requirements as established by CalOptima.

13.1.2.1 All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus the administrative fee from the HMO's Capitation Payment.

13.1.2.2 HMO may appeal CalOptima's decision to impose a sanction, by filing a complaint pursuant to CalOptima Policies. HMO shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policy, before commencing a civil action.

13.1.3 Termination for Cause - Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 13.1. HMO may appeal CalOptima's decision to terminate the Contract for cause by filing a complaint pursuant to CalOptima Policies. HMO shall exhaust all administrative remedies before commencing any civil action.

13.1.3.1 In the event of a "Termination for Cause" as provided by this Section, CalOptima may procure, upon such terms and in such manner as it shall deem appropriate, supplies or services similar to those terminated. HMO shall be liable to CalOptima for any excess costs for the provision of such similar supplies or services. In addition, HMO shall be liable to CalOptima for administrative costs or other damages incurred by CalOptima in procuring such similar supplies or services. CalOptima shall also charge an administrative fee when paying a claim on behalf of HMO.

13.1.3.2 CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

13.2 TERMINATION FOR INSUFFICIENT CALOPTIMA MEDI-CAL ENROLLMENT --- CalOptima reserves the right in accordance with CalOptima Policies to terminate the HMO in the event that membership falls below five-thousand (5,000) total members at any time based upon a three (3) month rolling average of HMO membership.

13.3 TERMINATION FOR FAILURE TO MEET QUALITY REQUIREMENTS --- CalOptima may terminate this Contract immediately should HMO fail to comply with or fail to be in compliance with quality requirements as may be established and modified from time to time by CalOptima and/or DHCS.

13.4 TERMINATION FOR FAILURE TO MEET MEDICAL LOSS RATIO REQUIREMENTS --- CalOptima may terminate this Contract with thirty (30) days written notice should HMO fail to comply with or be in compliance with medical loss ratio requirements established in this Contract and CalOptima Policies.

13.5 TERMINATION OF STATE CONTRACT --- CalOptima may terminate this Contract immediately upon termination of the State Contract.

13.6 TERMINATION UPON LOSS OF WAIVER --- This Contract shall terminate immediately upon written notice from CalOptima to HMO that HHS has withdrawn its approval of the waiver granted under Section 1915(b) of the Social Security Act for COHS.

13.7 TERMINATION FOR HMO ORGANIZATION AND OPERATIONS STRUCTURE --- CalOptima may terminate this Contract immediately should HMO fail to comply with requirements for HMO's organization and operation structure established in this Contract and CalOptima Policies.

13.8 Not Applicable to this Contract.

13.9 TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred eighty (180) calendar days advance written notice to the other party prior to the effective date of such termination.

13.10 TERMINATION FOR HMO INSOLVENCY --- If HMO becomes insolvent, HMO shall immediately advise CalOptima, and CalOptima shall have the right to terminate the Contract upon the same terms and conditions as a "Termination for Cause", set forth in Section 13.1. In the event of the filing of a petition for bankruptcy by or against HMO or a principal Subcontractor, HMO shall assure that all HMO's functions and duties related to the Subcontract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to HMO until HMO fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all HMO obligations have been met.

13.11 TERMINATION BY HMO FOR CAUSE --- Provided that HMO is not in default hereunder, HMO may terminate this Contract for cause upon thirty (30) calendar days' prior written notice to CalOptima. Cause shall mean CalOptima's failure for a period of thirty (30) calendar days to pay the Capitation Payment due to HMO under this Contract. Termination shall be

effective at the end of the thirty (30) calendar day notice period, unless CalOptima pays to HMO any such past due payments.

13.12 MODIFICATIONS OR TERMINATIONS 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 the State 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 HMO in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and HMO shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

13.13 PERFORMANCE MEASURE AND PAYMENTS TO HMO --- CalOptima may establish key performance measures of HMO to set minimum contract performance thresholds and/or pay financial incentives to Health Network. CalOptima may take the following actions, at its sole discretion, based upon the results of such performance measures: require corrective action plans, impose sanctions against HMO, terminate this Contract, and establish Capitation Rates and other payments to HMO.

13.13.1 HMO will distribute directly to Participating Providers a minimum of eighty-five percent (85%) of any quality pay for value incentive payment(s) that CalOptima makes to HMO, beginning with Measurement Year 2024.

13.14 PROHIBITION ON USE OF CERTAIN PROVIDERS --- HMO agrees as follows:

13.14.1 CalOptima reserves the right to require HMO, upon notification from CalOptima, to prohibit any Subcontractor and/or Provider from providing services, whether Covered Services or otherwise, to Members when CalOptima deems such prohibition to be in the best interests of the Members, provided that the imposition of the foregoing prohibition shall not terminate this Contract.

13.14.2 CalOptima requires that HMO Participating Providers and/or Subcontractors who do not meet all of Minimum Standards as described in applicable CalOptima Policies, be prohibited from furnishing items or services and/or submitting claims and/or receiving reimbursement for items and/or services furnished to Members. CalOptima may also require that HMO terminate a Participating Provider's right to furnish items or services and/or submit claims and/or receive reimbursement for items and/or services furnished to Members based on the denial of such Participating Provider's right to participate in CalOptima Direct whether based on a credentialing, recredentialing and/or peer review decision.

13.15 NOTICE OF NON-RENEWAL --- In order for CalOptima to facilitate Member transition to other Health Networks, HMO shall provide CalOptima with an advance notice of non-renewal of the Contract in accordance with Section 13.9 prior to the end date of the Contract term in the event HMO elects not to participate in any extension period or new contract term.

13.16 Not Applicable to this Contract.

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13.17 EXTENSION, RENEWAL, OR MODIFICATION --- Any extension, renewal, or modification of this Contract shall be made by written amendment signed by the parties, upon formal approval by CalOptima Board of Directors, and in accordance with Section 8.4 of this Contract.

ARTICLE 14
Miscellaneous

14.1 INTERPRETATION OF CONTRACT LANGUAGE --- CalOptima has the right to final interpretation of the Contract language when disputes arise. HMO has the right to appeal disputes concerning Contract language to CalOptima.

14.2 INDEPENDENT CAPACITY OF HMO --- CalOptima and HMO agree that HMO and any agents or employees of HMO, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima.

14.3 NO WAIVER OF IMMUNITY OR PRIVILEGE --- 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.

14.4 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.

14.5 GOVERNING LAW AND VENUE --- This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between CalOptima and DHCS. HMO shall be required to bring all legal proceedings against CalOptima in State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

14.6 WAIVER --- No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance 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.

14.7 SEVERABILITY--- If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

14.8 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

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catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes.

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

14.10 ASSIGNMENT OR DELEGATION --- HMO 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 HMO or Subcontractor (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 HMO or Subcontractor; (iii) the merger, reorganization, or consolidation of HMO or Subcontractor with another entity with respect to which HMO or Subcontractor is not the surviving entity; and/or (iv) a change in the management of HMO or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of HMO or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

14.11 NO LIABILITY OF COUNTY OF ORANGE --- As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the HMO 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 therefore.

14.12 CONFIDENTIALITY OF RECORDS --- As a condition of access to any record utilized or maintained by DHCS, the Declaration of Confidentiality, a copy of which is incorporated into this Contract as Attachment D, shall be signed and filed with DHCS for every individual prior to that individual being allowed access to computer files or any other data or files which are made confidential by statute, including identification of individual Members.

14.13 DEBARMENT CERTIFICATION --- By signing this Contract, the HMO 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.

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

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

14.13.1.2 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

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embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

14.13.1.3 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 this Section herein; and

14.13.1.4 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.

14.13.1.5 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.

14.13.1.6 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.

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

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

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

14.14 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, HMO 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. HMO further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

14.15 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. HMO agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14.16 LOBBYING RESTRICTIONS AND DISCLOSURE CERTIFICATION -

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

14.16.2 Certification and Disclosure Requirements

14.16.2.1 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 F, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Section 14.16.2.2.

14.16.2.2 Each recipient shall file a disclosure in the form set forth in Attachment F, 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 Section 14.16 if paid for with appropriated funds.

14.16.2.3 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 affect the accuracy of the information contained in any disclosure form previously filed by such person under this Section herein. An event that materially affects the accuracy of the information reported includes:

14.16.2.3.1 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;

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

14.16.2.3.3 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.

14.16.2.4 Each person (or recipient) who requests or receives from a person referred to in this Section 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.

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

14.16.3 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.

14.17 NOTICES --- All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Director of Contracting
505 City Parkway West
Orange, California 92868

To: HMO
AltaMed Health Network, Inc.
1401 N Montebello Blvd
Montebello, CA 90640
Attn: VP of Health Plan Contracts

14.18 GOVERNMENT CLAIMS ACT --- HMO shall ensure that HMO 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

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Code section 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

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 Exclusive Remedy. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 14.19.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

14.19.4 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.

ARTICLE 15
SIGNATURES

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 NOVEMBER 1, 2024, THROUGH JUNE 30, 2027 AND FIVE (5) ADDITIONAL ONE-YEAR AUTOMATIC EXTENSIONS (JULY 1 THROUGH JUNE 30) EXCEPT AS DIRECTED OTHERWISE BY THE BOARD.

Back to Agenda Back to Item

IN WITNESS WHEREOF, CalOptima and AltaMed Health Network, Inc. have executed this Contract:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim_____
PRINT NAME	PRINT NAME
_____	Chief Operating Officer_____
TITLE	TITLE
_____	_____
DATE	DATE

Contract for Health Care Services

ATTACHMENT A - (EFFECTIVE 11/1/2024)
CalOptima Medi-Cal Division of Financial Responsibility

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Physician	Hospital	Other
Acupuncture	**X**		
Allergy Testing & Treatment			
Testing	**X**		
Serum	**X**		
Immunotherapy injections	**X**		
Ambulance	**-See Transportation-**		
Amniocentesis	**X**		
Anesthesia-for medical diagnosis (Includes Medical, Dental, Mental Health, etc….)			
Professional component	**X**		
Facility component		**X**	
Birth Control	**-See Family Planning-**		
Blood and Blood Products			
From blood bank		**X**	
Transfusions, blood and blood components		**X**	
Autologous Transfusion (including collection of)		**X**	
Outpatient Transfusion, Blood and Blood Components		**X**	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	**X**		
Facility component		**X**	
Breast Reconstructive Surgery (after cancer)			
Professional component	**X**		
Facility component		**X**	
CBAS			**CalOptima (Claims)**
CHDP	**-See Pediatric Preventative Services-**		

	Physician	Hospital	Other
Chemotherapy			
Professional component	**X**		
Outpatient Facility component		**X**	
Medication	**-See Medication-**		
Chiropractic Services	**X**		
Cosmetic Surgery (Medically Necessary)			
Professional component	**X**		
Facility component (licensed surgical center or acute care facility only)		**X**	
Dental Services			
General dental services-Including teeth			**Denti-Cal**
Oral Maxillofacial Surgery (Repair or accident/injury; medically necessary-Excluding teeth)			
Professional component	**X**		
Facility component		**X**	
Anesthesia Services (related to dental services)			
Professional component (Other than provided by Dentist)	**X**		
Professional component (Provided by Dentist)			**Denti-Cal**
Facility component		**X**	
Detoxification – Medical (inpatient acute medical facility only)			
Professional component	**X**		
Facility component		**X**	
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service)			
Professional component	**X**		
Facility component	**X**		
Diagnostic Services (Inpatient), Including Radiology			
Professional component	**X**		
Facility component		**X**	
Dialysis			
Professional component	**X**		
Facility component		**X**	

	Physician	Hospital	Other
Durable Medical Equipment (DME) (including insulin pumps) and Medi-Cal covered Glucose Continuous Monitors			
Inpatient		**X**	
Outpatient (including supplies necessary for use of the equipment i.e. oxygen tubing, dressings, blood glucose meters)	**X**		
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**		
Customer Wheelchair Assessments through MTP			**OC** **HCA/ State**
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital		**X**	
Emergency Services (hospital based)			
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**		
Facility component, i.e. room use, surgical and medical supplies, and the technical component of diagnostic testing.		**X**	
Mental Health Post Triage / Emergency Stabilization Treatment – admitted to inpatient psychiatric facility			**OC HCA/ State**
Enteral and Parenteral Nutrients, Pumps and Supplies	***-See Nutritional Products -***		
EPSDT Services[2]			
Acupuncture	**X**		
Autism Screening	**X**		
Audiology	**X**		
Chiropractic	**X**		
Cochlear Implant	**X**		
Dental Services			**State**
EPSDT Case Management	**X**		
Hearing Aid Batteries	**X**		
In-Home Private Duty Nursing (PDN)			***CalOptima (Claims)***
Mental Health – Specialty Outpatient			**OC HCA/ State**
Medical Nutrition Services	**X**		
Occupational Therapy[1]	**X**		
Orthodontic Services			**Denti-Cal**
Pediatric Day Health Care Services (CCS)			**State**
Speech Therapy	**X**		

	Physician	Hospital	Other
Family Planning (all provider types)			
Professional component	**X**		
Surgically implanted sterilization devices		**X**	
IUDs (with or without medication)	**X**		
Contraceptive items/supplies billed by a non pharmacy provider	**X**		
Condoms, diaphragms and cervical caps when billed by a Pharmacy			**DHCS PBM**
Medications	**-See Medications-**		
Genetic Disease Screening			
Prenatal Triple Marker Screening			***DHCS Genetic Disease Branch***
Follow-up services for positive prenatal screening			***DHCS Genetic Disease Branch***
Newborn screening panel		**X**	
Other Genetic Testing/Counseling	**X**		
Hearing Aids	**X**		
Hearing Screening	**X**		
Home Health Care			
Care for medical conditions		**X**	
Care for psychiatric conditions			**OC HCA / State**
Injectable medications	***-See Medication -***		
Home infusion	***-See Medication -***		
Home Health and Home Infusion Pumps & Supplies (including Total Parenteral Nutrition Supplies)		**X**	
Hospice Services (ALL levels of services at any facility/location/setting)		**X**	
Hospitalization – Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided In lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)			
Acute Medical		**X**	
Psychiatric			**OC HCA / State**
Hyperbaric Oxygen Therapy		**X**	
Immunizations	***- See Preventive Services -***		

	Physician	Hospital	Other
Laboratory Services			
Inpatient – Medical (technical component)		**X**	
Inpatient – Psychiatric			**OC HCA / State**
Inpatient – Medical (professional component)	**X**		
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**		
Emergency Room	***- See Emergency Services -***		
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities			
Room and Board (facility daily rate)			**CalOptima (Claims)**
Professional services	**X**		
Ancillary services	**X**		
Mammography and Screening	**X**		
Medical/Surgical Supplies and Dressings			
Inpatient		**X**	
Outpatient Medical/Surgical Supplies and Dressings			
Disposable Medical Supplies (including Medi-Cal Categories: Enteral, Tracheostomy, Ostomy, Urological, Wound Care, Infusion Tubing) and Supplies billed by a non-Pharmacy provider	**X**		
Other Disposable Medical Supplies when billed by a Pharmacy			**DHCS PBM**
Medication			
Inpatient			
Acute Medical		**X**	
Acute Psychiatric			***OC HCA/ State***
Long Term Care Facility			**DHCS PBM**
Outpatient Medication billed by a Pharmacy			**DHCS PBM**
Outpatient Medication billed by non-Pharmacy Providers			***CalOptima (Claims)***

	Physician	Hospital	Other
Mental Health			
Behavioral Health Professional Services			
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing			***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit			***OC HCA/ State***
Electroconvulsive Treatment (psychiatrist)			***OC/HCA/ State***
Applied Behavior Analysis (ABA)			***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)		**-In OC- Service is NOT a Medi-Cal Benefit-**	
Behavioral Health Facility			
Acute Care Facility ER not resulting in psych admission		**X**	
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit			**OC/HCA/ State**
Partial Hospitalization Program or Intensive Outpatient PHP, IOP		**-In OC-Service is NOT a Medi-Cal Benefit-**	
Electroconvulsive Treatment Outpatient		**X**	
Substance Use Disorder (SUD) Professional			
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist			**CalOptima (Claims)**
Outpatient-DMC Provider, Intensive Outpatient - DMC Provider			**Drug Medi-Cal**
ER-SUD Consultation			**CalOptima (Claims)**
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**		
Substance Use Disorder (SUD) Facility			
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)		**X**	
Acute Care Facility (Voluntary Inpatient Detox)			**DHCS**
Residential (Detox/Rehab)			**Drug Medi-Cal**
Neuropsych Testing	**X**		

	Physician	Hospital	Other
Nuclear Medicine Diagnostic and Treatment/Therapy			
Professional Component	**X**		
Facility Technical Component (hospital & free-standing centers)		**X**	
Nutritional Dietetic Counseling/Medical Nutrition Therapy/ Health Education	**X**		
Nutritional Products			
Total Parenteral Nutrients (TPN) when provided by Pharmacy			***DHCS PBM***
Total Parenteral Nutrition (TPN) when provided by non-Pharmacy provider			***CalOptima (Claims)***
Total Parenteral Nutrition (TPN) supplies and pumps		**X**	
Enteral Nutrition products included in the DHCS Enteral Nutrition product list			**DHCS PBM**
Enteral Nutrients, Supplies and Pumps	**X**		
Other Nutrition Products when not covered by DHCS PBM	**X**		
Obstetrical Care			
Outpatient diagnostic services	**X**		
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Emergent diagnostic (OB Unit)		**X**	
Ultrasound	**X**		
Perinatal care (Includes 60 days postpartum)	**X**		
Perinatal Support Services			***CalOptima (Capped & Claims)***
Fetal Monitoring			
Professional component	**X**		
Facility component		**X**	
Occupational Therapy	***- See Rehabilitation -***		
Orthotics	**X**		
Outpatient Diagnostic Services	***-See Diagnostic Services (Outpatient) -***		
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)			
Professional component	**X**		
Facility component		**X**	
Out of Area Services	**Follows appropriate DOFR Section**		
Pharmacy	***- See Medication -***		
Physical Therapy	***- See Rehabilitation -***		

	Physician	Hospital	Other
Physician Services			
Inpatient	**X**		
Outpatient	**X**		
Podiatry Services	**X**		
Pediatric Preventive Services (includes CHDP)			
Well Child Visits	**X**		
Immunizations (Ages 0-18 years)			
Vaccine			***VFC (Vaccines for Children Program)***
Administration fee	**X**		
Immunizations (19 years and over)			
Vaccine billed by a non-Pharmacy provider (inclusive of Medi-Cal administration fee)	**X**		
Vaccine billed by a Pharmacy			**DHCS PBM**
Adult Periodic Health Exams	**X**		
Prosthetic Devices			
Surgical implantation	**X**		
Surgically implanted device/prosthetic		**X**	
Non-implanted device/prosthetic	**X**		
Radiation Therapy			
Professional component	**X**		
Facility component		**X**	
Radiology Services	***- See Diagnostic Services -***		
Rehabilitation – Physical, Occupational, & Speech Therapy			
Inpatient professional component	**X**		
Inpatient facility component		**X**	
Outpatient professional component[1]	**X**		
Outpatient facility component[1]	**X**		
Long Term Care Facility	**X**		
Skilled Nursing Facility			
Custodial – Long Term Care	***- See Long Term Care Services -***		
Short stay	***- See Hospitalization -***		
Speech Therapy	***- See Rehabilitation -***		
Termination of Pregnancy			
Professional component (including Mifepristone/RU-486)	**X**		
Facility component		**X**	
Transgender Services			
Professional component	**X**		
Facility component		**X**	

	Physician	Hospital	Other
Transplants – Including Procurement			
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)			***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)			***CalOptima (Claims)***
All Other Transplants (e.g. bone, cornea, skin)			
Professional component	**X**		
Facility component		**X**	
Transportation (includes ambulance)			
Emergency		**X**	
Non-Emergency Medical Transportation (NEMT)		**X**	
Non-Medical Transportation (NMT)			***CalOptima (Claims)***
Tuberculosis (TB) Treatment			
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)			***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA			***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**		
Vision Care			
Routine adult and child eye refraction examination			***CalOptima (TPA)***
Contact lenses			***CalOptima (TPA)***
Lenses and Frames			***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**		
Intraocular lens – surgically implanted		**X**	
Ophthalmological services	**X**		
Prosthetic eye	**X**		
Whole Child Model-Previously California Children's Services			
Professional component including all Special Care Center services billable on a professional claim	**X**		
Facility component including all Special Care Center services billable on a facility claim		**X**	
Maintenance and Transportation			***CalOptima (Claims)***
Medical Therapy Program			***OC HCA / State***
CalOptima reserves the right to determine the ultimate payor for any given service.			
[1] *Services are the responsibility of MTP if provided under the MTP program.*			
[2] *Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.*			

ATTACHMENT B
DISCLOSURE FORM

Pursuant to DHCS APL 23-006, Medi-Cal managed care plans like CalOptima must comply with the ownership and control disclosure requirements as set forth in 42 CFR § 455.104 by collecting information on whether their Subcontractors are persons with ownership or control interest or managing employees. Provider shall complete and return this form to CalOptima in accordance with CalOptima instructions prior to the Effective Date and submit updates to this form to CalOptima within thirty (30) days of any change to this form.

The undersigned hereby certifies that the following information regarding _____ (the "**Provider**") is true and correct as of the date set forth below:

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

_____

Officer(s)/Director(s)/General Partner(s)/Managing Employees: _____

_____

Co-Owner(s): _____

_____

Individuals with an Ownership or Control Interest owning more than five percent (5%) of the Provider's stock: Please list all individuals with an ownership or control interest. Include each person's name, address, date of birth (DOB), and Social Security Number (SSN). Indicate the title (*e.g.* chief executive officer, owner) and if an owner, the percentage of ownership.

Name	Title	% Ownership	DOB	SSN

Corporation with and Ownership or Controlling Interest holding more than five percent (5%) of the Provider's debt: Please list all corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, the P.O. Box address(es). Attach additional pages as needed.

Name of Corporation	TIN	% Ownership	P.O. Box

[*signature page follows*]

Dated: _____ Signature: _____

Name: _____
(Please type or print)

Title: _____

ATTACHMENT C

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ATTACHMENT D

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES COMPUTER FILES FOR THE MEDI-CAL PROGRAM

DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized/ maintained by the Department of Health Care Services (DHCS) and CalOptima, I, _____, agree not to divulge any information obtained in the course of my assignment to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to _____, _____ fiscal agent, State and federal personnel who require the information in the performance of their duties and to such others as may be authorized by CalOptima.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signed

_____
Date

ATTACHMENT E
Capitation Rates

Effective 11/1/2024

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

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child/Adult	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40-64 years, Both			
	65+ years, Both			
Medi-Cal Expansion	00-00 year, Both			
	01-14 years, Both		$	
	15-18 years, Female			
	15-18 years, Male	$	$	$
	19-39 years, Female			
	19-39 years, Male	$	$	$
	40- 64 years, Both	$	$	$
	65+ years, Both	$	$	$
SPD	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female	$	$	$
	15-18 years, Male			
	19-39 years, Female	$	$	$
	19-39 years, Male	$	$	$
	40- 64 years, Both	$	$	$
	65+ years, Both	$	$	$
WCM	00-00 year, Both	$	$	$
	01-14 years, Both	$	$	$
	15-18 years, Female	$	$	$
	15-18 years, Male	$	$	$
	19-39 years, Female	$	$	$
	19-39 years, Male	$	$	$

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
ESRD	All ages, Both	$[redacted]	$[redacted]	$[redacted]
AIDS	All ages, Both	$[redacted]	$[redacted]	$[redacted]

Overall average capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy.

Supplemental OB Delivery Care Payment will be payable for all qualified deliveries based on DHCS guidance.

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment - All	$[redacted]	$[redacted]	$[redacted]

ATTACHMENT E-1

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ATTACHMENT E-2

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ATTACHMENT1 E-3

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ATTACHMENT E-4

SUPPLEMENTAL PAYMENT FOR HOME HEALTH AGENCY SERVICES

On September 17, 2018, DHCS received federal approval for State Plan Amendment 18-0037 to sunset the one percent (1%) payment reduction for home health agency services and to increase reimbursement rates in effect on June 30, 2018, for state plan home health agency services by fifty percent (50%) effective July 1, 2018. Certain procedure codes, that mainly apply to pediatric Medi-Cal members, provide increased Medi-Cal reimbursement rates for certain home health agency services effective July 1, 2018. These supplemental payments will only apply to the cost of services that are not considered part of California Children Services, also known as Whole Child Model covered services.

To obtain the supplemental payment, HMO will submit encounter data to CalOptima for procedures codes, Z5804/S9123, Z5805, Z5806/S9124, Z5807, Z5832/G0299, Z5833/T1002, Z5834/G0300, Z5835/T1003, Z5836/G0162, Z5838/G0156, Z5840/T1016 and Z5868/T1026 or equivalent HIPAA compliant codes evidencing the HMOs' reimbursement of the home health agency services at the increased rates during the period of July 1, 2018, through June 30, 2019. CalOptima will review the encounters eligible for supplemental payment made July 1, 2018, through June 30, 2019 at two different points in time. The initial reconciliation will be for payments made and submitted to CalOptima by October 15th, 2019 at which point CalOptima will make payment by November 30th, 2019. The final reconciliation will be for payments made and submitted by April 15th, 2020 at which point CalOptima will make payment by May 31st, 2020. CalOptima shall validate that services are not CCS covered services prior to payment.

The supplemental payment shall not be applicable to dates of service after June 30, 2019, since the cost changes are incorporated in CalOptima's regular rebasing exercise which are inclusive of forward trend assumptions. Expenses for CCS Eligible Conditions shall be subject to Risk Corridor reconciliation per the Contract and in accordance with CalOptima Policy.

ATTACHMENT E-5

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ATTACHMENT E-6

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ATTACHMENT E-7

MEDI-CAL RATE ENHANCEMENT

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ATTACHMENT E-8

Funding for Enhanced Care Management (ECM) Services

Effective November 1, 2024, subject to approval by DHCS, CalOptima shall make an ECM Supplemental Payment to HMO for ECM services provided to an ECM Member, in accordance with the terms and conditions of CalOptima Policy FF.4002.

1. ECM Services Supplemental Payment

   1.1 CalOptima shall pay HMO the ECM Supplemental Payment rate of $[redacted] PMPM for each Member who receives two (2) or more hours of ECM services in a given month as identified by eight (8) or more units, subject to HMO's compliance with all of the following conditions:

   - Member is identified as an ECM-eligible Member as determined by CalOptima based on ECM eligibility criteria as defined by DHCS and in accordance with CalOptima Policy GG.1354;
   - Member is authorized to receive ECM services;
   - Member receives one of the ECM core service components (as set forth in Section 6.23.9.4 of the Contract) in the prior month;
   - The ECM services are billed and reported to CalOptima consistent with CalOptima Policy FF.4002 and DHCS requirements; and;
   - If applicable, the HMO paid the provider for the ECM services; and
   - The HMO authorized such ECM services.

   1.2 For purposes of this Attachment E-8 only, the term "PMPM" means an all-inclusive case rate that applies whenever HMO, as the ECM Provider, has provided the minimum level of service payable to an enrolled Member. This rate is paid on the basis of submitted claims and is not to be considered a capitation payment.

2. HMO shall submit ECM billing data for the ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

3. Upon validation of the ECM billing data and in accordance with CalOptima Policy FF.4002 CalOptima shall pay ninety (90) percent of all clean claims within thirty (30) calendar days of the date of receipt and ninety-nine (99) percent of all clean claims within ninety (90) calendar days of the date of receipt. The date of receipt shall be the date CalOptima receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date on the check or other form of payment.

4. In addition to Section 9.4 of this Contract, HMO agrees to CalOptima's recovery of any overpayment of ECM Services Supplemental Payment in accordance with CalOptima Policy FF.4002.

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 $[redacted] 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.

ATTACHMENT F-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

ATTACHMENT F-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:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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

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

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

Identify the status of the covered federal action.

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

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

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

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

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

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

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

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

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

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

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

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

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

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

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

ATTACHMENT G
CALIFORNIA REGULATORY REQUIREMENTS

This Attachment G sets forth the Medi-Cal program requirements and other California statutory and regulatory provisions applicable to this Contract. In the event of a conflict between this Attachment G and any other provision in the Contract, the provisions in this Attachment G control.

1. Definitions.

1.1 "**Downstream Subcontractor**" means an individual or an entity that has an agreement with a Subcontractor or a Downstream Subcontractor that includes a delegation of HMO's and Subcontractor's duties and obligations under the Contract.

1.2 "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following: (i) placing the Member's health in serious jeopardy; (ii) serious impairment of bodily functions; (iii) serious dysfunctions to any bodily organ or part; or (iv) death.

1.3 "**Fully Delegated Downstream Subcontractor**" means a Downstream Subcontractor that contractually assumes all duties and obligations of HMO under the Contract, through a Downstream Subcontractor agreement.

1.4 "**Fully Delegated Subcontractor**" means a Subcontractor that contractually assumes all duties and obligations of HMO where HMO has assumed all duties and obligations of CalOptima, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.

1.5 "**Health Equity**" means the reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations.

1.6 "**Laws**" means, without limitation, federal, state, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Attachment G.

1.7 "**Quality Improvement and Health Equity Transformation Program**" or "**QIHETP**" means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in Laws, Government Program Requirements.

2. Compliance with Laws. This Contract shall be governed by and construed in accordance with all Laws and applicable regulations governing the DHCS Contract, including 42 Code of Federal Regulations ("**CFR**") § 438.230; the Knox Keene Act, Health and Safety ("**H&S**") Code §§ 1340 *et seq*., unless otherwise excluded under the DHCS Contract; 28 CCR §§ 1300.43 *et seq*; Welfare & Institutions ("**W&I**") Code §§ 14000 and 14200 *et seq*.; and 22 CCR §§ 53800 *et seq.*, 53900 *et seq*. HMO will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including all applicable requirements specified in the DHCS Contract, Laws, sub-regulatory guidance, and DHCS All Plan Letters ("**APLs**") and policy letters, and CalOptima Policies. HMO shall comply with all monitoring requirements of the Contract, the DHCS Contract,

and any other monitoring requests by DHCS and CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.4), (A.5), (A.11), (B.7), (B.8), and (B.11)]

3. Provider Data. As applicable, HMO and its Subcontractors will submit to CalOptima complete, accurate, reasonable, and timely provider data, Program Data, Template Data, and any other reports or data as requested by CalOptima to meet its reporting requirements to DHCS. HMO shall submit all provider data to CalOptima in the form, format, and timeframe requested by CalOptima. HMO will make corrections to provider data as requested by CalOptima. HMO data shall include all data required under the Contract – including reports and HMO rosters. For purposes of this section, (1) "**Program Data**" means data that includes but is not limited to: Grievance data, Appeals data, medical exemption request denial reports and other continuity of care data, out-of-network request data, and PCP assignment data as of the last calendar day of the reporting month; and (2) "**Template Data**" means data reports submitted to DHCS by CalOptima, which includes, but is not limited to: data of Member populations, health care benefit categories, or program initiatives. [DHCS Contract, Exhibit A, Attachment III, §§ 1.2.5, 2.1.4, 2.1.5, 2.1.6, 3.1.5(A.6) and (B.10)]

4. Encounter Data. As applicable, HMO will submit to CalOptima complete, accurate, reasonable, and timely Encounter Data requested by CalOptima in order to meet its reporting requirements to DHCS in compliance with applicable DHCS APLs, including APL 14-020 and any superseding or amendment APLs. All Encounter Data shall be submitted to CalOptima no later than ninety (90) days from the Date of Service in the form and format as designated by CalOptima. HMO will cooperate as requested by CalOptima if corrections to Encounter Data are required for CalOptima to comply with reporting requirements to DHCS. [DHCS Contract, Exhibit A, Attachment III, §§ 2.1.2, 3.1.5(A.6) and (B.10)]

5. Reports. HMO, and its Participating Providers, agree to submit all reports required and requested by CalOptima to comply with applicable laws in a form acceptable to CalOptima. [DHCS APL 19-001, Attachment A, Requirement 6]

6. California Health and Human Services ("**CalHHS**") Data Exchange. HMO shall (i) execute the CalHHS Data Sharing Agreement ("**DSA**"); (ii) comply with the DSA requirements, including the CalHHS policies and procedures incorporated into the DSA; and (iii) participate in the real-time exchange of, or provision of access to, health information between and among other DSA participants, including CalOptima and any other Participating Providers providing services to Members. [H&S Code § 130290]

7. Additional Subcontracting Requirements. If HMO is allowed to subcontract services under this Contract and does so subcontract, then HMO shall, upon request, provide copies of such Subcontracts to CalOptima and/or DHCS.

    7.1 Subcontracts for Provision of Covered Services. HMO shall maintain copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Contract. HMO will ensure that such contacts are in writing. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.7)]

    7.2 Subcontracts. HMO shall require all Subcontracts and downstream Subcontracts that relate to the provision of Covered Services be in writing and include all applicable provisions of the Contract and this Medi-Cal Program Addendum including:

        7.2.1 The 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.

7.2.2 As applicable, Section 2, *Compliance with Laws*; Section 3, *Provider Data*; Section 4, *Encounter Data*; Section 7, *Additional Subcontractor Requirements*; Section 8, *Records Retention*; Section 9, *Access to Books and Records*; Section 10, *Records Related to Recovery for Litigation*; Section 11, *Transfer*; Section 12, *Unsatisfactory Performance*; Section 13, *Hold Harmless*; Section 14, *Prohibition on Member Claims and Member Billing*; Section 15, *Prospective Requirements*; Section 16, *Network Provider Training*; Section 17, *Language Assistance and Interpreter Services*; Section 18, *Fraud, Waste, and Abuse Reporting*; Section 19, *Provider Identified Overpayments*; Section 20, *Health Care Provider's Bill of Rights*; Section 21, *Provider Grievances*; Section 22, *Effective Dates*; Section 23, *Assignment and Sub-delegation*; Section 24, *Quality Improvement & Utilization Management*; Section 25, *Emergency Services and Post-Stabilization Delegation*; Section 28, *Amendment and Termination*; Section 29, *Delegated Activities*; Section 30, *Utilization Data*; Section 59, *DHCS Beneficiary*; and any other section of this Attachment G that is applicable to the obligations Subcontractor has undertaken.

7.2.3 An agreement that Subcontractors shall notify HMO of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

7.2.4 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 14.12 of the base 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.

[DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.12)]

8. Records Retention. HMO and Subcontractors shall maintain and retain all books and records of all items and services provided to Members, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the DHCS Contract, 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. HMO's books and records shall be maintained within, or be otherwise accessible within, the State and pursuant to H&S Code § 1381(b). 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 agency immediate and direct access and inspection of all such records at the time of any onsite audit or review.

This provision shall survive the expiration or termination of this Contract.

[DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.9) and (B.14); H&S Code § 1381; 28 CCR 1300.81]

9. Access to Books and Records. HMO agrees, and shall ensure its Subcontractors agree in Subcontracts, to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining directly or indirectly to the goods and services furnished

under the terms of the Contract available for the purpose of an audit, inspection, evaluation, examination or copying at any time (i) in accordance with inspections and audits as directed by CalOptima, Regulators, the Department of Justice ("**DOJ**"), Office of Attorney General Division of Medi-Cal Fraud and Elder Abuse ("**DMFEA**"), DHCS's External Quality Review Organization contractor, and any other State or federal entity and their duly authorized designees statutorily entitled to have oversight responsibilities over CalOptima and/or HMO and its Subcontractors; (ii) at all reasonable times at HMO's and Subcontractor's respective places of business or at such other mutually agreeable location in the State; and (iii) in a form maintained in accordance with the general standards applicable to such book or record keeping. HMO and Subcontractors shall provide access to all security areas and facilities and cooperate and assist State representatives in the performance of their duties. If DHCS, CMS, DMFEA, or DOJ or any other authorized State or federal agency, determines there is a credible allegation of fraud against HMO, CalOptima reserves the right to suspend or terminate the HMO from participation in the Medi-Cal program; immediately suspend payments to HMO; seek recovery of payments made to HMO or any Subcontractor; impose other sanctions provided under the DHCS Contract, and conduct additional monitoring.

HMO and Subcontractors shall cooperate in the audit process by signing any consent forms or documents required by but not limited to: DHCS, DMHC, the DOJ, Attorney General, Federal Bureau of Investigation, Bureau of Medi-Cal Fraud, and/or CalOptima to release any records or documentation HMO may possess in order to verify HMO's records.

This provision shall survive the expiration or termination of this Contract and Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 1.3.4(D), § 3.1.5(A.8) and (B.13); Exhibit E, § 1.1.22(B); APL 19-001, Attachment A; APL 17-001]

10. Records Related to Recovery for Litigation. Upon request by CalOptima, HMO shall timely gather, preserve and provide to CalOptima, DHCS, CMS, DMFEA, and any authorized State or federal agency in the form and manner specified by such entity, any information, subject to any lawful privileges, in HMO's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If HMO asserts that any requested documents are covered by a privilege, HMO shall: (i) identify such privileged documents with sufficient particularity to reasonably identify the documents while retaining the privilege; and (ii) state the privilege being claimed that supports withholding production of the document. HMO agrees to promptly provide CalOptima with copies of any documents provided to any party in any litigation by or against CalOptima or DHCS. HMO acknowledges that time is of the essence in responding to such requests. HMO shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by HMO or its Subcontractors related to this Contract or Subcontracts. HMO further agrees to timely gather, preserve, and provide to DHCS any records in HMO's or its Subcontractor's possession. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.10) and (B.15); Exhibit E, § 1.1.27]

11. Transfer. HMO agrees, and will require its Subcontractors to assist, CalOptima in the transfer of Member care if in the event of: (i) termination of the DHCS Contract for any reason in accordance with the terms of the DHCS Contract; (ii) termination of this Contract for any reason; or (iii) a Subcontract terminates for any reason. Such assistance will include making available to CalOptima and DHCS copies of each Member's medical records and files, and any other pertinent information necessary to provide affected Members with case management and continuity of care. Such records will be made available at no cost to CalOptima, DHCS, or Members. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.11) and (B.16); Exhibit E, § 1.1.17(B)]

12. Unsatisfactory Performance. HMO agrees that the Contract or HMO's participation in the Medi-Cal program will be terminated, or subject to other remedies, if DHCS or CalOptima determine that HMO has not performed satisfactorily. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.12)]

13. Hold Harmless. HMO and its Subcontractors shall accept CalOptima's payment as described in this Contract as payment in full for all Covered Services and Administrative Services. HMO and its Subcontractors agree to hold harmless both the State and Members in the event that CalOptima cannot or will not pay for obligations undertaken by HMO pursuant to this Contract. This provision does not [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.13) and (B.18)]

14. Prohibition on Member Claims and Member Billing. HMO and its Subcontractors will not bill or otherwise collect reimbursement from a Member for any services provided under this Contract. HMO and Subcontractors will ensure that Members are not balance billed for any service provided out of network. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.14), 3.3.6, 5.2.7]

15. Prospective Requirements. CalOptima will inform HMO of prospective requirements added by State or federal law, or DHCS to the DHCS Contract that would impact HMO's obligations before the requirement becomes effective. HMO agrees to comply with the new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by CalOptima or DHCS. HMO will ensure Subcontractors are (i) informed of prospective requirements that would impact their obligations before the requirements become effective and (ii) agree to comply with new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by CalOptima or DHCS. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.15), (B.22), and (B.23)]

16. Network Provider Training. HMO shall participate in training required by CalOptima in order for CalOptima to comply with the DHCS Contract. Such provider training may include, utilization management training, quality of care for children (early periodic screening, diagnosis and testing) training, Member's rights, and advanced directives. Training will also include training on cultural competency and linguistic programs as outlined in this section. HMO shall ensure that all Subcontractors receive all applicable training. [DHCS Contract, Exhibit A, Attachment III, §§ 2.3(F), 3.2.5, 5.1.1, 6.1.3(C)]

    16.1 Diversity, Health Equity, Cultural Competency, and Sensitivity Training. HMO shall ensure that annual diversity, Health Equity, cultural competency/humility, and sensitivity training is provided for employees and staff at key points of contact, pursuant to the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.16) and (B.24), 5.2.11(C)]

    16.2 Cultural/Linguistic Training Programs. HMO shall participate in and comply with any applicable performance standards, policies, procedures, and programs established from time to time by CalOptima and federal and State agencies and provided or made available to HMO with respect to cultural and linguistic services, including attending training programs and collecting and furnishing cultural and linguistic data to CalOptima and federal and State agencies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.11]

    16.3 Discharge Planning and Transitional Care Training. HMO will educate its discharge planning staff on the services, supplies, medications, and durable medical equipment requiring prior authorization, and CalOptima's policies regarding discharge planning and transitional care services, as applicable. [DHCS Contract, Exhibit A, Attachment III, § 4.3.10(A.6) and (A.7)]

17. Language Assistance and Interpreter Services. HMO and its Subcontractors will comply with language assistance standards developed pursuant to H&S Code § 1367.04 and the DHCS Contract. HMO agrees to provide or arrange for the provision of interpreter services for Members. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.17) and (B.25), 5.1.3(F)]

18. Fraud, Waste, and Abuse Reporting. HMO shall report suspected fraud, waste, or abuse to CalOptima in accordance with the Contract. HMO agrees to provide CalOptima with all information reasonably requested by CalOptima, DHCS, or other State and federal agencies with jurisdiction in order for CalOptima to comply with fraud, waste, or abuse investigations and reporting requirements. In the course of a fraud, waste, or abuse investigation, CalOptima may share with HMO information that DHCS has disclosed to CalOptima ("**FWA Confidential Data**"). HMO acknowledges and agrees to maintain FWA Confidential Data confidentially. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.2(D), 3.1.5(A.18) and (B.26)]

19. Provider Identified Overpayments. In addition to Overpayment requirements under the Contract, HMO shall report in writing to CalOptima when it has received an Overpayment, identify the reason for the Overpayment, and promptly return the overpayment to CalOptima as outlined within sixty (60) days of the date HMO identified the Overpayment. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.6, 3.1.5(A.19), (B.27)]

20. Health Care Providers' Bill of Rights. Notwithstanding anything in this Contract to the contrary, HMO shall be entitled to the protections of the Health Care Providers' Bill of Rights, as set forth in H&S Code § 1375.7, in the administration of this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.20)]

21. Provider Grievances. HMO has the right to submit a dispute or grievance through CalOptima's formal process to resolve provider disputes and grievances pursuant to H&S Code § 1367(h)(1). CalOptima's process to resolve HMO disputes or grievances are set forth in this Contract and the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.20), 3.2.2(B)]

22. Effective Dates. This Contract and its amendments will become effective only as set forth in the DHCS Contract, which requires filing and approval by DHCS of template contracts and amendments, and Subcontractor and Downstream Subcontractor agreements and amendments. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.2, 3.1.5(B.4)]

23. Assignment and Sub-delegation. HMO agrees that any assignment or delegation of an obligation or responsibility under this Contract by HMO to a Subcontractor shall be void unless prior written approval is obtained from CalOptima and DHCS. HMO further agrees that assignment or delegation by a Subcontractor is void unless prior written approval is obtained from DHCS. CalOptima or DHCS may withhold consent at their sole and absolute discretion. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.5) and (B.6); APL 19-001, Attachment A, Requirement 14]

24. Quality Improvement & Utilization Management. HMO agrees to cooperate and participate in CalOptima's QMI program including participating in QI Program, UM Program, QIHETP, and population needs assessments. [DHCS Contract, Exhibit A, Attachment III, §§ 2.2.4, 3.1.5(B.19)]

25. Emergency Services and Post-Stabilization Delegation.

    25.1 Emergency Services and Post-Stabilization Delegation. HMO must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has an agreement with HMO.

25.1.1 HMO must not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR § 438.114(a)(i)-(iii). Further, HMO must not deny payment for treatment obtained when a representative of HMO instructs the Member to seek Emergency Services. Emergency Services must not be subject to prior authorization by HMO.

25.1.2 HMO must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to cover Emergency Services based on the emergency department provider, hospital, or fiscal agent not notifying HMO, the Member's PCP, CalOptima, or DHCS of the Member's screening and treatment for Emergency Services. A Member who has an Emergency Medical Condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Member.

25.2 Non-Contracting HMO Emergency Services Payment.

25.2.1 HMO shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from HMO, or the Member is stabilized sufficiently to permit discharge. The treating provider is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on HMO. Emergency Services shall not be subject to prior authorization by HMO.

25.2.2 At a minimum, HMO must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

25.2.3 For all non-contracting providers, reimbursement by HMO or its Subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered by a non-contracting provider pursuant to this provision shall be made in accordance with the DHCS Contract, 42 USC § 1396u-2(b)(2)(D), W&I Code § 14091.3, and other Laws.

25.3 Post-Stabilization Care Services. Except for response time periods set forth in 42 CFR 422.113(c)(2)(ii) and (iii)(A), HMO will pay for post-stabilization care services in accordance with 42 CFR § 422.113(c) and DHCS APL 23-009 (and any successor guidance). HMO is financially responsible for post-stabilization care services obtained within or outside of HMO's network that are authorized by HMO, Subcontractors, or Downstream Subcontractors.

25.3.1 In accordance with 28 CCR § 1300.71.4, HMO must approve or disapprove a request for post-stabilization care services made by a provider on behalf of a Member within thirty (30) minutes of the request. If HMO fails to approve or

disapprove authorization within the required timeframe, the authorization is deemed approved.

25.3.2 HMO is also financially responsible for post-stabilization care services obtained within or outside of HMO's network that are not authorized by HMO, Subcontractor, or a Downstream Subcontractor but administered to maintain, improve, or resolve the Member's stabilized condition if HMO, Subcontractor, Downstream Subcontractor, or a Participating HMO do not respond to a request for authorization within thirty (30) minutes; HMO, Subcontractor, Downstream Subcontractor or Participating HMO cannot be contacted; or HMO, Subcontractor, or Downstream Subcontractor and the treating provider cannot reach an agreement concerning the Member's care. In this situation, the treating provider may continue with care of the Member until HMO, Subcontractor, or Downstream Subcontractor is reached and assumes responsibility for the Member's care or one of the criteria of 42 CFR § 422.113(c)(3) is satisfied.

25.3.3 HMO's financial responsibility for post-stabilization care services it has not authorized ends when a Participating Provider with privileges at the treating hospital assumes responsibility for the Member's care, a Participating Provider assumes responsibility for the Member's care through transfer, HMO's representative and the treating provider reach an agreement concerning the Member's care; or the Member is discharged.

25.3.4 Consistent with 42 CFR §§ 438.114(e), 422.113(c)(2), and 422.214, HMO is financially responsible for payment of post-stabilization care services, following an emergency admission, at the hospital's Medi-Cal FFS payment rates for general acute care inpatient services rendered by a non-contracting, Medi-Cal certified hospital, unless a lower rate is agreed to in writing and signed by the hospital.

25.3.4.1 For the purposes of this Section 25, the Medi-Cal FFS payment amounts for dates of service when the post-stabilization care services were rendered must be the Medi-Cal FFS payment method known as diagnosis-related groups, which for the purposes of this Section 25.3.4 must apply to all acute care hospitals, including public hospitals that are reimbursed under the certified public expenditure basis methodology (W&I Code § 14166 *et seq*.), less any associated direct or indirect medical education payments to the extent applicable.

25.3.4.2 Payment made by HMO to a hospital that accurately reflects the payment amounts required by this Section 25.3.4 shall constitute payment in full, and must not be subject to subsequent adjustments or reconciliations by HMO, except as provided by Medicaid Laws. A hospital's tentative and final cost settlement processes required by 22 CCR § 51536 shall not have any effect on payments made by HMO pursuant to this Section 25.3.4.

25.4 Emergency Services or Post-Stabilization Claims Disputes. Disputed Emergency Services or post-stabilization care services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 3831 North Freeway Blvd, Suite 200, Sacramento, CA 95834, for resolution under W&I Code § 14454 and 22 CCR § 53620 *et seq*. (except 22 CCR § 53698). HMO agrees to abide by the findings of DHCS in such cases, to

promptly reimburse the non-contracting provider within thirty (30) calendar days of the effective date of a DHCS decision and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHCS within thirty (30) calendar days shall result in liability offsets in accordance with W&I Code §§ 14454(c) and 14115.5 and 22 CCR § 53702 and may subject HMO to sanctions pursuant to W&I Code § 14197.7.

[DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.9)]

26. Telehealth. When providing any Covered Services through telehealth and/or subsequently billing for telehealth Covered Services, HMO shall ensure that it complies with all applicable statutory and regulatory requirements, including H&S Code § 1374.13; W&I Code §§ 14132.72, 14132.100, and 14132.725; Business & Professions Code § 2290.5, and DHCS APL 23-007 (and any successor guidance) (collectively "**Telehealth Requirements**"). These Telehealth Requirements include (i) obtaining and documenting Member consent to use telehealth; (ii) ensuring the services can be appropriately delivered via telehealth; (iii) offering telehealth services via in-person, face-to-face interactions, as well, or arranging for referrals and facilitating in-person care so that a Member does not have to independently contact a different Provider; (iv) establishing all new patients through telehealth using an approved methodology; (v) complying with all privacy and confidentiality laws in rendering services; and (vi) satisfying the required documentation and coding requirements, as further outlined in CalOptima Policies. Claims for Covered Services provided through telehealth may not be reimbursable if they do not comply with these Telehealth Requirements.

27. Electronic Prescriptions. HMO shall ensure that any Participating Providers who may issue prescriptions under Business & Professions Code § 4040(a) have the capacity to prescribe electronically and shall issue electronic prescriptions in accordance with Business & Professions Code § 688.

28. Amendment and Termination. HMO agrees to notify DHCS if this Contract or an agreement with a Subcontractor is amended or terminated for any reason. For purposes of this section, notice is considered given when the notice is properly addressed and deposited in the United States Postal Service as first-class registered mail, postage prepaid. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.17); APL 19-001, Attachment A, Requirement 13]

29. Delegated Activities. If HMO is specifically delegated by CalOptima, delegated activities and reporting requirements will be further set forth in a separate attachment or addendum to this Contract. Such delegation may include, claims processing, utilization management, quality improvement, Health Equity activities, credentialing activities, and any other obligation that CalOptima is permitted to delegated to HMO, to the extent agreed upon between CalOptima and HMO. HMO agrees to perform and will require its Subcontractors to perform the obligations and functions of CalOptima undertaken pursuant to the Contract, including but not limited to reporting responsibilities, in compliance with CalOptima's obligations under the DHCS Contract in accordance with 42 CFR § 438.230(c)(1)(ii). HMO agrees to the revocation of the delegated activities and/or obligations, and/or any other specific remedies in instances where DHCS or CalOptima determine that HMO has not performed satisfactorily. If CalOptima delegates quality improvement activities, the Parties agree that the Contract will include provisions that address, at a minimum: (i) quality improvement responsibilities, and specific delegated functions and activities of CalOptima and HMO; (ii) CalOptima's oversight, monitoring, and evaluation processes and HMO's agreement to such processes; (iii) CalOptima's reporting requirements and approval processes, including, HMO's responsibility to report findings and actions taken as a result of the

quality improvement activities at least quarterly; and (iv) CalOptima's actions/remedies if HMO's obligations are not met. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.1, 3.1.5(B.1), (B.8), (B.20), and (B.28); APL 19-001, Attachment A, Requirement 22]

30. Utilization Data. If and to the extent that the HMO is responsible for the coordination of care for Members, CalOptima shall share with HMO, in accordance with the appropriate Declaration of Confidentiality signed by HMO and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and HMO shall receive the utilization data provided by CalOptima and use solely for the purpose of Member care coordination. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.21); APL 19-001, Attachment A, Requirement 23]

31. Medical Decisions. HMO will ensure that medical decisions or any course of treatment in the provision of Covered Services by HMO, Subcontractors, or Downstream Subcontractors are not unduly influenced by fiscal and administrative management. [DHCS Contract, Exhibit A, Attachment III, § 1.1.5]

32. Capacity, Licensure, and Enrollment. HMO and its Subcontractors shall furnish to Medi-Cal Members those Medically Necessary Covered Services that HMO and Subcontractor is authorized to provide under this Contract, consistent with the scope of HMO's and/or Subcontractor's license, certification, and/or accreditation, and in accordance with professionally recognized standards. HMO and its Subcontractors agree to comply with required provider screening, enrollment, and credentialing and recredentialing requirements. HMO warrants that it has and shall maintain through the Term adequate staff to comply with its obligations under the Contract and will require. [DHCS Contract, Exhibit A, Attachment III, § 1.3.3]

33. Medi-Cal Enrollment. If HMO is a provider type that is not able to enroll in Medi-Cal through the DHCS, HMO 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 22 CCR § 51000.35.

34. Prohibition Against Payment to Excluded Providers. HMO agrees that CalOptima is prohibited from contracting with individuals excluded from participation in State or federal programs and agrees that CalOptima shall not pay HMO if HMO is excluded from State or federal programs, as outlined in Sections 3.31 and 5.12 of the Contract. HMO further agrees to not contract with or make payments to Subcontractors excluded from State or federal programs. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.4, 3.3.18]

35. Ownership Disclosure Statement. Prior to commencing services under this Contract, HMO shall provide CalOptima with the disclosures required by 42 CFR §§ 438.608(c)(2), 438.602(c), and 455.105, including the names of the officers and owners of HMO holding more than five percent (5%) of the stock issued by HMO, and major creditors holding more than five percent (5%) of the debt of HMO by completing the form in Attachment B, and HMO shall notify CalOptima whenever changes occur to the information provided therein. HMO shall promptly notify CalOptima of any change in the required disclosures. [DHCS Contract, Exhibit A, Attachment III, § 1.3.5; Exhibit E, § 1.1.11(A.5)]

    35.1 If Participating Provider is not eligible to enroll in Medi-Cal, HMO 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 22 CCR § 51000.35 for its Participating Providers.

36. Performance Improvement Projects. HMO and Subcontractors shall comply with all applicable performance standards and participate in performance improvement projects ("**PIP**s"), including any collaborative PIP workgroups, as may be directed by CMS, DHCS, or CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 2.2.9(A)-(B)]

37. No Punitive Action. CalOptima will not take punitive action against HMO if HMO requests an expedited resolution of or supports a provider or Member appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member (i) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, including any information the Member needs in order to decide among all relevant treatment options; (ii) for the risks, benefits, and consequences of treatment or non-treatment; (iii) for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment; and (iv) to express preferences about future treatment decisions. [DHCS Contract, Exhibit A, Attachment III, §§ 3.2.7, 4.6.5(A)]

38. Claims Processing. CalOptima will process claims in accordance with the DHCS Contract, H&S Code §§ 1371 through 1371.36 and their implementing regulations, and as outlined in the CalOptima Policies. If HMO is responsible for claims payments, HMO will pay claims consistent with this provision. [DHCS Contract, Exhibit A, Attachment III, § 3.3.5]

39. Cost Avoidance/Other Health Coverage. HMO acknowledges that Medi-Cal is a payor of last resort except for services in which Medi-Cal is required to be the primary payer. Accordingly, CalOptima shall not pay claims for services provided to a Member who has third-party coverage without proof that HMO has first exhausted all other payment sources. HMO shall not refuse to provide Covered Services to Members when OHC is indicated in the Member's Medi-Cal eligibility record. HMO shall review the Member's eligibility record for third party coverage, and if the Member has third-party coverage, HMO must notify the Member to seek the service from the third-party coverage. [DHCS Contract, Exhibit E, § 1.1.25(G)]

40. Public Record. Notwithstanding any other term of the Contract, this Contract and all information received in accordance with the DHCS Contract will be public record on file with DHCS, except as specifically provided by Laws. DHCS ensures the confidentiality of information and contractual provisions filed with DHCS to the extent the information and provisions are specifically exempted by Laws. [DHCS Contract, Exhibit A, Attachment III, § 3.1.11]

41. Provider Preventable Condition. CalOptima will not pay for a provider preventable condition as described in 42 CFR § 438.3(g). HMO will ensure it does not pay for provider preventable conditions. [DHCS Contract, Exhibit A, Attachment III, § 3.3.17]

42. Member Rights. HMO and Subcontractors will not retaliate or take any adverse action against a Member for exercising the Member's rights under the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(A.1.r)]

43. Medical Records. All medical records shall be maintained in accordance with CalOptima Policies. HMO shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Subcontractor site. [DHCS Contract, Exhibit A, Attachment III, § 5.2.14]

44. Timely Access/Standards of Accessibility. HMO and Subcontractors will comply with applicable standards of accessibility and timely access requirements as outlined in the Contract and in CalOptima Policies. HMO and Subcontractors will comply with CalOptima's procedures for

monitoring HMO's and Subcontractor's compliance with this section. [DHCS Contract, Exhibit A, Attachment III, § 5.2.5]

45. Minor Consent Services. HMO and its Subcontractors are prohibited from disclosing, and agree not to disclose, any information related to minor consent services without the express consent of the minor Member. HMO and its Subcontractors will comply with CalOptima's requirements for services to minor Members as outlined in the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.8(D)]

46. Emergency Preparedness Requirements. HMO agrees to cooperate with and comply with CalOptima's Emergency requirements, CalOptima Policies, and training to ensure continuity of care for Members during an Emergency. For purposes of this section, "**Emergency**" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by a public health crisis, natural and man-made hazards, or disasters. HMO will (i) annually submit to CalOptima evidence of adherence to CMS Emergency Preparedness Final Rule 81 Fed. Reg. 63859 and 84 Fed. Reg. 51732; (ii) advise CalOptima of HMO's Emergency plan; and (iii) notify CalOptima within twenty-four (24) hours of an Emergency if HMO closes down, is unable to meet the demands of a medical surge or is otherwise affected by an Emergency. [DHCS Contract, Exhibit A, Attachment III, §§ 6.1, 6.1.3(C)]

47. State's Right to Monitor. HMO and Subcontractors shall comply with all monitoring provisions of this Contract, the DHCS Contract, and any monitoring requests by CalOptima and Regulators. 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 HMO's operation for compliance with the provisions of this Contract and Laws. Such monitoring, inspection, or evaluation activities will include inspection and auditing of HMO, Subcontractor, and HMO's and Subcontractors' facilities, management systems and procedures, and books and records, at any time, pursuant to 42 CFR § 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the HMO. Access will be undertaken in such a manner as to not unduly delay the work of the HMO and/or the Subcontractor(s). [DHCS Contract, Exhibit D(f) § 8; Exhibit E, § 1.1.22(B)]

48. Laboratory Testing. HMO agrees that if any performance under this Contract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC § 263a and the regulations thereto. [DHCS Contract, Exhibit D(f), § 18]

49. Third Party Tort Liability. HMO and Subcontractors 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, worker's compensation, class action claims or casualty liability insurance awards and uninsured motorist coverage. HMO 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 that may result in casualty insurance payments, tort liability, Workers' Compensation awards, class action claims, or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under W&I Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9. [DHCS Contract, Exhibit E, §§ 1.1.25 and 1.1.26]

50. 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. HMO's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least seventy-five (75) days prior to the proposed effective date. [Exhibit A, Attachment III, § 5.2.9]

51. Confidentiality of Medi-Cal Members.

51.1 HMO and its Subcontractors shall have policies and procedures in place to guard against unlawful disclosure of protected health information, personally identifying information, and any other Member confidential information in accordance with 45 CFR Parts 160 and 164, Civil Code §§ 1798 *et seq*. HMO and its Subcontractors shall obtain prior written authorization from the Member in order to disclose such information unless exempted by 22 CCR § 51009. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(B)]

51.2 In accordance with 42 CFR § 431.300 *et seq*., as well as W&I Code § 14100.2 and regulations adopted thereunder, HMO and its employees, agents, and Subcontractors shall protect from unauthorized disclosure the names and other identifying information, records, data, and data elements concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to HMO, its employees, and/or agents as a result of services performed under this Contract, except for statistical information not identifying any such persons. HMO and its employees, agents, and Subcontractors shall not use or 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.

51.2.1 HMO and its employees, agents, and Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. HMO may release medical records in accordance with Laws pertaining to the release of this type of information. HMO is not required to report requests for medical records made in accordance with Laws.

51.2.2 With respect to any identifiable information concerning a Member under this Contract that is obtained by HMO or its Subcontractors, HMO will, at the termination or expiration of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the HMO by CalOptima for this purpose.

51.2.3 For purposes of this Section 51.2, identity shall include the name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

[DHCS Contract, Exhibit D(f) § 14; Exhibit E, § 1.1.23]

52. Debarment Certification. By signing this Contract, HMO agrees to comply with applicable federal suspension and debarment regulations, including 2 CFR 180 and 2 CFR 376.

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

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

52.1.2 Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for: (i) 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; (ii) a violation of federal or State antitrust statutes; or (iii) commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

52.1.3 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 Section 52.1.2, above;

52.1.4 Have not within a three (3)-year period preceding the Effective Date had one or more public transactions (federal, state, or local) terminated for cause or default;

52.1.5 Have not, within a three (3)-year period preceding this Contract, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376;

52.1.6 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 Part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

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

52.2 If the HMO is unable to certify to any of the statements in this Section 52, HMO shall submit an explanation to CalOptima prior to the Effective Date and then immediately upon any change in the certifications above during the Term.

52.3 The terms and definitions in this Section 52 not otherwise defined in the Contract have the meanings set out in 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

52.4 If the HMO knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause.

[DHCS Contract, Exhibit (D)(f) § 20]

53. DHCS Directives. If required by DHCS, HMO and its Subcontractors shall cease specified services for Members, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS. [DHCS Contract, Exhibit (D)(f) § 34)]

54. Lobbying Restrictions and Disclosure Certification.

54.1 This Section 54 is applicable to federally funded contracts in excess of one hundred thousand dollars ($100,000) per 31 USC § 1352. If this Section 54 is applicable to the Contract, HMO shall comply with the requirements in this Section 54, as well as complete the disclosure forms in Attachment B prior to the Effective Date.

54.2 Certification and Disclosure Requirements.

54.2.1 If this Contract is subject to 31 USC § 1352 and exceeds one hundred thousand dollars ($100,000) at any tier, HMO shall file the certification and disclosure forms in Attachment E prior to the Effective Date.

54.2.2 HMO shall file a disclosure (in the form set forth in Attachment E, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if HMO has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant that would be prohibited under Section 54.3 if paid for with appropriated funds.

54.2.3 HMO 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 HMO under Section 54.2.2. An event that materially affects the accuracy of the information reported includes:

54.2.3.1 A cumulative increase of twenty-five thousand dollars ($25,000) or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

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

54.2.3.3 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.

54.2.4 Each Subcontractor who requests or receives from HMO or Subcontractor a contract, subcontract, grant, or subgrant exceeding one hundred thousand dollars ($100,000) at any tier under this Contract shall file a certification, and a disclosure form, if required, to the next tier above that Subcontractor.

54.2.5 All disclosure forms (but not certifications) completed under this Section 54.2 and Attachment E shall be forwarded from tier to tier until received by CalOptima. CalOptima shall forward all disclosure forms to DHCS program contract manager.

54.3 Prohibition. 31 USC § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of

any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

[DHCS Contract, Exhibit (D)(f) § 37.b]

55. Air or Water Pollution Requirements. Any federally funded agreement and/or Subcontract in excess of one hundred thousand dollars ($100,000) must comply with the following provisions unless said agreement is exempt by Laws. If applicable, HMO agrees to comply with all standards, orders, or requirements issued under the Clean Air Act (42 USC §§ 7401 *et seq*.), as amended, and the Clean Water Act (33 USC §§ 1251 *et seq*.), as amended. [DHCS Contract, Exhibit (D)(f) § 12]

56. Smoke-Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994, 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 eighteen (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 one thousand dollars ($1,000) for each violation and/or the imposition of an administrative compliance order on the responsible party. HMO shall comply with the applicable requirements of the Pro-Children Act. HMO further agrees that it will insert this certification into any Subcontracts, if required by the Pro-Children Act. [DHCS Contract, Exhibit (D)(f) § 21]

57. Domestic Partners. Pursuant to H&S Code § 1261, if HMO is licensed pursuant to H&S Code § 1250, HMO agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child. [H&S Code § 1261]

58. Conflict of Interest. HMO agrees to avoid conflicts of interest or the appearance of a conflict of interest and shall (i) comply with conflict of interest avoidance requirements of the DHCS Contract; (ii) comply with any conflict avoidance plan issued by CalOptima; and (iii) notify CalOptima within ten (10) calendar days of becoming aware of any potential, suspected, or actual conflict of interest. [DHCS Contract, Exhibit H]

59. DHCS Beneficiary. HMO expressly agrees and acknowledges that (i) DHCS is a direct beneficiary of the Contract and any Subcontractor or Downstream Subcontractor agreement with respect to the obligations and functions undertaken under the Contract; and (ii) DHCS may directly enforce any and all provisions of the Subcontractor agreement or Downstream Subcontractor agreement. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.29)]

60. Employment Non-Discrimination. During the performance of this Contract, neither HMO nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, medical condition, mental disability, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, military and veteran status. HMO and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for

employment are free of such discrimination and shall comply with the provisions of the Fair Employment and Housing Act (Government Code §§ 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 11000 *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code § 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. HMO and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. HMO shall include the non-discrimination and compliance provisions of this Section 60 in all Subcontracts. [DHCS Contract, Exhibit E. § 1.1.28]

60.1 HMO and all Subcontractors shall comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations promulgated under the above-listed statutes. HMO and all Subcontractors shall comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I Code section 14029.91, and State implementing regulations. [DHCS Contract, Exhibit E. §1.1.29]

61. Member Non-Discrimination. Neither HMO nor Subcontractors shall discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, including the statutes identified in Section 60 above. For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; (v) assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, to the Members to be served; (vi) treating a Member or potential Member differently from others in determining whether they satisfy any admission, Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service; (vii) utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination; (viii) failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and (ix) failing to ensure meaningful access to programs and activities for limited English proficiency Members and potential Members.

61.1 HMO shall take affirmative action to ensure all Members are provided Covered Services without unlawful discrimination, except where needed to provide equal access to limited

English proficiency Members or Members with disabilities, or where medically indicated. For the purposes of this Section 61, 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 Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

61.2 HMO shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

61.3 HMO shall require all Participating Providers to cooperate with CalOptima's Member Complaint Policy and time requirements to Appeal within designated time frames.

[DHCS Contract, Exhibit E §1.1.30]

62. Program Integrity and Compliance Program. HMO will establish a robust integrity and compliance program with administrative and management policies and procedures designed to prevent and detect fraud, waste, and abuse in compliance with the requirements of 42 CFR § 438.608. [DHCS Contract, Exhibit A, Attachment III, § 1.3]

63. Key Personnel Changes. HMO will report to CalOptima within ten (10) calendar days any changes in HMO's executive-level personnel, including the chief executive officer, chief financial officer, chief operations officer, the medical director, the chief health equity officer, or the compliance officer and government relations persons. HMO will also report to CalOptima changes in executive-level personnel of any Subcontractors and Downstream Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 1.1.8]

64. Medical Loss Ratio. HMO will comply with all applicable medical loss ratio requirements, including reporting and remittance requirements as required by DHCS and CalOptima. When reporting medical loss ratio, HMO will distinguish which amounts were actually paid for benefits or activities that improve health care quality and which amounts were actually paid for Administrative Services, taxes, or other activities in accordance with the Center for Medicaid and CHIP Services Informational Bulletin published May 15, 2019, with the subject "Medical Loss Ratio Requirements Related to Third-Party Vendors. [DHCS Contract, Exhibit A, Attachment III, § 1.2.5]

65. Federally Qualified Health Centers, Rural Health Centers ("**RHC**"), or Indian Health Services ("**IHS**") Facility.

65.1 HMO will cooperate with and provide to CalOptima any information necessary for CalOptima to meet its obligations to DHCS pertaining to FQHCs and RHCs, including (i) submitting documentation of services provided, reimbursement level, and payment amounts; and (ii) allowing DHCS review and audit of CalOptima's records pertaining FQHC and RHC reimbursement.

65.2 HMO acknowledges and agrees that CalOptima is not required to pay HMO the Medi-Cal per-visit rate for the clinic. The Parties agree that any financial incentive arrangements that HMO and CalOptima enter into will comply with DHCS guidance including DHCS Contract, Attachment III, § 3.3.7(B.7) and applicable APLs.

65.3 To the extent HMO is an Indian Health Services facility that qualifies as an FQHC and RHC; HMO agrees and acknowledges that the terms of this section applicable to FQHCs and RHCs also apply to HMO.

[DHCS Contract, Exhibit A, Attachment III, § 3.3.7(B)]

66. Lead Screening. As applicable, HMO shall ensure the provision of a blood lead screening test to Members at ages and intervals specified in 17 CCR §§ 37000-37100 and applicable APLs. HMO will follow the Childhood Lead Poising in Prevention Branch guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including making referrals to the local public health department. HMO shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's medical record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent or guardian shall be documented in the Member's medical record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's medical record. Documented attempts that demonstrate HMO's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement. [DHCS Contract, Exhibit A, Attachment III, § 5.3.4(D)]

67. Financial Viability. If HMO accepts financial risk for the provision of Covered Services, HMO will comply with CalOptima's system, Laws, and DHCS Contract's requirements to evaluate and monitor HMO's financial viability. [DHCS Contract, Exhibit A, Attachment III, § 3.1.6]

68. Community Reinvestment Plan and Report. On an annual basis, HMO will submit and require that its Fully Delegated Subcontractors and Fully Delegated Downstream Subcontractors submit to CalOptima a Community Reinvestment Plan for DHCS approval in a form and manner specified by DHCS. HMO must commit the following percentage from its annual net income attributable to this Contract to community reinvestment activities: (i) five percent (5%) of the portion of the annual net income that is less than or equal to seven and a half percent (7.5%) of the amount paid under the Contract; and (ii) seven and a half percent (7.5%) of the portion of annual net income that is greater than seven and a half percent (7.5%) of the amount paid under the Contract. HMO will require that its Fully Delegated Subcontractors and Fully Delegated Downstream Subcontractors commit the same percentage of net income attributable to services under this Contract. HMO will provide CalOptima with information necessary for CalOptima to complete its annual Community Reinvestment Report for DHCS submission. Percentages committed to community reinvestment activities will be automatically updated to reflect any updated percentages required by any amendment to the DHCS Contract or DHCS requirements. For purposes of this section "**Community Reinvestment Plan**" means a document outlining the reinvestment activities in local communities. [DHCS Contract, Exhibit A, Attachment III, § 1.2.7; Exhibit B, § 1.1.17(B)]

69. NCQA Accreditation. By January 1, 2026, HMO agrees that it will obtain full NCQA Health Plan Accreditation and Health Equity Accreditation. HMO further agrees that upon full NCQA Health Plan Accreditation and Health Equity Accreditation, it will maintain said accreditation throughout the Term. HMO will provide a copy of HMO's NCQA Health Plan Accreditation and Health Equity Accreditation report to CalOptima within fifteen (15) calendar days from receipt of a completed report from NCQA. HMO further agrees to complete additional NCQA accreditation programs as directed by DHCS or CalOptima and to comply with any corrective actions imposed by DHCS or CalOptima. Failure to comply with these provisions may lead to corrective actions, termination, sanctions, and/or damages. HMO further agrees to ensure Fully Delegated Subcontractors and Fully

Delegated Downstream Subcontractors comply with this provision. [DHCS Contract, Exhibit A, Attachment III, § 2.2.8]

Continued to the August 1, 2024 Board Meeting

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

25. Approve the CalOptima Health Comprehensive Community Cancer Screening and Support Grantees

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Marie J. Jeannis, Executive Director, Equity and Community Health, (714) 246-8591

Recommended Actions

1. Approve CalOptima Health staff recommendation to administer and execute grant agreements and award payments totaling up to $15 million to selected grant recipients (listed in Attachment 2) for the CalOptima Health Comprehensive Community Cancer Screening and Support Community Grants initiative.

Background

In December 2022, the CalOptima Health Board (Board) approved the Comprehensive Community Cancer Screening and Support Program with a reallocation from Intergovernmental Transfer (IGT) 9 funds and an allocation from IGT 10 funds not to exceed $50.1 million, in aggregate, over five years. The goals of the program are to decrease late-stage cancer diagnosis rates, increase early detection through improved awareness and access to cancer screening, and improve quality and member experience during cancer screening and treatment among Medi-Cal members for breast, cervical, colon, and lung cancer (in certain smokers).

In November 2023, the Board approved the Comprehensive Cancer Screening Awareness and Education Campaign for $5.3 million over four years to develop and launch a multimedia, multilingual campaign that ensures a unified and clear message is spread across all residents of Orange County, including CalOptima Health members. The campaign discovery phase launched in January 2024 with internal and external stakeholder input planned throughout February.

Between January and December 2023, as part of the overall program development, CalOptima Health sought input from community stakeholders such as the University of California, Irvine Chao Family Comprehensive Cancer Center, Orange County Cancer Coalition (comprised of 19 organizations), and the Coalition of Orange County Community Health Centers. Stakeholders shared many barriers faced in their efforts to improve cancer awareness, screening access, and member experience throughout cancer treatment.

In February 2024, based on stakeholder input, data analysis, and a review of research and best practices, CalOptima Health staff proposed, and the Board approved, five program initiatives: (i) Community Grants, (ii) Orange County Cancer Screening and Support Collaborative, (iii) Vendor Contracts to Support the Member Journey, (iv) Program Research and Evaluation, and (v) Internal Program Support. Following Board approval, CalOptima Health staff developed and released a notice of funding opportunity (NOFO) to support screening activities that may include costs for capacity building, infrastructure and capital improvements, and care coordination to increase screening and decrease late-stage discovery.

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Discussion
The NOFO was released to the public on February 7, 2024, via distribution lists, press releases, and CalOptima Health's website. CalOptima Health staff facilitated a question and answer (Q&A) session describing the grant application process, funding categories, and applicant eligibility criteria and responded to questions. CalOptima Health posted the Q&A presentation and a frequently asked questions document to the CalOptima Health website. The application period commenced immediately following the Q&A session and remained open until March 29, 2024.

In total, CalOptima Health received and reviewed 27 proposals from 22 organizations totaling $28,568,052, exceeding the $15 million allocated for this round of funding. An internal committee of CalOptima Health representatives from Medical Management, Equity and Community Health, Case Management, and Quality Analytics departments reviewed and scored the submitted proposals; 15 of the proposals received recommendations for full or partial funding. With Board approval, staff would like to proceed with prompt development and execution of grant agreements with the organizations listed in Attachment 2.

Staff will provide oversight of the grants in accordance with CalOptima Health Policy AA.1400: Grant Management and will return to the Board to provide updates on the status of these grants at future meetings.

Fiscal Impact
There is no additional fiscal impact. A previous Board action on February 1, 2024, authorized up to $15.0 million from the Board-allocated $50.1 million for the Comprehensive Community Cancer Screening and Support Program for the first round of community grants. CalOptima Health reserves the right to adjust or recoup funds for lack of demonstrating effort and performance against targeted measures.

Rationale for Recommendation
CalOptima Health is committed to improving cancer screening rates, health outcomes, and member experience. Approving the recommended actions will support improvement of cancer screenings, early cancer diagnosis, and treatment for CalOptima Health members. Staff will bring additional recommendations to the Board for review and approval in the future, including a NOFO and direct contracts for research and evaluation and vendor services to support the member journey.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Organizations Selected for Award and Recommended Amounts
3. Presentation of NOFO Process and Funding Recommendations
4. CalOptima Health Policy AA.1400: Grant Management

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 1, 2022	Authorize Actions Related to the CalOptima Health Comprehensive Community Cancer Screening and Support Program for Medi-Cal Members	5 Years	$50.1 million
February 1, 2024	Approve the CalOptima Health Comprehensive Community Cancer Screening and Support Program Initiatives and Actions to Develop and Release a Notice of Funding Opportunity	2 Years	$15 million (from the previously Board-allocated $50.1 million)

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

Continued to the August 1, 2024 Board Meeting

Attachment to the June 6, 2024, Board of Directors Meeting – Agenda Item 25

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Korean Community Services	451 W Lincoln Ave.	Anaheim	CA	92805
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
Celebrating Life Community Health Center	27800 Medical Center Road, Suite 110	Mission Viejo	CA	92691
mPulse	21255 Burbank Blvd	Los Angeles	CA	91369
UCI Family Health Center	800 N. Main Street	Santa Ana	CA	92701
Hurtt Family Health Clinic	14642 Newport Ave, Suite 300	Tustin	CA	92780
Laguna Beach Community Health Center	362 Third Street	Laguna Beach	CA	92656
Friends of Family Health Center	501 S Idaho St	La Habra	CA	90631
Share Ourselves	20151 SW Birch Street, STE 100	Newport Beach	CA	92660
Families Together of Orange County	661 W. 1st Street	Tustin	CA	92780
Latino Health Access	405 W. 4th Street	Santa Ana	CA	92701
The G.R.E.E.N Foundation	2030 E. Fourth Street, Suite D213	Santa Ana	CA	92705
American Cancer Society, Inc.	270 Peachtree Street, Suite 1300	Atlanta	GA	30303

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CalOptima Health

Attachment to the June 6, 2024 Board of Directors Meeting – Agenda Item 25

CalOptima Health Comprehensive Community Cancer Screening and Support Community Grants - Organizations Selected for Award and Recommended Amounts

Organization	Proposal Description	Score	Requested Amount	Funding Amount
Korean Community Services (KCS)	Incorporate medical providers from KCS and Southland Integrated Services alongside patient navigators from Orange County Asian Pacific Islander Community Alliance, The Cambodian Family, and Vietnamese American Cancer Foundation, to facilitate direct pathways from outreach to clinical service.	92	$3,900,072	$ 3,000,000
AltaMed Health Services Corporation (App. # 1)	Centralize AltaMed's cancer screening programs to identify and address gaps in current breast, cervical, and colon cancer screening; expand scope of patient navigation services for cancer screening in Orange County to help connect members with abnormal results to specialty care; and establish a comprehensive lung cancer screening program.	89	$345,336	$345,336
Celebrating Life Community Health Center (App. #2)	Develop and implement a communication campaign to reach all target demographics; provide community-oriented outreach incorporating lived experience and/or topic expertise; incorporate cancer risk assessments; and strengthen workforce to increase access to equitable and culturally-competent health care services.	89	$1,290,575	$1,290,575
mPulse	Improve general awareness of cancer prevention, increase breast, cervical, colorectal, and lung cancer screening rates, and support members facing cancer through equitable and targeted two-way	87	$1,197,625	$1,197,625

	SMS programs. This program will be designed to identify health action barriers at the individual level and provide tailored/actionable information.			
UCI Family Health Center	In partnership with American Cancer Society and UCI Chao Cancer Institute, improve the rates of breast, cervical, and colorectal cancer screenings and strengthen relationships with imaging and cancer centers to ensure timely screening and follow up; hire additional staff to support expansion of services; and leverage technology to provide timely reminders and linkages to screenings.	87	$1,541,298	$1,500,000
Hurtt Family Health Clinic	Expand patient navigation services, implement a comprehensive outreach strategy, standardized workflows and protocols for Universal Screening, and establish data-driven clinical workflows to optimize patient care and outcomes related to cancer screening and treatment.	85	$ 1,018,600	$ 1,018,600
Laguna Beach Community Health Center	Conduct outreach and education to increase cancer screening among CalOptima Health Members. In addition, LBCC will provide patient navigation and resource support to promote treatment compliance.	84	$116,000	$116,000
AltaMed Health Services Corporation (App. # 2)	Provide outreach and education, encourage timely screening, and provide care navigation support to patients from screening through diagnosis and treatment. In addition, AltaMed plans to enhance electronic health record to improve systems and workflow from screening through diagnosis and treatment.	83	$752,349	$752,349
Friends of Family Health Center (App. # 1)	Expand its Women's Health Program by incorporating on-site mammography services. FOFHC plans to recruit and hire, trained and certified staff to oversee and operate the mammography services offered.	83	$554,875	$554,875
Share Ourselves	Recruit Manager of Population Health and Quality Improvement and Population	83	$362,500	$362,500

	Health Coordinator to strengthen their breast, cervical, and colorectal cancer screening program. This program will focus on cancer screening, outreach, education, care coordination, and patients access to social support and health services.			
Families Together of Orange County (App. # 2)	Provide comprehensive screening services to detect early signs of breast, cervical, and colorectal cancer by: 1) Developing educational, social media and marketing materials informed by local cancer coalitions and committees; 2) Recruiting members for the patient advisory committee and to help identify strategies to educate and increase cancer screenings; 3) Partnering with at least two organizations serving communities of focus to increase access to cancer screening.	82	$3,832,437	$1,500,000
Celebrating Life Community Health Center (App. # 1)	Identify a team-based approach using providers and health information technology to increase awareness, conduct a risk assessment, and complete preventative cancer screenings. This approach also includes the implementation of IT solutions to improve population health, data integration, and ease reporting.	81	$329,428	$329,428
Latino Health Access	Expand Community Health Worker services by recruiting and training a group of promotores to provide breast, cervical, colorectal and lung cancer screening education, navigation, and peer support services and expand partnerships to address barriers to screening access and treatment.	81	$2,255,296	$1,368,806
The G.R.E.E.N Foundation	Bolster cancer prevention education, early detection, treatment, and social support for African American and Black Medi-Cal members. Through tailored approaches, addressing members' concerns and raise their confidence in CalOptima Health's commitment to equitable care to help	81	$295,100	$295,100

	foster stronger relationships with primary care efforts.			
American Cancer Society, Inc.	Increase community outreach, education, and patient service offerings in Orange County and to amplify work with OC health systems to improve enduring adherence to cancer screening guidelines and provide optimal cancer care.	80	$2,011,728	$1,368,806

Continued to the August 1, 2024 Board Meeting

CalOptima Health

Comprehensive Community Cancer Screening and Support Program – NOFO Round 1 Recommended Grantees

Board of Directors Meeting
June 6, 2024

Richard Pitts, D.O., Ph.D., Chief Medical Officer

Our Mission

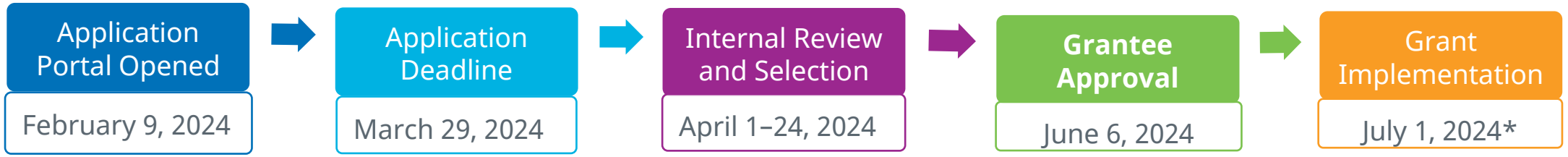
To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

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

Notice of Funding Opportunity (NOFO)

- Up to **$15 million** in grant funding to support activities related to capacity building, infrastructure and capital improvements, and care coordination collaboratives.
- Grants are intended to improve services and supports for Medi-Cal members and at minimum result in the following outcomes:
  - Increase community and member cancer awareness and engagement.
  - Increase access and utilization of cancer screening services.
  - Decrease late-stage cancer discovery.
  - Improve member experience throughout cancer treatment.



Dates subject to change.

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Applications Received

- Received 27 applications from 22 unique organizations totaling $28,568,052 million that spanned the identified funding categories and county.

Funding Categories	Number of Applications	Total Funds Requested
Capacity Building	16	$16,899,357
Care Coordination Collaboratives	4	$5,728,566
Infrastructure and Capital Improvements	7	$5,940,129
Total	**27**	**$28,568,052**

Review Process

- A committee of nine internal staff reviewed, scored and selected the top-scoring applicants.
- Reviewers were selected based on three areas of expertise:
  - Cancer screening program awareness
  - Clinical and quality context
  - Community and equity context
- Each proposal was reviewed and scored on its own merit.
- Proposals were rated on seven criteria identified and published on the NOFO.
- Geographic coverage, location, racial/ethnic population and cancer types were considered when deciding between applicants with similar scope and score.

Evaluation Criteria

Criterion	Maximum Points	Description of Basis for Assigning Points
Alignment with program	Yes/No	• Project aligns with the program goals to increase awareness and access to cancer screening, decrease late-stage cancer diagnosis, and/or improve quality and member experience during cancer screening and treatment procedures.
CalOptima Health's core mission and value alignment	20	• Project improves member health outcomes by addressing health disparities, removing barriers to access, and providing opportunities for more CalOptima Health members to be treated with excellence and dignity.
Decrease late-stage cancer diagnosis	20	• Project demonstrates ability to increase screening as a means to decrease late–stage cancer diagnosis.
Equity	20	• Applicant describes how they will identify and tailor grant activities to meet the needs of the Medi-Cal populations most impacted by cancer.
Project Implementation	20	• Project plan is complete, incorporates evidence-based practices, and includes specific objectives, logical and feasible activities, as well as clearly defined measures of success.
Budget and Financial Management	10	• Project budget is sound and provides details on program plan. • Able to demonstrate strong financial management capacity.
Capacity and Project Readiness	10	• Applicant demonstrates experience in developing programs and interventions for Medi-Cal populations in Orange County. • Projects can be launched soon after the grant award.
Total Possible Points	**100**	

Award Recommendations

- Applications that scored 80 points and above through the competitive scoring process are recommended for a grant award.
- To ensure equitable distribution of funds, review committee recommended:
  - A maximum grant award of $3 million per organization.
  - One grant per category, not to exceed two grants per organization.
  - Maximum allocation per category:
    - Capacity Building: $9 million
    - Care Coordination Collaboratives: $4 million
    - Infrastructure/Capital Improvements: $2 million
- Grant awards are recommended for 15 applications from 13 organizations based on the competitive scoring process and maximum grant award amount.

Recommended Grant Awards

Organization Name	Score	Requested Amount	Recommended Award
Korean Community Services (KCS)	92	$3,900,072	$3,000,000
AltaMed Health Services Corporation (Application # 1)	89	$345,336	$345,336
Celebrating Life Community Health Center (Application # 2)	89	$1,290,575	$1,290,575
mPulse	87	$1,197,625	$1,197,625
UCI Family Health Center	87	$1,541,298	$1,500,000
Hurtt Family Health Clinic	85	$1,018,600	$1,018,600
Laguna Beach Community Health Center	84	$116,000	$116,000
AltaMed Health Services Corporation (Application # 2)	83	$752,349	$752,349
Friends of Family Health Center (Application # 1)	83	$554,875	$554,875
Share Ourselves	83	$362,500	$362,500
Families Together of Orange County (Application # 2)	82	$3,832,437	**$1,500,000**
Celebrating Life Community Health Center (Application # 1)	81	$329,428	$329,428
Latino Health Access	81	$2,255,296	$1,368,806
The G.R.E.E.N Foundation	81	$295,100	$295,100
American Cancer Society, Inc.	80	$2,011,728	$1,368,806

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Applications Not Recommended for Funding

Organization Name	Proposed Program Title
Vista Community Clinic	Improving Cancer Screening and Follow-up in North Orange County
Serve the People Community Health Center	ScreenSmart: Cancer Prevention Program
Families Together of Orange County (Application # 3)	C3 Health Initiative: Cervical, Colorectal and Breast Cancer Screening Program-Care Coordination Collaboratives
Planned Parenthood of Orange and San Bernardino Counties - Melody Health	Increasing early-stage cancer diagnosis across the community through Infrastructure and Capital Improvements
Friends of Family Health Center (Application # 2)	FOFHC - Closing the Gaps in CCS
Cancer Kinship	From Screening to Survivorship: Cancer Kinship's Path to Early Detection and Improved Quality of Life for CalOptima Health Members
North Orange County Regional Foundation	The Family Health Matters VitalCheck Mobile Screening Program
Families Together of Orange County (Application # 1)	C3 Health Initiative: Cervical, Colorectal, and Breast Cancer Screening Program-Infrastructure and Capital Improvements
Camino Health Center	Improving Quality of Life through Cancer Screening Opportunities
Asian American Senior Citizens Service Center	Cancer Awareness, Risk, & Educational Support Program
Southern California Youth Engagement Association (SoCalYEA)	Cancer Awareness and Prevention Program for the Asian and Pacific Islander community, Primarily in Chinese, Korean, and Vietnamese.
Ashtrix inc.	Implementing HealthGuard AI for Cancer initiative

* Applications were not recommended for funding based on collective review score of 80 points and below.

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Recommended Grant Awards

Organization Name	Score	Requested Amount	Recommended Award	Brief Description
Korean Community Services (KCS)	92	$3,900,072	$3,000,000	Incorporate medical providers from KCS and Southland Integrated Services alongside patient navigators from Orange County Asian Pacific Islander Community Alliance, The Cambodian Family, and Vietnamese American Cancer Foundation, to facilitate direct pathways from outreach to clinical service.
AltaMed Health Services Corporation (Application # 1)	89	$345,336	$345,336	Centralize AltaMed's cancer screening programs to identify and address gaps in current breast, cervical, and colon cancer screening; expand scope of patient navigation services for cancer screening in Orange County to help connect members with abnormal results to specialty care; and establish a comprehensive lung cancer screening program.
Celebrating Life Community Health Center (Application # 2)	89	$1,290,575	$1,290,575	Develop and implement a communication campaign to reach all target demographics; provide community-oriented outreach incorporating lived experience and/or topic expertise; incorporate cancer risk assessments; and strengthen workforce to increase access to equitable and culturally-competent health care services.

Recommended Grant Awards (cont.)

Organization Name	Score	Requested Amount	Recommended Award	Brief Description
mPulse	87	$1,197,625	$1,197,625	Improve general awareness of cancer prevention, increase breast, cervical, colorectal, and lung cancer screening rates, and support members facing cancer through equitable and targeted two-way SMS programs. This program will be designed to identify health action barriers at the individual level and provide tailored/actionable information.
UCI Family Health Center	87	$1,541,298	$1,500,000	In partnership with American Cancer Society and UCI Chao Cancer Institute, improve the rates of breast, cervical, and colorectal cancer screenings and strengthen relationships with imaging and cancer centers to ensure timely screening and follow up; hire additional staff to support expansion of services; and leverage technology to provide timely reminders and linkages to screenings.
Hurtt Family Health Clinic	85	$ 1,018,600	$ 1,018,600	Expand patient navigation services, implement a comprehensive outreach strategy, standardized workflows and protocols for Universal Screening, and establish data-driven clinical workflows to optimize patient care and outcomes related to cancer screening and treatment.

Recommended Grant Awards (cont.)

Organization Name	Score	Requested Amount	Recommended Award	Brief Description
Laguna Beach Community Health Center	84	$116,000	$116,000	Conduct outreach and education to increase cancer screening among CalOptima Health Members. In addition, LBCC will provide patient navigation and resource support to promote treatment compliance.
AltaMed Health Services Corporation (Application # 2)	83	$752,349	$752,349	Provide outreach and education, encourage timely screening, and provide care navigation support to patients from screening through diagnosis and treatment. In addition, AltaMed plans to enhance electronic health record to improve systems and workflow from screening through diagnosis and treatment.
Friends of Family Health Center (Application # 1)	83	$554,875	$554,875	Expand its Women's Health Program by incorporating on-site mammography services. FOFHC plans to recruit and hire, trained and certified staff to oversee and operate the mammography services offered.
Share Ourselves	83	$362,500	$362,500	Recruit Manager of Population Health and Quality Improvement and Population Health Coordinator to strengthen their breast, cervical, and colorectal cancer screening program. This program will focus on cancer screening, outreach, education, care coordination, and patients access to social support and health services.

Recommended Grant Awards (cont.)

Organization Name	Score	Requested Amount	Recommended Award	Brief Description
Families Together of Orange County (Application # 2)	82	$3,832,437	$1,500,000	Provide comprehensive screening services to detect early signs of breast, cervical, and colorectal cancer by: 1) Developing educational, social media and marketing materials informed by local cancer coalitions and committees; 2) Recruiting members for the patient advisory committee and to help identify strategies to educate and increase cancer screenings; 3) Partnering with at least two organizations serving communities of focus to increase access to cancer screening.
Celebrating Life Community Health Center (Application # 1)	81	$329,428	$329,428	Identify a team-based approach using providers and health information technology to increase awareness, conduct a risk assessment, and complete preventative cancer screenings. This approach also includes the implementation of IT solutions to improve population health, data integration, and ease reporting.

Recommended Grant Awards (cont.)

Organization Name	Score	Requested Amount	Recommended Award	Brief Description
Latino Health Access	81	$2,255,296	$1,368,806	Expand Community Health Worker services by recruiting and training a group of promotores to provide breast, cervical, colorectal and lung cancer screening education, navigation, and peer support services; develop a bilingual cancer education program inclusive of educational material, community curricula, and other tools to increase community awareness; expand partnerships to address barriers to screening access and treatment; and implement *Juntes Contra el Cancer* pilot to increase direct community engagement, linkages to screening, and peer support.
The G.R.E.E.N Foundation	81	$295,100	$295,100	Bolster cancer prevention education, early detection, treatment, and social support for African American and Black Medi-Cal members. Through tailored approaches, addressing members' concerns and raise their confidence in CalOptima Health's commitment to equitable care to help foster stronger relationships with primary care efforts.
American Cancer Society, Inc.	80	$2,011,728	$1,368,806	Increase community outreach, education, and patient service offerings in Orange County and to amplify work with OC health systems to improve enduring adherence to cancer screening guidelines and provide optimal cancer care.

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Continued to the August 1, 2024 Board Meeting

Policy:	AA.1400
Title:	**Grant Management**
Department:	Strategic Development
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 05/04/2023*
Effective Date:	05/04/2023
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the criteria and expectations to ensure consistency and accountability in managing discretionary Grant funding disbursed by CalOptima Health.

II. POLICY

A. Approach

1. When resources permit, CalOptima Health may designate authorized funds specifically for CalOptima Health Board of Directors (hereinafter, 'Board')-approved Grants to eligible external organizations with the goal of improving the health of CalOptima Health's Members.

2. CalOptima Health shall ensure the distribution of Grant funds is reflective of CalOptima Health's mission, consistent with CalOptima Health's Strategic Plan, any Board-approved fund allocation plan, and/or any funding source legal parameters and funding restrictions. CalOptima Health shall uphold the following tenets when awarding Grants:

   a. CalOptima Health shall consider Proposals from external organizations that provide services for programs or projects aligned with CalOptima Health's mission, Strategic Plan, and/or any Board-approved fund allocation plan and directly serve CalOptima Health Members.

   b. Each Grant application shall receive a thorough, unbiased evaluation and review including an assessment of organizational experience, capacity, fiscal soundness, alignment with CalOptima Health's mission, Strategic Plan, and/or Board-approved fund allocation plan, demonstrated need, benefit to CalOptima Health Members, and feasibility.

   c. CalOptima Health shall strive for timely application approval and payment of award and shall regularly evaluate the application process to identify areas for greater efficiency.

   d. Reporting requirements for Grant awards shall align with section III.B. of this policy and shall be commensurate with the amount of funds being awarded and with the nature of the funding opportunity.

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III. PROCEDURE

A. Pre-Award Assessment:

1. Grant objectives shall be in alignment with organizational strategic priorities.

2. Grant outcomes shall improve or address critical needs of CalOptima Health Members.

B. Award Grant: Establishing Goals and Metrics

1. CalOptima Health will work with Grantees to ensure that all Grants have established one or more goals that direct the use of Grant funds.

2. CalOptima Health will work with all Grantees to ensure that Grants align with one or more metrics signifying the successful accomplishment of its goal or goals. These metrics will be the basis for monitoring and reporting outcomes and successes.

C. Post-Award: Grant Monitoring and Reporting Requirements

1. CalOptima Health Operations department and/or other internal subject matter experts shall monitor a Grantee's compliance and progress towards achieving the goals presented in the Grantee's Proposal by reviewing the Grant Progress Reports.

    a. Unless otherwise specified in the Grant contract, Grantees shall submit semi-annual Grant Progress Reports, detailing Grant activities, along with any required supporting materials.

        i. The format and specific details of the Grant Progress Report shall be mutually agreed upon by CalOptima Health and the Grantee.

    b. The semi-annual Grant Progress Reports may require a breakdown of funding utilization by category as mutually agreed upon by CalOptima Health and the Grantee.

2. CalOptima Health may also utilize Grant Progress Reports to provide updates to CalOptima Health's executives and the CalOptima Health Board about its Grant funding activities.

3. Grantees shall also submit a final closeout report as stipulated in the Grant contract, summarizing the actions taken by the Grantee over the course of the entire Grant contract term.

    a. The final closeout report will include a breakdown by category of the funds used, and a reconciliation to indicate all funds were used according to the intended purpose.

4. As part of CalOptima Health's due diligence, CalOptima Health's designated representative(s) may also elect to conduct site visits to a Grantee's business premises and/or site(s) of Grant-funded service delivery during the Grant contract term for the following actions including, but not limited to:

    a. Meet the Grantee's senior leadership, as well as the Grantee's staff or volunteers with primary responsibility for conducting the funded activities;

    b. Engage in dialogue with the Grantee about progress toward project milestones and objectives, notable successes, implementation challenges, and early lessons learned;

c. Learn of any anticipated requests for scope or budget changes, or no-cost extensions; and

d. See program services/activities first-hand, if applicable and feasible.

5. Grant payments may be delayed or withheld if site visits and/or Grant Progress Reports reveal Grantees are not making sufficient progress towards stated goals or are not meeting other Grant contract requirements.

   a. If sufficient progress is not being made toward Grant contract goals and metrics, CalOptima Health will work with Grantees to understand why metrics were not achieved and work with the Grantee to realign metrics if deemed appropriate.

6. CalOptima Health may conduct audits of the Grantee and/or of the related CalOptima Health operational areas and financial data during the course of the Grant and/or at the conclusion of the Grant.

   a. The audits will be conducted to confirm reported expenditures, performance measures, compliance with key Grant requirements, and other relevant factors as applicable to the specific Grant.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Strategic Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/04/2023	AA.1400	Grant Management	Administrative

IX. GLOSSARY

Term	Definition
Grantee	A recipient of a grant.
Grants	A financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved grant project.
Member	A beneficiary enrolled in a CalOptima Health program.
Proposal	An application submitted to CalOptima Health used to formally request funding for a specific project.
Strategic Plan	CalOptima Health's strategic priorities, objectives, and action plans.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
26. Adopt the Proposed CalOptima Health Board of Directors Meeting Schedule for Fiscal Year 2024-25

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

Recommended Action
Adopt the proposed meeting schedule of the CalOptima Health Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee for the period of July 1, 2024, through June 30, 2025.

Background
Section 5.2(b) of the CalOptima Health Bylaws specifies that the Board of Directors (Board) shall conduct an annual organizational meeting at a regular meeting to be designated in advance by the Board. At the annual organizational meeting, the Board shall:

1. Adopt a schedule stating the dates, times, and places of the Board's regular meetings for the following year.
2. Organize itself by the election of one of its Directors as Chair and one as Vice Chair, and by the election of such other officers as the Board may deem appropriate.

Discussion
The proposed schedule of meetings for the period of July 1, 2024, through June 30, 2025, is as follows:

1. The Board of Directors will meet at 2:00 p.m. on the first Thursday of each month, with the following exceptions:

   - Due to the Independence Day holiday, staff recommends that the Board consider not meeting in July. Should unanticipated items arise during July 2024 that require Board review/approval, the Chief Executive Officer (CEO) will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

   - Due to the New Year's holiday, staff recommends that the Board consider not meeting in January 2025. Should unanticipated items arise during January requiring Board review/approval, the CEO will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

2. The Finance and Audit Committee will meet quarterly at 3:00 p.m. on the third Thursday in the months of September, November, February, and May[1].

3. The Quality Assurance Committee will meet quarterly at 3:00 p.m. on the second Wednesday in the months of October, December, March, and June.

[1] May meeting will occur on the fourth Thursday.

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4. The annual Organizational Meeting will be held at the regular meeting scheduled December 5, 2024.

The meetings of the Board, the Finance and Audit Committee, and the Quality Assurance Committee are held at the CalOptima Health offices located at 505 City Parkway West, 1st Floor, Orange, California, unless notice of an alternate location is provided.

The proposed Fiscal Year (FY) 2024-25 Board of Directors Meeting Schedule is attached.

Fiscal Impact
The fiscal impact for FY 2024-25 Board meetings is up to $18,000 in per diem costs and mileage reimbursement for Board members. Funding is included as part of the proposed CalOptima Health FY 2024-25 Operating Budget pending Board approval.

Rationale for Recommendation
The recommended action will confirm the Board's meeting schedule for the next fiscal year as required in Section 5.2 of the Bylaws.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
1. Proposed Schedule of Meetings of the CalOptima Health Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee – July 1, 2024 through June 30, 2025

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

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Board of Directors Meeting Schedule
July 1, 2024 – June 30, 2025

All meetings are held at the following location, unless notice of an alternate location is provided:

505 City Parkway West
Orange, California 92868

Board of Directors **Monthly – First Thursday** **Meeting Time: 2:00 p.m.**	**Finance and Audit Committee** **Quarterly – Third Thursday** **Meeting Time: 3:00 p.m.**	**Quality Assurance Committee** **Quarterly – Second Wednesday** **Meeting Time: 3:00 p.m.**
July 2024^		
August 1, 2024		
September 5, 2024	September 19, 2024	
October 3, 2024		October 9, 2024
November 7, 2024	November 21, 2024	
December 5, 2024[1]		December 11, 2024
January 2025^		
February 6, 2025	February 20, 2025	
March 6, 2025		March 12, 2025
April 3, 2025		
May 1, 2025	May 22, 2025[2]	
June 5, 2025		June 11, 2025

^No Regular meeting scheduled
[1]Organizational Meeting
[2]4th Thursday

As of May 30, 2024

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
27. Election of Officers of the Board of Directors for terms beginning July 1, 2024

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

Recommended Action
Elect Board of Directors Chair and Vice Chair for terms effective July 1, 2024, through the last day of the month of the next organizational meeting, or until the election of a successor(s), unless the Chair or Vice Chair shall sooner resign or be removed from office.

Background/Discussion
In accordance with Article VIII, Section 8.1 of CalOptima Health's Bylaws, the Board of Directors (Board) shall elect one of its Directors as Chair at an organizational meeting. The Chair shall be the principal officer of the Board, shall preside at all meetings of the Board, and shall appoint all members of the Ad Hoc Committees, as well as the chair of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. The Chair shall perform all duties incident to the office and such other duties as may be prescribed by the Board from time to time.

Section 8.2 of the CalOptima Health Bylaws states that the Board shall elect one of its Directors to serve as Vice Chair at an organizational meeting. The Vice Chair shall perform the duties of the Chair if the Chair is absent from the meeting or is otherwise unable to act.

The Chair and Vice Chair terms shall commence on the first day of the month after the organizational meeting at which they are elected to their respective positions.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended actions are in accordance with Article VIII of the CalOptima Health Bylaws.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Ballot for Election of Chair
2. Ballot for Election of Vice Chair

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

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BOARD OF DIRECTORS' ELECTION OF OFFICERS

FISCAL YEAR 2024-25

VOTING BALLOT

CHAIR

VOTING DIRECTOR'S NAME: _____

- CLAYTON CORWIN ☐
- ISABEL BECERRA ☐
- _____ ☐
- _____ ☐

BOARD OF DIRECTORS' ELECTION OF OFFICERS

FISCAL YEAR 2024-25

VOTING BALLOT

VICE CHAIR

VOTING DIRECTOR'S NAME: _____

- ISABEL BECERRA ☐
- BLAIR CONTRATTO ☐
- VICENTE SARMIENTO ☐
- JOSE MAYORGA, M.D. ☐
- _____ ☐
- _____ ☐

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