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

DECEMBER 7, 2023
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Clayton Corwin, Chair
Blair Contratto, Vice Chair
Debra Baetz
Isabel Becerra
Supervisor Doug Chaffee
Norma García Guillén
José Mayorga, M.D.
Supervisor Vicente Sarmiento
Trieu Tran, M.D.
Vacant
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_4V2bKuvqQWicQDVYF5-wNA and Join the Meeting.
Webinar ID: **826 5533 3282**

Passcode: **007265** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
1. Homeless Housing Incentive Program Grantee Awards

2. CalOptima Health Recognition – Brigette Hoey, Chief Human Resources Officer

MANAGEMENT REPORTS
3. Chief Executive Officer Report

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

CONSENT CALENDAR
4. Minutes
   a. Approve Minutes of the November 2, 2023 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the September 21, 2023 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

5. Authorize and Direct Execution of Amendments to CalOptima Health's New Primary and Secondary Agreements with the California Department of Health Care Services

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

7. Approve Modifications to Policy GA.5002: Purchasing Policy

8. Approve Modifications to CalOptima Health Policy GA.3400: Annual Investments

9. Approve Modifications to CalOptima Health Policy PA.6001: Medical Records Maintenance

10. Approve updates to the CalOptima Health Provider Dispute Resolution Process Effective January 1, 2024, and Impacted Policies MA.9006, MA.9009, HH.1101, FF.2001 and MA.3101

11. Adopt Resolution No. 23-1207-03 Declaring CalOptima Health Employee Handbook as a Guideline Document and Adopt Resolution No. 23-1207-04 Approving and Adopting Updated CalOptima Health Human Resources Policies

12. Adopt Resolution No.23-1207-02 Authorizing the Adoption of the Public Agency Retirement Services (PARS) Trust Agreement and the Appointment of a Plan Administrator

13. Authorize Utilization of a Customized Contract

14. Approve Reappointment to the CalOptima Health Board of Directors' Investment Advisory Committee

15. Authorize Actions Related to the mPulse Vendor Contract

16. Ratify and Authorize Actions Related to the Contract of a Managed Security Service Provider (MSSP) to Manage the LogRhythm Security Incident and Event Monitoring System (SIEM)

17. Ratify and Authorize Actions Related to the Purchase End of Replacement of End of Life Equipment and the Migration from Existing LogRhythm Appliance, Increasing Logging Capacity License

18. Adopt Resolution No. 23-1207-01 to Add Two Additional Seats and Rename One Seat on the CalOptima Health Board of Directors' Member Advisory Committee

19. Receive and File: CalOptima Health Community Outreach and Program Summary

20. Receive and File:
    a. October 2023 Financial Summary
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports

REPORTS/DISCUSSION ITEMS

21. Authorize Adult Expansion Outreach Strategy to Enroll Eligible Adults Ages 26 through 49 into Full-Scope Medi-Cal

22. Approve Actions Related to Workforce Development Strategic Priority

23. Authorize a Contract with Behavioral Health Virtual Visits Vendor

24. Approve CalOptima Health Measurement Year 2024 and Modification to Measurement Year 2023 Medi-Cal and OneCare Pay for Value Programs

25. Approve Actions Related to the Housing and Homelessness Incentive Program for Transitional Housing

26. Approve Actions Related to the Incentive Payment Program for Community Health Worker Academy

27. Approve Actions Related to the Street Medicine Program City Expansion

28. Approve Actions Related to the Homeless Clinic Access Program

29. Approve Amendment to Extend CalOptima Health Public Health Services Contract with the County of Orange and Add Provisions for New CalAIM Services

30. Approve Use of New MOU Templates Mandated by the Department of Health Care Services

31. Approve Contract Amendments to CalOptima Health Fee-for-Service Professional Services and Ancillary Services Provider Contracts, for Cyber Liability Insurance Requirements, and Ownership and Disclosure Requirements

32. Approve Contract Amendments for CalOptima Medi-Cal Health Network Providers Reflecting Cyber Liability Insurance Requirements, New Hospital Referral Procedures, Ownership and Disclosure Requirements, and Pay for Value Performance Program Incentive Payment Requirements

33. Authorize Amendment to CalOptima Health Medi-Cal Fee-for-Service Contract for Long Term Care Facility Services with Alta Newport Hospital, Inc, dba Foothill Regional Medical Center

34. Adopt CalOptima Health Board of Directors Rules of Procedure

35. Election of Officers of the CalOptima Health Board of Directors for Fiscal Year 2023-24

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on December 7, 2023 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_4V2bKuvqQWicQDVYF5-wNA

To **Join** from a PC, Mac, iPad, iPhone or Android device:
https://us06web.zoom.us/s/82655333282?pwd=weI5NMK5cwa97MT9vGDXtfHbkAb9NC.1

Passcode: 007265

Or One tap mobile:
+16694449171,,82655333282#,,,,*007265# US
+17193594580,,82655333282#,,,,*007265# 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: 826 5533 3282
Passcode: 007265

International numbers available: **https://us06web.zoom.us/u/kbfrqFwvW4**

PRESENTATIONS/INTRODUCTIONS

1. Homeless Housing Incentive Program Grantee Awards – Verbal Presentation

Back to Agenda

PRESENTATIONS/INTRODUCTIONS

2. CalOptima Health Recognition – Brigette Hoey, Chief Human Resources Officer – Verbal Presentation

Back to Agenda

MEMORANDUM

DATE:	November 30, 2023
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — December 7, 2023, 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. Medi-Cal Renewal Efforts Continue

CalOptima Health and the County of Orange Social Services Agency (SSA) continue to actively partner on the Medi-Cal renewal process. As I have shared before, data is fluid because members can continue to renew without a gap in coverage for 90 days after their renewal month ends. That said, CalOptima Health data shows that 15% of members due for renewal in the monthly cohorts from June to October are not currently eligible. At the same time, based on continued economic conditions affecting income levels in our community, we are continuing to welcome many new members each month, so our overall membership remains higher than originally planned. For a recent look at California's Medi-Cal enrollment and renewal trends, the Department of Health Care Services (DHCS) released the statewide dashboard with data through September. Our efforts to engage members due for renewal remain steady and strong, ranging from texting and advertising to community outreach and provider engagement. Below are summaries of selected outreach activities from November.

- **Billboard Donation**
  The City of Placentia has generously donated to CalOptima Health the use of its three digital billboards on the 57 freeway to raise awareness about Medi-Cal renewals. The ads ran throughout November in English and Spanish.
- **City Presentations**
  On November 21, CalOptima Health raised awareness about Medi-Cal renewal by visiting the Placentia City Council. I was joined by Supervisor Doug Chaffee and SSA Director An Tran in highlighting renewal efforts and noting that 27% of Placentia residents are CalOptima Health members.

B. CalOptima Health Hosts First Naloxone Community Event

CalOptima Health will hold our first Naloxone Community Event on Saturday, December 2, at our building. We plan to distribute free naloxone to members and offer optional educational presentations in three languages. The Orange County Health Care Agency will also be on-site should a non-member attend and want a free dose of naloxone. Prior to the event, we sent approximately 100,000 text messages to invite members (age 18–69) living within a four-mile radius of our building to attend, ran targeted social media advertising and widely promoted the event by sharing the news with our elected

officials and community-based organizations. We will provide an update about the event at the December 7 Board meeting. As we plan for future events, we will ensure availability across Orange County.

C. California State Auditor Six-Month Update Submitted

On November 2, CalOptima Health submitted to the California State Auditor (CSA) the attached six-month status update on the implementation of CSA's audit recommendations. This is the second of three updates due 60 days, six months and one year after the release of the audit report on May 2, 2023. This document is also being publicly posted on the CalOptima Health website. Following the submission of the 60-day update on July 2, CSA confirmed that CalOptima Health fully implemented three of the seven recommendations relating to grant management, hiring and recruitment, and fraud, waste and abuse policies. I am pleased to share that this six-month update will report that we have implemented three additional recommendations related to reserve funds and non-retaliation policies. Specifically, on September 7, 2023, the Board approved an updated Board-Designated Reserve Funds policy that formalizes processes for the Board to review reserve funds as part of the annual budget/annual financial planning process as well as on an ongoing basis. Also on September 7, 2023, the Board approved an updated Non-Retaliation for Reporting Violations policy that continues this year's annual survey to ensure staff understand how to report noncompliance and feel comfortable doing so. With one other recommendation deemed closed out by legal counsel, no further recommendations are pending implementation. Our Chief Compliance Officer will update the Board when CSA completes its assessment of our six-month response.

D. Managed Care Organization (MCO) Tax May Become to Ballot Measure

As you know, the FY 2023–24 state budget reauthorized the MCO tax to provide additional Medi-Cal funding through December 31, 2026. At the same time, a broad coalition of health care organizations, with the support of CalOptima Health, had been working to negotiate and submit a 2024 ballot initiative that would codify a permanent MCO tax extension with strict funding allocations to support quality and access to care in Medi-Cal. California Attorney General Rob Bonta has officially released the title and summary of the submitted initiative, allowing the coalition to start collecting signatures to qualify for the November 5, 2024, ballot. The title and summary is attached. At this stage, CalOptima Health is now significantly restricted in our coalition participation as a public agency.

E. Federal Government Shutdown Averted (Again!)

This month, both houses of the U.S. Congress passed and Pres. Joe Biden signed into law H.R. 6363: Further Continuing Appropriations and Other Extensions Act, 2024, an additional short-term Continuing Resolution (CR) that further extends Fiscal Year (FY) 2023 federal spending levels through January 19 or February 2, depending on the federal agency (e.g., funding for the U.S. Department of Health & Human Services [HHS] expires on February 2). FY 2023 federal spending had previously been extended via a short-term CR from September 30 through November 17. In addition, H.R. 6363 reauthorizes the Supplemental Nutrition Assistance Program (SNAP) — known as CalFresh in California — through FY 2024, which ends on September 30, 2024. As the new FY 2023 funding expiration dates approach, I will provide further updates regarding the status of final, negotiated FY 2024 federal spending bills.

F. Analysis of 2023 Signed and Vetoed State Legislation

As previously mentioned, on October 13, Gov. Gavin Newsom finished signing or vetoing all legislation passed by the California State Legislature in 2023. Following internal review, staff has prepared the enclosed analysis of signed and vetoed legislation identified for potential impact to CalOptima Health. Next, the California Department of Health Care Services (DHCS) and other state agencies are expected

to issue further guidance on the implementation of signed legislation in the coming months. On January 3, the State Legislature will reconvene from interim recess for the second year of its 2023–24 legislative session.

G. DHCS Publishes New CalAIM Data

DHCS recently published the Enhanced Care Management (ECM) and Community Supports Implementation Update: Data Through Q2 2023. It highlights the continued growth of ECM and Community Supports at the aggregate state level, along with a map showing that Orange County now offers all 14 Community Supports. Statewide, there has been 29% growth in cumulative ECM enrollment and 108% growth in cumulative Community Supports recipients since the end of 2022. This update builds on the previous ECM and Community Supports Year One Report and offers a first look at ECM enrollment for the two Long-Term Care Populations of Focus, which became eligible for ECM in January 2023. DHCS will soon publish a comprehensive report that includes detailed plan-level and county-level ECM and Community Supports data through Q2 2023.

H. White House Releases Social Determinants of Health Playbook

On November 16, The White House released its first-ever U.S. Playbook to Address Social Determinants of Health (SDOH). In coordination with U.S. Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS), this publication aims to help support federal agencies, states, and local and tribal governments to better coordinate medical care, public health and social services. In addition to the primary publication, HHS and CMS have also released several supplemental materials specific to Medicaid coverage of SDOH as well as the use of Community Care Hubs to address SDOH.

I. CEO Michael Hunn Joins California Association of Health Plans (CAHP) Board of Directors

I was honored to be appointed as the newest member of the CAHP Board of Directors, where I will join other Medi-Cal, Medicare and commercial plan leaders to help drive statewide advocacy efforts that improve health outcomes for our members. On November 16, CalOptima Health distributed a press release to the media announcing the board role.

J. CalOptima Health Rolls Out Statewide Equity and Practice Transformation Program

CalOptima Health is participating in the statewide Equity and Practice Transformation (EPT) five-year program that aligns with the DHCS Comprehensive Quality Strategy, Health Equity Roadmap and the 50X2025 Bold Goals. The statewide Directed Provider Payments of $650 million will flow to the providers who are approved to participate in this program. Led by Michael Gomez, Executive Director of Network Operations, CalOptima Health quickly rolled out the key components of this program to our health networks, individual CalOptima Health Community Network providers and the Coalition of Orange County Community Health Centers to ensure requirements and timelines were met. CalOptima Health received seventy-one provider applications. Sixty-two met the program eligibility requirements. CalOptima Health recommended all sixty-two be approved by DHCS.

K. Skilled Nursing Facilities Access Program Addresses Service Gaps

The purpose of CalOptima Health's Skilled Nursing Facilities (SNF) Access Program is to enhance quality through better access and further strengthen the safety net system across Orange County for individuals who require SNF post-hospitalization care. The workgroup has identified gaps in the process and continues to work on mitigating the service gaps. As of November 2023, CalOptima Health has updated a list of barriers to discharge. Fourteen Board and Care (B&C) facilities have been identified to participate in a future pilot program. We currently are seeking contracts with B&C facilities that can

accept members who are not accepted by SNF and Recuperative Care (e.g., unhoused, young age, behavioral health, legal issues, etc.). The Contracting department is also in the process of updating SNF contracts for facilities that can have dialysis on-site. The estimated start date of the revised contracts is December 1, 2023. We recently met with Inland Empire Health Plan to learn about the interventions they use to assist with SNF discharges.

L. OneCare Open Enrollment Comes to Close

CalOptima Health's OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, open enrollment for 2024 began October 15 and ends on December 7. OneCare combines Medicare and Medi-Cal benefits in a single plan and has been serving Orange County since 2005. Members can get supplemental services not covered by Medicare or Medi-Cal at no extra co-pay cost. This year, our Communications team created an outstanding, easy-to-use Enrollment Kit that combines all the necessary information and forms for potential members. The booklets are available in all seven threshold languages. Boosting enrollment into OneCare is a priority, so thank you for helping spread the word about OneCare in Orange County. To be eligible to join OneCare, a member must be:

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

M. CalOptima Health Receives The Eli Home's Humanitarian Award

The Eli Home honored CalOptima Health with its Humanitarian Award at its annual Christmas Ball. Each year, The Eli Home chooses to honor an individual or organization that has made the most significant contribution in the past year or cumulatively to its mission of serving abused and unhoused children and families. CalOptima Health was chosen for recognizing that homelessness is truly a health issue and working to support agencies and projects whose missions align with that acknowledgment. I accepted the award, on behalf of our members, staff, board, and caregivers and presented a ceremonial check for $5 million that The Eli Home will receive as part of the Board's recent approval of the Housing and Homelessness Incentive Program grants.

N. New Medical Management Platform to Go Live in 2024

Progress on implementing CalOptima Health's new clinical documentation platform, known as Jiva (Jee-Va), is on schedule. The workgroup is targeting completion by January 15, 2024, with the go-live date scheduled for February 1, 2024. Jiva is expected to significantly enhance CalOptima Health's service to members. The Jiva team and all business units are collaborating closely with the vendor on configuration, functional testing, quality assurance validation testing, user acceptance testing and staff training to prepare for the February rollout.

O. CalOptima Health Nominated for Two Orange County Business Council Awards

CalOptima Health received two nominations for the Orange County Business Council's (OCBC) 2023 Turning Red Tape Into Red Carpet Awards. In the Public-Private Partnership category, CalOptima Health's CalAIM Workforce Development Program was nominated for our innovative partnership with Chrysalis to enroll our members into a job readiness program for placement and employment at our homeless services delivery sites. Second, we were nominated in the Leadership in Public Service category. Winners will be announced at the awards reception on Wednesday, December 6.

P. Health Literacy for Equity Program Exceeds Staff Participation Goal

Since launching the Health Literacy for Equity Program in partnership with the Institute for Healthcare Advancement (IHA) in May, CalOptima Health has 168 staff participating, exceeding our goal of 100 participants. We anticipate that 30% will complete the training by the end of the year, and we hope to have 100% completion by the end of the grant program in April 2024. In January, IHA will be hosting an inter-agency workshop for communications professionals in collaboration with the Orange County Health Care Agency, County of Orange Social Services Agency and St. Jude's Neighborhood Health Clinic.

Q. Orange County Hispanic Chamber of Commerce Holds Health & Wellness Summit

The Orange County Hispanic Chamber of Commerce held its Health & Wellness Summit in our building on November 16. Board member Dr. Jose Mayorga and I provided welcome remarks, and Chief Health Equity Officer Dr. Michaell Rose presented about the state of Hispanic health in Orange County.

R. Members to Attend CalOptima Health Baby Shower

Our Population Health Management team will host a Medi-Cal member baby shower for new or expectant parents on Friday, December 1 at our building. Thanks to toy donations from staff, children up to age 3 received a toy. The baby shower will also include community resources, free diapers, games and activities.

S. CalOptima Health Gains Media Coverage

Reflecting our ongoing innovation and program development, CalOptima Health received recent positive and valuable media coverage, including the following:

- On October 26, Kelly Bruno-Nelson, MSW, Executive Director, Medi-Cal/CalAIM, was featured on a Tradeoffs podcast on "Growing Pains as California Adds Social Services to Medicaid."
- On October 30, Bruno-Nelson joined Sunday Morning Newsmakers with Larry Marino on KRLA's series "At the Heart of the Homeless Crisis." Listen to Segment 1 here and Segment 2 here.
- On November 2, the Orange County Register included news about CalOptima Health's $2 million contribution to Anaheim's Tampico Motel conversion to affordable housing for young adults.
- On November 15, NPR published an article quoting Bruno-Nelson on the subject of CalAIM services.
- On November 17, I was quoted in the Orange County Register for an article on Medi-Cal's adult expansion starting January 1, 2024. The article also ran in the Mercury News.
- On November 28, the Orange County Register ran a story on our grants for the construction of permanent housing units.

CalOptima Health

Fast Facts
December 2023

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

Membership Data* (as of October 31, 2023)

Total CalOptima Health Membership

969,731

Program	Members
Medi-Cal	951,532
OneCare (HMO D-SNP)	17,757
Program of All-Inclusive Care for the Elderly (PACE)	442

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for four months ended October 31, 2023)

	YTD Actual	YTD Budget	Difference
Revenues	$1,616,176,101	$1,414,821,271	$201,354,830
Medical Expenses	$1,468,149,251	$1,319,139,901	($149,009,350)
Administrative Expenses	$71,778,684	$82,359,797	$10,581,113
Operating Margin	$76,248,166	$13,321,573	$62,926,593
Medical Loss Ratio (MLR)	90.8%	93.2%	(2.4%)
Administrative Loss Ratio (ALR)	4.4%	5.8%	1.4%

Reserve Summary (as of October 31, 2023)

	Amount (in millions)
Board Designated Reserves	$613.9*
Capital Assets (Net of depreciation)	$92.0
Resources Committed by the Board	$622.9
Resources Unallocated/Unassigned	$439.0*
Total Net Assets	$1,767.8

Total of Board designated reserves and unallocated resources can support approximately 92 days of CalOptima Health's current operations.

Total Annual Budgeted Revenue **$4 Billion**

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

CalOptima Health Fast Facts

December 2023

Personnel Summary (as of November 18, 2023, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,307.3	86.6	40.42%	59.58%	7.83%
Supervisor	78	7	71.43%	28.57%	3.56%
Manager	113	10	40.00%	60.00%	8.36%
Director	57	6.5	50.00%	50.00%	15.75%
Executive	21	1	0%	100.00%	7.90%
Total FTE Count	1,576.3	111.1	40.53%	59.47%	8.68%

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

Provider Network Data (as of October 31, 2023)

	Number of Providers
Primary Care Providers	1,260
Specialists	9,053
Pharmacies	553
Acute and Rehab Hospitals	44
Community Health Centers	52
Long-Term Care Facilities	107

Treatment Authorizations (as of September 30, 2023)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	11.41 hours
Prior Authorization – Urgent	72 hours	14.89 hours
Prior Authorization – Routine	5 days	1.64 days

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

Member Demographics (as of October 31, 2023)

Member Age	
0 to 5	8%
6 to 18	24%
19 to 44	35%
45 to 64	20%
65 +	13%

Language Preference	
English	59%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	39%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

CSA Audit Status Update (as of 11/2/23)

Rec #	Recommendation	CalOptima Health Status	CalOptima Health's 6-Month Narrative Response (250 words or less)	CSA Due Date	CSA Status
1	To ensure that it uses its existing surplus funds for the benefit of its members and to comply with county ordinance, ***by June 2024 CalOptima should create and implement a detailed plan to spend*** its surplus funds for expanding access, improving benefits, or augmenting provider reimbursement, or for a combination of these purposes. This plan should be reviewed by its board and approved in a public board meeting.	Fully Implemented	As will be mentioned in response #2, CalOptima Health's (COH) Board of Directors (Board) approved revisions to its Board-Designated Reserve Funds Policy on September 7, 2023. See response #2 for details. As required by the Board-approved policy, reserve spending decisions are being incorporated into COH's current and future annual budgets, as permitted by CSA's comment #4 on COH's response to the audit report. Additionally, management will continue to give the Board and its Finance & Audit Committee (FAC) updates on net asset levels, reserve funds, and the status of Board-approved initiatives on an ongoing basis to provide decision support as needs arise on current and future initiatives. In addition to CEO updates at regular Board meetings, other recent examples of the Board's review of reserves include: • At the May 22, 2023, FAC meeting and June 1, 2023, Board meeting, management presented a net asset analysis providing information on reserve levels as of December 31, 2022, resources committed by the Board, a comparison of reserve levels to other California health plans, and a reserve analysis (Attachment A1). • At the September 7, 2023, Board meeting, the CFO presented a reserve levels update, including additional Board-requested information and a reserve level landscape (Attachment A2). • At its September 21, 2023, meeting, the FAC received a net asset analysis providing information on reserves levels as of June 30, 2023, resources committed by the Board, and a reserve level landscape (Attachment A3). The CFO will provide this report to the FAC on a quarterly basis.	June 2024	TBD
2	To comply with county ordinance and to ensure that in the future it does not accumulate surplus funds in excess of its reserve policy, ***by June 2023 CalOptima should adopt a surplus funds policy or amend its policy for board designated reserves to provide that if surplus funds accrue, CalOptima will use those funds to expand access, improve member benefits, or augment provider reimbursement, or for a combination of these purposes.*** The policy should require that the board review the amount of surplus funds each year when it receives CalOptima's audited financial statements and direct staff to create an annual spending plan subject to the board's approval to use those funds within the next 12 months.	Fully Implemented	On September 7, 2023, CalOptima Health's (COH) Board of Directors (Board) reviewed and determined the appropriate reserve levels as well as approved revisions to its Board-Designated Reserve Funds Policy (Attachment A1). These revisions clarified the Board's governance and oversight on total net assets as well as a review process of reserve levels, while keeping the range of Board-designated reserve funds unchanged at 1.4 months to 2.0 months of consolidated capitation revenues. The policy revisions included: • Reaffirming the Board's discretion on the appropriate reserve level above the minimum threshold, accounting for current and future economic conditions; • Clarifying that the minimum Board-designated reserve fund threshold does not constitute a mandate that the Board draw reserves down to that level; and • Including a new provision stating the Board will review levels of total assets and reserve funds on an annual basis, at a minimum, including an assessment of resources to be used for the purposes identified in County ordinance. Recently, there was a relevant example of the need to continually adjust to current and future economic conditions. For August 2023 monthly capitation, COH did not receive payment from the State until September 25, 2023, which was more than a two-week delay from the usual payment schedule.	June 2023	TBD

Back to Agenda

CSA Audit Status Update (as of 11/2/23)

Rec #	Recommendation	CalOptima Health Status	CalOptima Health's 6-Month Narrative Response (250 words or less)	CSA Due Date	CSA Status
3	To ensure that it can determine whether funds allocated to initiatives intended to improve the health of CalOptima members experiencing homelessness are accomplishing their intended purpose, ***by June 2023 CalOptima should develop a policy*** that requires it to do the following when spending those funds or allocating funds for that purpose in the future: • Establish one or more goals for the use of the funds. • Establish one or more metrics signifying the successful accomplishment of its goals. • Measure progress toward the established metric and provide the board with periodic updates on the effectiveness of its use of funds based on those measurements.	Fully Implemented	*A response was not requested by CSA as this recommendation was considered fully implemented following the previous 60-day response.*	June 2023	Fully Implemented
4	To ensure that members of CalOptima's board do not violate state law by entering into employment contracts made by the board on which they serve, ***by June 2023 CalOptima should amend its bylaws*** to prohibit all CalOptima board members from being employed by CalOptima for a period of one year after their term on the board ends.	Will Not Implement	Government Code Section 1090 already prohibits Board members from being financially interested in any contract made by them, such as entering into a CEO contract. CalOptima Health's Bylaws reiterate that prohibition, as of April 6, 2023, (Attachment A1) which addresses the specific past example raised in the audit report. However, no other agency is required to subject its Board members to a blanket employment prohibition for any position that is not appointed by the Board itself.	June 2023	Will Not Implement
5	To better protect itself from criticism about the objectivity, appropriateness, and transparency of its hiring practices and to help ensure that CalOptima attracts and selects the most qualified candidates, ***by June 2023 CalOptima's board should adopt a policy that governs its hiring processes for all positions, including executive positions.*** Such a policy should incorporate best practices, including the minimum length of time that CalOptima will advertise job openings, the minimum number of qualified candidates CalOptima will interview for each position, and a requirement that it will use the same interview method for each candidate for a position. These steps should be documented for each recruitment.	Fully Implemented	*A response was not requested by CSA as this recommendation was considered fully implemented following the previous 60-day response.*	June 2023	Fully Implemented

Back to Agenda

CSA Audit Status Update (as of 11/2/23)

Rec #	Recommendation	CalOptima Health Status	CalOptima Health's 6-Month Narrative Response (250 words or less)	CSA Due Date	CSA Status
6	To reduce the risk that it does not appropriately evaluate allegations of fraud, waste, and abuse and report them to DHCS, ***by June 2023 the FWA unit should revise its written procedures*** to clearly specify the types of cases that should be addressed through investigations and the types that should be addressed through monitoring activities. In addition, it should establish written procedures for conducting monitoring activities.	Fully Implemented	*A response was not requested by CSA as this recommendation was considered fully implemented following the previous 60-day response.*	June 2023	Fully Implemented
7	To help ensure the maintenance of an atmosphere free from fear of retaliation for reporting misconduct, ***by October 2023 and annually thereafter, CalOptima should conduct or contract for an anonymous survey of staff and contractors*** to determine whether they understand how to make such reports and feel comfortable doing so.	Fully Implemented	CalOptima Health updated policy HH.3012: Non-Retaliation for Reporting Violations (Attachment A5). This policy has been updated to include a requirement for conducting an annual survey for all staff. CalOptima Health's Board of Directors approved the implementation of this policy on September 7, 2023. In addition to the updated policy, CalOptima Health submits the requested completion analysis for the 2023 Best Places to Work Survey launched in March 2023 (Attachment A6).	October 2023	TBD

Back to Agenda

November 13, 2023
Initiative 23-0024 (Amdt. 1)

The Attorney General of California has prepared the following title and summary of the chief purpose and points of the proposed measure:

PROVIDES PERMANENT FUNDING FOR MEDI-CAL HEALTH CARE SERVICES.

INITIATIVE STATUTE. Makes permanent the existing tax on managed health care insurance plans, currently set to expire in 2026, which the state uses to pay for health care services for low-income families with children, seniors, people with disabilities, and other groups covered by the Medi-Cal program. Requires revenues to be used only for specified Medi-Cal services, including primary and specialty care, emergency care, family planning, mental health, and prescription drugs. Prohibits revenues from being used to replace other existing Medi-Cal funding. Caps administrative expenses and requires independent audits of programs receiving funding.

Summary of estimate by Legislative Analyst and Director of Finance of fiscal impact on state and local governments: **Uncertain overall impact on state revenues and spending, including reduced legislative flexibility over the use of MCO tax funds. The extent of this impact depends on whether the measure would result in different state decisions around imposing, structuring, and spending proceeds from the managed care organization tax than in the absence of the measure.** (23-0024A1.)

Back to Agenda

2023 Signed and Vetoed State Legislation

Executive Summary

On October 13, 2023, Governor Gavin Newsom finished signing or vetoing all legislation that had been passed by the California State Legislature in 2023 — the first year of its 2023–24 legislative session, which recessed on September 14.

This *Executive Summary* includes the final outcomes and brief summaries of policy (non-budget) bills that were signed (14) or vetoed (13) by the governor and have been identified for potential impacts to CalOptima Health. In addition, *Full Summaries and Potential Impacts* of the identified legislation are included on subsequent pages.

Bill Number	Bill Title/Summary
SIGNED INTO LAW	
SB 43	**Gravely Disabled:** Expands "gravely disabled" to include a condition resulting from a severe substance use disorder (SUD), or co-occurring mental health disorder and severe SUD, or chronic alcoholism.
SB 311	**Medicare Part A Buy-In:** Requires the California Department of Health Care Services (DHCS) to enter a Medicare Part A buy-in agreement with the Centers for Medicare & Medicaid Services (CMS) that allows DHCS to automatically enroll individuals with a Part A premium into Part A on their behalf.
SB 326	**The Behavioral Health Services Act (BHSA):** If approved by voters on March 5, 2024, would rename the Mental Health Services Act (MHSA) to the BHSA, expand services to address SUDs and revise funding distributions to provide a housing support service.
SB 496	**Biomarker Testing:** Adds biomarker testing, including whole genome sequencing, as a covered Medi-Cal benefit.
SB 525	**Health Care Workers Minimum Wage:** Increases the minimum wage for health care workers through the establishment of multilevel wage schedules for covered health care employers.
SB 770	**Unified Health Care Financing:** Directs the California Health & Human Services Agency (CalHHS) to research, develop and pursue discussions of a waiver framework with the federal government to create a unified health care system that incorporates a comprehensive package of benefits without share of cost.
AB 271	**Homeless Death Review Committee:** Authorizes counties to establish a homeless death review committee to improve coordination and information gathering to identify the causes of homeless deaths.
AB 425	**Pharmacogenomic Testing:** Adds pharmacogenomic testing as a covered Medi-Cal benefit.
AB 531	**The Behavioral Health Infrastructure Bond Act of 2023:** If approved by voters on March 5, 2024, authorizes $6.4 million in bonds for supportive housing and community-based treatment facilities for those experiencing or at risk of homelessness and living with behavioral health challenges.
AB 557	**Brown Act Flexibilities:** Permanently extends Brown Act teleconferencing flexibilities — when a declared state of emergency is in effect — beyond January 1, 2024.
AB 847	**Pediatric Palliative Care Services:** Authorizes extended Medi-Cal coverage for palliative care and hospice services after 21 years of age for individuals deemed eligible prior to that age.
AB 904	**Doula Access:** Requires a health plan to develop a health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas.
AB 1241	**Medi-Cal Telehealth Access:** Requires Medi-Cal telehealth providers to maintain and follow protocols to either offer in-person services or arrange a referral to in-person services.
AB 1481	**Medi-Cal Presumptive Eligibility for Pregnancy:** Extends Medi-Cal presumptive eligibility for pregnant people until an application for full-scope Medi-Cal is approved or denied.

VETOED	
SB 257	**Mammography:** Would have required health plans to cover, without cost sharing, screening mammography and medically necessary diagnostic breast imaging.
SB 694	**Self-Measured Blood Pressure (SMBP) Device Services:** Would have added two SMBP device-related services — patient training and device calibration as well as 30-day data collection — as covered Medi-Cal benefits.
AB 85	**Social Determinants of Health (SDOH) Screenings:** Would have added SDOH screenings as a covered Medi-Cal benefit.
AB 576	**Abortion Reimbursement:** Would have required DHCS to fully reimburse Medi-Cal providers for providing medication to terminate a pregnancy that aligns with clinical guidelines.
AB 608	**Perinatal Services:** Would have required DHCS to cover additional prenatal assessments, individualized care plans and other services during the one-year postpartum Medi-Cal eligibility period.
AB 719	**Public Transit Contracts:** Would have required Medi-Cal plans to contract with public paratransit operators for nonmedical transportation (NMT) and nonemergency medical transportation (NEMT).
AB 907	**PANDAS and PANS:** Would have required health plans 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).
AB 931	**Physical Therapy Prior Authorization:** Would have prohibited health plans from requiring prior authorization for the initial 12 treatment visits for physical therapy.
AB 1060	**Naloxone Hydrochloride:** Would have added prescription and non-prescription naloxone hydrochloride as a covered Medi-Cal benefit for the complete or partial reversal of an opioid overdose.
AB 1085	**Housing Support Services:** Would have required DHCS to transition three Community Supports relating to housing support services to covered Medi-Cal benefits.
AB 1202	**Health Care Services Data for Children, Pregnancy and Postpartum:** Would have required DHCS to conduct an analysis to ensure compliance with Medi-Cal time and distance standards for pediatric primary care.
AB 1288	**Medication-Assisted Treatment Prior Authorization**: Would have prohibited 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.
AB 1451	**Urgent and Emergency Mental Health and SUD Treatment:** Would have required health plans to cover treatment for urgent and emergency mental health and SUDs without preauthorization.

DHCS and/or other state agencies are expected to issue further guidance regarding the implementation of signed legislation. Staff will monitor developments and share any updates from DHCS that may impact CalOptima Health.

On January 3, 2024, the California State Legislature will reconvene from interim recess for the second year of its 2023–24 legislative session.

[Continued]

Full Summaries and Potential Impacts

Bill Number Author	Bill Summary/Impact	Bill Status	Position/Notes
SIGNED INTO LAW			
SB 43 Eggman	**Gravely Disabled Definition:** Effective January 1, 2026, expands the definition of "gravely disabled" to include a condition resulting from a severe SUD, or a co-occurring mental health disorder and a severe SUD, as well as chronic alcoholism. Also requires DHCS to submit a report to include the number of persons admitted or detained for grave disability. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health Medi-Cal members newly considered as gravely disabled.	**10/10/2023** Signed into law	CalOptima Health: Watch
SB 311 Eggman	**Medicare Part A Buy-In:** Requires DHCS to submit a Medicaid state plan amendment to enter into a Medicare Part A buy-in agreement with CMS, effective January 1, 2025, or DHCS's readiness date, whichever is later. This will allow DHCS to automatically enroll individuals with a Part A premium into Part A on their behalf. ***Potential CalOptima Health Impact:*** Simplified Medicare enrollment and increased financial stability for dual-eligible CalOptima Health members with Part A premium requirements.	**10/10/2023** Signed into law	CalOptima Health: Watch LHPC: Support CalPACE: Support
SB 326 Eggman	**The Behavioral Health Services Act (BHSA):** Places this act on the March 5, 2024, statewide primary election ballot. If approved by voters, would rename the Mental Health Services Act (MHSA) to the BHSA, expand services to include SUDs, revise the distribution of up to $36 million for behavioral health workforce funding and remove provisions related to innovative programs by, instead, establishing priorities and a program — administered by counties — to provide a housing support service. ***Potential CalOptima Health Impact:*** Increased resources and access to behavioral health services and housing interventions for CalOptima Health members.	**10/12/2023** Signed into law	CalOptima Health: Watch
SB 496 Limón	**Biomarker Testing:** No later than July 1, 2024, adds biomarker testing — subject to utilization management controls — including whole genome sequencing, as a covered Medi-Cal benefit for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a disease or condition to guide treatment decisions, if the test is supported by medical and scientific evidence, as prescribed. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**10/07/2023** Signed into law	CalOptima Health: Watch CAHP: Oppose Unless Amended

Bill Number Author	Bill Summary/Impact	Bill Status	Position/Notes
SB 525 Durazo	**Health Care Workers Minimum Wage:** Establishes three separate minimum wage schedules for covered health care employers, including integrated health care delivery systems; health care systems; dialysis clinics; health facilities owned, affiliated, or operated by a county; licensed skilled nursing facilities; and clinics that meet certain requirements. ***Potential CalOptima Health Impact:*** Increased direct wage costs for certain CalOptima Health PACE employees to be incorporated into DHCS rates; increased indirect costs from contracted providers subject to wage increases.	**10/13/2023** Signed into law	CalOptima Health: Watch
SB 770 Wiener	**Unified Health Care Financing System:** Directs the CalHHS Secretary to research, develop and pursue discussions of a waiver framework with the federal government to create a health care system that incorporates a comprehensive package of medical, behavioral health, pharmacy, dental and vision benefits, without a share of cost for essential services. No later than January 1, 2025, the Secretary must submit an interim report to the Legislature, including proposed statutory language to authorize submission of a waiver application. No later than June 1, 2025, a draft waiver framework must be completed and made available to the public for a 45-day public comment period. No later than November 1, 2025, the finalized waiver framework must be submitted to the governor and Legislature for review. ***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.	**10/07/2023** Signed into law	CalOptima Health: Watch
AB 271 Quirk-Silva	**Homeless Death Review Committee:** Authorizes counties to establish a homeless death review committee for the purpose of gathering information to identify the root causes of the deaths of homeless individuals and to determine strategies to improve coordination of services for the homeless population. ***Potential CalOptima Health Impact:*** Increased coordination and data review between the County of Orange and CalOptima Health.	**09/01/2023** Signed into law	**03/02/2023** CalOptima Health: SUPPORT
AB 425 Alvarez	**Pharmacogenomics Advancing Total Health for All Act:** Effective July 1, 2024, adds pharmacogenomic testing as a covered Medi-Cal benefit, defined as laboratory genetic testing to identify how an individual's genetics may impact the efficacy, toxicity and safety of medications. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**10/07/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary/Impact	Bill Status	Position/Notes
AB 531 Irwin	**The Behavioral Health Infrastructure Bond Act of 2023**: Places this bond act on the March 5, 2024, statewide primary election ballot. If approved by voters, would authorize $6.4 million in bonds to fund conversion, rehabilitation or new construction of supportive housing and community-based treatment facilities for those experiencing or at risk of homelessness and living with behavioral health challenges. ***Potential CalOptima Health Impact***: Increased behavioral health services and community supports for some CalOptima Health members.	**10/12/2023** Signed into law	CalOptima Health: Watch
AB 557 Hart	**Brown Act Flexibilities**: Permanently extends current Brown Act teleconferencing flexibilities — when a declared state of emergency is in effect — beyond January 1, 2024. Also extends the period for a legislative body to make findings related to a continuing state of emergency from every 30 days to every 45 days. ***Potential CalOptima Health Impact:*** Extended teleconferencing flexibilities for Board and advisory committee meetings.	**10/08/2023** Signed into law	CalOptima Health: Watch
AB 847 Rivas, L.	**Pediatric Palliative Care Services**: Authorizes extended Medi-Cal coverage for palliative care and hospice services after 21 years of age for individuals deemed eligible prior to that age. ***Potential CalOptima Health Impact:*** Expanded covered benefit for certain CalOptima Health Medi-Cal members.	**10/13/2023** Signed into law	CalOptima Health: Watch
AB 904 Calderon	**Doula Access**: Beginning January 1, 2025, requires a health plan to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. ***Potential CalOptima Health Impact:*** Increased access to prenatal care for eligible CalOptima Health Medi-Cal members; additional provider contracting and credentialing; additional staff time for program management.	**10/07/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary/Impact	Bill Status	Position/Notes
AB 1241 Weber	**Medi-Cal Telehealth Access:** Requires Medi-Cal telehealth providers to maintain and follow protocols to either offer in-person services or arrange a referral to in-person services. However, this does not require a provider to schedule an appointment with a different provider on behalf of a patient. ***Potential CalOptima Health Impact:*** Continued flexibility to access in-person, video and audio-only health care services for CalOptima Health Medi-Cal members.	**09/08/2023** Signed into law	CalOptima Health: Watch
AB 1481 Boerner	**Medi-Cal Presumptive Eligibility for Pregnancy**: Expands Medi-Cal presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). If an application for full-scope Medi-Cal benefits is submitted between the date of a PE4PP determination and the last day of the subsequent month, PE4PP coverage will be effective until the Medi-Cal application is approved or denied. ***Potential CalOptima Health Impact:*** Improved Medi-Cal enrollment process and timelier access to covered benefits for eligible pregnant individuals.	**10/07/2023** Signed into law	CalOptima Health: Watch
VETOED			
SB 257 Portantino	**Mammography:** Beginning January 1, 2025, would have required health plans to cover, without cost sharing, screening mammography and medically necessary diagnostic breast imaging, including following an abnormal mammography result and for individuals with a risk factor associated with breast cancer. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed due to high costs that exceed provisions under the Affordable Care Act (ACA). Breast cancer screenings are already covered for those ages 40–74 (see full veto message).	CalOptima Health: Watch CAHP: Oppose
SB 694 Eggman	**Self-Measured Blood Pressure (SMBP) Devices and Services**: Would have added two SMBP device-related services — patient training and device calibration as well as 30-day data collection — as covered Medi-Cal benefits to promote the health of beneficiaries with high blood pressure (hypertension) or another diagnosis that supports the use of an at-home blood pressure monitor. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed due to high costs that were not included in the Fiscal Year (FY) 2024 state budget (see full veto message).	CalOptima Health: Watch CalPACE: Support

Back to Agenda

Bill Number Author	Bill Summary/Impact	Bill Status	Position/Notes
AB 85 Weber	**SDOH Screenings**: Would have added SDOH screenings as a covered Medi-Cal benefit. Would have also required health plans to provide primary care providers with adequate access to community health workers, social workers and peer support specialists. Would have also required Federally Qualified Health Centers and Rural Health Clinics to be reimbursed for these services at the Med-Cal fee-for-service (FFS) rate. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed due to existing investments to improve SDOH, such as Adverse Childhood Experiences (ACEs) screenings and CalAIM (see full veto message).	CalOptima Health: Watch CAHP: Oppose
AB 576 Weber	**Abortion Reimbursement**: Would have required DHCS to fully reimburse Medi-Cal providers for providing medication to terminate a pregnancy that aligns with clinical guidelines, evidence-based research and provider discretion. ***Potential CalOptima Health Impact:*** Increased financial stability for eligible CalOptima Health contracted providers.	**10/07/2023** Vetoed due to duplication of elements from the July 2023 updated policies for medication abortions (see full veto message).	CalOptima Health: Watch
AB 608 Patterson	**Perinatal Services**: Would have required DHCS to cover additional perinatal assessments, individualized care plans and other services during the one-year postpartum Medi-Cal eligibility period at least proportional to those available during pregnancy and the initial 60-day postpartum period. DHCS would have been required to collaborate with the California Department of Public Health (CDPH) and stakeholders to determine the specific levels of additional coverage. Would have also allowed perinatal services to be rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site. Lastly, would have allowed such workers to be supervised by a community-based organization or local health jurisdiction. ***Potential CalOptima Health Impact:*** Expanded covered benefit and associated provider network for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed due to duplication of elements. Medi-Cal already provides full-scope coverage for one year after pregnancy as well as the introduction of the "Birthing Care Pathway" proposal to improve services during the perinatal period (see full veto message).	CalOptima Health: Watch
AB 719 Boerner	**Public Transit Contracts**: Would have required Medi-Cal managed care plans to contract with public paratransit operators for NMT and NEMT services. Would have required reimbursement to be based on the Medi-Cal FFS rates for those services. ***Potential CalOptima Health Impact:*** Execution of additional NMT and NEMT contracts; increased transportation options for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed due to such services not being currently allowable under federal guidance (see full veto message).	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose

Bill Number Author	Bill Summary/Impact	Bill Status	Position/Notes
AB 907 Lowenthal	**PANDAS and PANS**: Beginning January 1, 2024, would have required 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. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed due to duplication of existing laws for timely access standards and grievances; also removes medical necessity, which is a standard condition for health plans (see full veto message).	CalOptima Health: Watch CAHP: Oppose
AB 931 Irwin	**Physical Therapy Prior Authorization**: Beginning January 1, 2025, would have prohibited health plans from requiring prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. ***Potential CalOptima Health Impact:*** Modified utilization management procedures for a covered Medi-Cal benefit.	**10/07/2023** Vetoed due to absence of policy oversight and unintentional costs (see full veto message).	CalOptima Health: Watch CAHP: Oppose
AB 1060 Ortega	**Naloxone Hydrochloride**: Would have added prescription and non-prescription naloxone hydrochloride or another drug approved by the U.S. Food and Drug Administration as a covered benefit under the Medi-Cal program for the complete or partial reversal of an opioid overdose. ***Potential CalOptima Health Impact:*** New Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed due to exceeding essential health benefits under the ACA and increasing General Fund costs (see full veto message).	CalOptima Health: Watch CAHP: Oppose Unless Amended
AB 1085 Maienschein	**Housing Support Services**: Would have required DHCS, if the state has sufficient network capacity, to add housing support services as a covered Medi-Cal benefit for individuals experiencing or at risk of homelessness, consistent with the following Community Supports offered through CalAIM: • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services ***Potential CalOptima Health Impact:*** Formalization of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed due to duplication of forthcoming elements within CalAIM transitional rent starting in 2024-25; additional costs need to be considered as part of the state's budget (see full veto message).	CalOptima Health: Watch CalPACE: Support

Back to Agenda

Bill Number Author	Bill Summary/Impact	Bill Status	Position/Notes
AB 1202 Lackey	**Health Care Services Data for Children, Pregnancy and Postpartum:** No later than January 1, 2025, would have required DHCS to report to the Legislature the results of an analysis to identify the number and geographic distribution of Medi-Cal providers needed to ensure compliance with time and distances standards for pediatric primary care. The report would have also included data on the number of children, pregnant and postpartum individuals receiving certain Medi-Cal services. ***Potential CalOptima Health Impact:*** Increased network analysis and reporting to DHCS.	**10/08/2023** Vetoed due to duplicative reporting standards for existing DHCS efforts (see full **veto message**).	CalOptima Health: Watch
AB 1288 Reyes	**Medication-Assisted Treatment Prior Authorization**: Would have prohibited 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 utilization management procedures for a covered Medi-Cal benefit.	**10/08/2023** Vetoed due to duplicative efforts already in place. (see full **veto message**).	CalOptima Health: Watch CAHP: Oppose
AB 1451 Jackson	**Urgent and Emergency Mental Health and SUD Treatment:** By January 1, 2024, would have required health plans to provide coverage for the treatment of urgent and emergency mental health and SUDs without prior authorization. ***Potential CalOptima Health Impact***: Increased scope of and/or modified utilization management procedures for behavioral health services provided to CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed due to duplication of services already available; additional costs need to be considered as part of the state's budget (see full **veto message**).	CalOptima Health: Watch

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

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

November 2, 2023

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on November 2, 2023, 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 Director Jose Mayorga, M.D., led the Pledge of Allegiance.

ROLL CALL

Members Present: Clayton Corwin, Chair; Blair Contratto, Vice Chair; Debra Baetz (non-voting); Isabel Becerra; Norma García Guillén; Jose Mayorga, M.D.; Supervisor Vicente Sarmiento; Trieu Tran, M.D.

(All Board members in attendance participated in person)

Members Absent: Supervisor Doug Chaffee

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 for the record that an attachment that should have been included for Consent Calendar Agenda Item 5 was not in the meeting materials and would be included in the archived materials following the meeting. The Clerk also noted for the record that staff is continuing Agenda Item 15 due to a lack of a voting quorum.

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Michael Hunn, Chief Executive Officer, reviewed the Fast Facts data, and noted an error in the Operating Margin Difference column, which showed $278,860,214 and should have shown $37,439,172. Mr. Hunn noted that the error would be corrected in the archived materials following the meeting. Mr. Hunn reported that CalOptima Health currently serves 979,148 individuals. CalOptima Health spends 91.4% of every dollar on medical care, and 4.4% is the overhead cost to administer the program.

CalOptima Health's Board-designated reserves are $580.5 million; its capital assets are $91.1 million; its resources committed by the Board are $596.5 million; and its unallocated and unassigned resources are $461.7 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $1.7 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 6.32% as of the October 21, 2023, pay period.

Back to Agenda

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 over 10,346 providers, 1,300 primary care providers, and 9,046 specialists; 553 pharmacies; 44 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 August 31, 2023. For urgent inpatient treatment authorizations, the average approval is within 12.39 hours; the state-mandated response is 72 hours. For urgent prior authorizations, the average approval is within 14.41 hours; the state-mandated response is 72 hours. And for routine prior authorizations, the average approval is 1.59 days; the state-mandated response is 5 days.

Mr. Hunn updated the Board on CalOptima Health's six-month update to the auditors regarding the California State Audit (CSA). He noted that the full update will be posted on CalOptima Health's website following its submission to CSA.

Mr. Hunn provided updates to the Board on several other topics, which included: Behavioral Health Access; the Federal Earmark Notice of Award for CalOptima Health's Care Traffic Control Command Center; an InfoSeries held on October 19, 2023 to inform health care professionals and stakeholders about opioid poisoning and CalOptima Health's plans for naloxone distribution; Workforce Development listening sessions; BeWell OC Irvine campus groundbreaking ceremony; the Salvation Army Center of Hope Grand Opening celebration and other updates.

Mr. Hunn responded to Board member comments and questions.

PUBLIC COMMENTS

1. William Manalo, ShuttleMED Medical, Oral re: Non-Medical Transportation.
2. Matthew Sprowls, Wellnet Medivan Transportation, Oral re: Non-Medical Transportation.
3. Arthur Lim, MedLink Medical Transport, Inc.; Oral re: Non-Medical Transportation.

CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the October 5, 2023 Regular Meeting of the CalOptima Health Board of Directors
b. Receive and File Minutes of the June 14, 2023 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

Chair Corwin and Supervisor Sarmiento abstained from voting on this item as they were both absent at the October 5, 2023, Board meeting.

3. Approve Appointment to the CalOptima Health Board of Directors' Investment Advisory Committee

4. Approve CalOptima Health's Calendar Year 2024 Member Health Rewards

Back to Agenda

5. Approve Actions Related to the Comprehensive Community Cancer Screening and Support Program

Supervisor Sarmiento commented that he is supportive of Agenda Item 5 regarding the community cancer screening support program and wanted to note the importance of CalOptima Health's campaign being culturally competent to its target audiences.

6. Ratify Amendments to CalOptima Health's Primary and Secondary Medi-Cal Agreements with the California Department of Health Care Services Related to Rate Changes

7. Ratify CalOptima Health's Agreement for Disclosure and Use of the Department of Health Care Services Data (2023 Post-Expiration Data Use Agreement (DUA)) and 2024 Operational Readiness (OR) DUA with the California Department of Health Care Services

8. Approve Modifications to Policy GA.5004: Travel and Other Reimbursable Expenses

9. Approve New CalOptima Health Policy GA.7111 Health Network Certification Process

10. Receive and File:

a. September 2023 Financial Summary
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Community Outreach and Program Summary

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 2 through 10, as presented, with Chair Corwin and Supervisor Sarmiento abstaining on Agenda Item 2. (Motion carried 7-0-0; excepted as noted above for Agenda Item 2; Supervisor Chaffee absent)***

REPORTS/DISCUSSION ITEMS

11. Approve Policy for Election of Officers

Vice Chair Contratto introduced the item noting that the Board Governance Ad Hoc Committee met three times and thanked Director Becerra and Supervisor Sarmiento for their participation and thoughtful discussion. Vice Chair Contratto also thanked Outside General Counsel James Novello for his guidance during the meetings. Vice Chair Contratto added that the discussions also included possible rules of procedure for the CalOptima Health Board to consider in addition to the policy being proposed today for the Election of Officers.

Supervisor Sarmiento thanked Vice Chair Contratto and Director Becerra for the robust discussion.

Director Mayorga recommended that the Chair and Vice Chair terms change from fiscal year to calendar year.

Back to Agenda

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors Approved policy for election of officers. (Motion carried; 7-0-0; Supervisor Chaffee absent)***

12. Election of Officers of the Board of Directors for Fiscal Year 2023-24

After considerable discussion, the Board continued this item to the December 7, 2023, Board meeting with the current Chair and Vice Chair serving until that meeting.

Action: ***On motion of Chair Corwin, seconded and carried, the Board of Directors continued this item to the December 7, 2023, meeting so that the Board could apply the policy it approved under Agenda Item 11 and also made a motion to extend the terms of the current Chair and Vice Chair until the December 7, 2023 meeting. (Motion carried; 7-0-0; Supervisor Chaffee absent)***

13. Approve Actions Related to the New Clinical Care Management System (ZeOmega Inc.)

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to make the following contract changes: a.) Execute a contract amendment with Ironwood Health, LLC (Ironwood Health) to expand the scope of work to provide continued consultation and support through implementation of CalOptima Health's new care management system, Jiva, provided by ZeOmega, Inc. (ZeOmega); b.) Execute a contract amendment with ZeOmega to expand the scope of work to add a data replication environment to the contract; c.) Authorized staff to execute a contract with Healthwise, Incorporated (Healthwise) to provide clinical member education and material integrated within the new care management system; and d.) Authorized the Chief Executive Officer to execute a contract amendment with HealthEdge Software, Inc. (HealthEdge) to expand the scope of work to provide read only access to the current HealthEdge care management system, Guiding Care, and extend the contract through June 30, 2025; 2.) Authorized unbudgeted expenditures and appropriate funds in an amount up to $700,000 from the Digital Transformation and Workplace Modernization Reserve (DTS Reserve) for the Fiscal Year (FY) 2023-24 Digital Transformation Year Two Capital Budget to fund: a.) Up to $350,000 to fund the contract amendment with Ironwood Health; and b.) Up to $350,000 to fund the extended ZeOmega care management system implementation and providing additional system functionality enhancement to support the clinical and regulatory requirements for CalOptima Health; 3.) Authorized unbudgeted expenditures and appropriate funds in an amount up to $880,000 from the DTS Reserve to the FY 2023-24 Digital Transformation Year Two Operating Budget to fund: a.) Up to $320,000 to fund the contract amendment with ZeOmega; b.) Up to $140,000 to fund the contract with Healthwise; and c.) Up to $420,000 to fund the contract amendment with HealthEdge. (Motion carried;7-0-0; Supervisor Chaffee absent)***

Back to Agenda

14. Authorize Payments to Health Networks for Fiscal Years 2017-18 through 2019-20 Medi-Cal Shared Risk Pools

Supervisor Sarmiento did not participate in this item due to potential conflicts of interest under the Levine Act.

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: 1.) Authorized adjustments to eligible Health Networks for Fiscal Years 2017-18 through 2019-20 Medi-Cal shared risk pool settlements; and 2.) Authorized unbudgeted expenditures in an amount up to $2.6 million from existing reserves to fund the Medi-Cal shared risk pool payments to eligible Health Networks. (Motion carried; 6-0-0; Supervisor Sarmiento recused; Supervisor Chaffee absent)***

15. Approve Updates to the CalOptima Health Provider Dispute Resolution Process Effective January 1, 2024, and Impacted Policies MA.9006, MA.9009, HH.1101, FF.2001 and MA.3101

This item was continued to a future meeting due to a lack of a voting quorum.

16. Adopt Resolution No. 23-1102-01 Approving and Adopting Updated CalOptima Health Human Resources Policies

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: 1.) Adopted resolution No. 23-1102-01 approving updated CalOptima Health policies: a.) GA.8018: Paid Time Off (PTO; b.) GA.8027: Harassment, Discrimination, and Retaliation Prevention; c.) GA.8038: Personal Leave of Absence; d.) GA.8041: Workers' Compensation Program; e.) GA.8044: Telework Program; f.) GA.8051: Hiring of Relatives; and 2.) Authorized unbudgeted expenditures in an amount up to $740,000 from existing reserves to fund revisions to GA.8018: Paid Time Off. (Motion carried; 7-0-0; Supervisor Chaffee absent)***

17. Approve New Medi-Cal Long Term Care Facility Services Contract Template for Intermediate Care Facility Services

Action: ***On motion of Director Mayorga, seconded and carried, the Board of Directors Approved new Medi-Cal Long Term Care (LTC) Facility Services Contract template for the LTC Intermediate Care Facility/Home for Individuals with Developmental Disabilities Program (ICF/DD), effective January 1, 2024. (Motion carried; 7-0-0; Supervisor Chaffee absent)***

ADVISORY COMMITTEE UPDATES

18. Regular Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee Update.

Jena Jensen, Chair of the Provider Advisory Committee, provided an update on the recent activities of the Member Advisory Committee and the Provider Advisory Committee.

Back to Agenda

Chair Corwin reordered the agenda to hear Board Member Comments and Board Committee Reports prior to adjourning to Closed Session.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Becerra thanked CalOptima Health staff for all the changes and the transparency with regard to the officer elections.

Vice Chair Contratto thanked Mr. Hunn for the thoughtful comments to the auditors regarding the California State Audit.

CLOSED SESSION

The Board adjourned to Closed Session at 3:50 p.m. CS-1: Pursuant to Government Code Section 54957(b)(1): PERFORMANCE REVIEW OF CHIEF EXECUTIVE OFFICER MICHAEL HUNN and CS-2: CONFERENCE WITH LEGAL COUNSEL – STRATEGY ON EXISTING LITIGATION Pursuant to Government Code Section 54956.9(d)(1).

The Board reconvened to open session at 4:52 p.m. with no reportable actions taken.

ADJOURNMENT

Hearing no further business, Chair Corwin adjourned the meeting at 4:53 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: December 7, 2023

Back to Agenda

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

September 21, 2023

A Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee (FAC) was held on September 21, 2023, 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 3:03 p.m., and Director 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; Yunkyung, Kim, Chief Operating Officer; Zeinab Dabbah, M.D., Ph.D., Deputy 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 (CFO), provided updates on the FAC reports. Ms. Huang reported that over the past month staff has reviewed the routine FAC reports that are prepared on a quarterly basis and have concluded that some of these reports can be retired. Specifically, staff recommend retiring the following quarterly reports: the Whole-Child Model Financial Report, the Enhanced Care Management Financial Report, the Reinsurance Report, and the Contingency Contract Report. In addition, staff recommended adding the following new reports on a quarterly basis: the Net Asset Analysis and the Enrollment Trend Analysis. Ms. Huang responded to committee member questions.

Chair Becerra noted that she wants to be sure that CalOptima Health does not lose sight of the utilization metrics for the Enhanced Care Management population.

Ms. Huang also noted for the record that there was a correction to the information under Agenda Item 8, which will be corrected in the archived materials. On the first page of Agenda Item 8, which is the Net

Asset Analysis, the pie chart on that page has the numbers transposed. The Resources Committed by the Board should reflect $643.3M, and the Unallocated Resources should reflect $366.0M.

2. 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 received notifications from three vendors experiencing cybersecurity incidents in the past three months and added that none of those incidents impacted CalOptima Health. Mr. Steele reviewed the details of the three CalOptima Health vendors that experienced cybersecurity incidents, including the date of the incident and how the cyber-attackers were able to compromise the vendors' systems.

Mr. Steele also reviewed the CalOptima Health playbook, which defines the steps that staff take when either CalOptima Health or one of its vendors experience cybersecurity incidents. In addition, he reviewed the status of three tools CalOptima Health staff are implementing to reduce security risks, which included Privileged Account Management (PAM) solution, Zero Trust Network Architecture (ZTNA), and Asset Management and Patch/Vulnerability remediation.

Mr. Steele responded to committee member questions.

INVESTMENT ADVISORY COMMITTEE UPDATE

3. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period of April 1, 2023, through June 30, 2023. The portfolio totaled approximately $3 billion as of June 30, 2023. Of this amount, $2.3 billion was in CalOptima Health's operating account, and $877 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 also noted that during this quarter, one of CalOptima Health's investment managers held 31.7% of its operating portfolio in commercial paper, which is out of compliance with CalOptima Health's policy. She noted that the California Government Code section 53600 *et seq.* allows a maximum of 40% in commercial paper, but CalOptima Health's policy is that an investment manager needs to hold below 25% in commercial paper. The investment manager took immediate steps to bring its portfolio into compliance.

Ms. Huang responded to committee member questions.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

4. Approve the Minutes of the May 22, 2023 Special Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee and Receive and File Minutes of the April 24, 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)***

REPORT ITEMS

5. Recommend Board of Directors Accept, Receive and File Fiscal Year 2022-23 CalOptima Health Audited Financial Statements

Ms. Huang introduced Moss Adams, LLP (Moss Adams), CalOptima Health's independent financial auditor, to provide further details on the audit results. Ms. Huang noted that she was happy to inform the FAC that there were no significant issues noted during the audit.

Aparna Venkateswaran, Engagement Reviewer at Moss Adams, presented the draft audit of the consolidated financial statements for the fiscal year ending June 30, 2023.

Ms. Venkateswaran presented an overview of the areas of audit emphasis, including capitation revenue and receivables, cash and investments, medical claims liability, and required communications. Ms. Venkateswaran reported that Moss Adams will be issuing an unmodified opinion indicating that the FY 2022-23 financial statements fairly state the financial condition of CalOptima Health in all material respects. Ms. Venkateswaran introduced Ashley Merda, Audit Manager, who provided additional details on the audit.

Action: ***On motion of Director Contratto, seconded and carried, the Committee Recommended that the CalOptima Health Board of Directors (Board) accept, receive, and file the Fiscal Year (FY) 2022-23 CalOptima Health consolidated audited financial statements as submitted by independent auditors Moss Adams, LLP (Moss Adams). (Motion carried 3-0-0)***

6. Recommend Appointment to the CalOptima Health Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Corwin, seconded and carried, the Committee Recommended that the Board of Directors (Board) appoint Rick Fulford to the Investment Advisory Committee (IAC) for a two (2)-year term, beginning October 6, 2023. (Motion carried 3-0-0)***

The following items were accepted as presented.

7. July 2023 Financial Summary

8. Net Asset Analysis

As reported under Agenda Item 1, the corrected Net Asset Report will be included in the archived meeting materials.

9. Enrollment Trend Analysis

10. Quarterly Operating and Capital Budget Update

Back to Agenda

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

COMMITTEE MEMBER COMMENTS
There were no committee member comments.

ADJOURNMENT
Hearing no further business, Chair Becerra adjourned the meeting at 4:19 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: November 16, 2023

Back to Agenda

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Authorize and Direct Execution of CalOptima Health's New Primary and Secondary Agreements with the California Department of Health Care Services

Contact

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

Recommended Actions

1. Authorize and direct the Chairman of the Board of Directors (Board) to execute the new Primary and Secondary Agreements between the California Department of Health Care Services (DHCS) and CalOptima Health related to the 2024 Managed Care Plan (MCP) Contract.

Background

As a County Organized Health System (COHS), CalOptima Health contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In December 2016, CalOptima Health entered into a new four-(4) year agreement with the DHCS for the Primary Agreement for Medi-Cal services. Amendments to this agreement are summarized in the attached appendix, including Amendment 62, which extends the Primary Agreement to December 31, 2023. *See*, Attachment 1. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services.

Discussion

Calendar Year (CY) 2024 Primary and Secondary Agreements

On November 1, 2023, DHCS provided CalOptima Health with a final version of the CY 2024 MCP Primary Agreement and CY 2024 MCP Secondary Agreement and notified CalOptima Health that they will submit the agreements to the Centers for Medicare and Medicaid Services (CMS) by the end of 2023. *See* Attachments 2 and 3 for the agreements. DHCS requested that CalOptima Health sign and return the agreements no later than Tuesday, December 12, 2023. As such, staff are requesting that the Board provide authority and direction to the Chair to execute these agreements.

The CY 2024 MCP Primary Agreement contains language changes and requirements effective January 1, 2024, which DHCS has generally already implemented by issuing sub-regulatory guidance such as All Plan Letters (APLs). A summary of language changes is outlined as a separate attachment to this COBAR. *See* Attachment 4.

Simultaneously, DHCS has been working with CMS to formalize the requirements in DHCS's agreements with MCPs, including CalOptima Health. DHCS's implementation of these requirements via sub-regulatory guidance prior to the formal inclusion of the requirements in MCP agreements is largely due to the lengthy CMS review process. CalOptima Health staff has

Back to Agenda

implemented the required operational changes and other contractual requirements by following the DHCS APLs and sub-regulatory guidance.

The CY 2024 MCP Secondary Agreement is a companion agreement to CalOptima Health's CY 2024 MCP Primary Agreement to cover specific Medi-Cal state-supported services for CalOptima Health's members enrolled under CalOptima Health's Primary Agreement. Additionally, the CY 2024 MCP Secondary Agreement includes capitation rates applicable to the state-supported services covered by agreement, updated definitions used in the agreement, and program terms and conditions.

As of this writing, CY 2024 contracted rates are preliminary in nature. DHCS will update MCPs once contracted rates are finalized and approved by CMS.

Fiscal Impact

CalOptima Health's Fiscal Year (FY) 2023-24 Operating Budget assumed an approximate 2.2% rate increase to the DHCS contracted rates (in aggregate) effective January 1, 2024. The rates in the new CY 2024 MCP Primary and CY 2024 MCP Secondary Agreements represent a rate increase of approximately 3.4%, resulting in an estimated net increase of 1.2% or $40 million per year. The current year fiscal impact for the six-month period of January 1, 2024, through June 30, 2024, is estimated at $20 million.

As CalOptima Health operationalizes the new and revised terms and conditions in the new CY 2024 MCP Primary and Secondary Agreements, management will request any additional resources required through the CalOptima Health FY 2024-25 Operating Budget or separate Board actions.

Rationale for Recommendation

CalOptima Health's execution of the CY 2024 Primary and Secondary Agreements with DHCS is necessary for the continued operation of CalOptima Health's Medi-Cal program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Attachment 1_Appendix Summary of Agreement Amendments with DHCS
2. Attachment 2_CY 2024 MCP Primary Agreement
3. Attachment 3_CY 2024 MCP Secondary Agreement
4. Attachment 4_Additional CY 2024 MCP Primary Agreement Detail

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 5

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

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

Back to Item

Back to Agenda

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

Back to Item

Back to Agenda

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

Back to Item

Back to Agenda

A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-56 incorporates updated Bridge Period (July 1, 2019 – December 31, 2020) capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) members, and includes new corresponding rate tables that split each existing category into a SIS and UIS version.	October 1, 2020
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022
A-59 incorporates new Calendar Year (CY) 2022 capitation rates and benefit changes implemented in CY 2022	August 5, 2021 March 3, 2022 August 4, 2022
A-60 incorporates new benefits changes for Calendar Year (CY) 2022.	August 4, 2022
A-61 incorporates new benefit changes for Calendar Year (CY) 2022.	May 4, 2023
A-62 extends the Primary Agreement with DHCS to December 31, 2023.	May 5, 2022
A-63 incorporates new benefits changes for Calendar Year (CY) 2023.	February 2, 2023
A-64 incorporates updated Calendar Year (CY) 2021 capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members.	Not applicable due to non – substantive changes.
A-65 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-66 incorporates updated Calendar Year 2022 Capitation Payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members and includes new corresponding rate tables that split each existing category into a SIS version and UIS version.	Not applicable due to non – substantive changes.

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010

Back to Item

Back to Agenda

A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-09 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021
Agreement 22-20494 incorporates both Hyde services ("Private Services") and the new Unsatisfactory Immigration Status members from January 1, 2023 to December 31, 2023.	December 1, 2022
A-01 incorporates rates for CY 2023 for Hyde services (now referred to as "Private Services") and the new Unsatisfactory Immigration Status (UIS) members.	December 1, 2022

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018

Back to Item

Back to Agenda

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

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

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

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

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

Back to Item

Back to Agenda

Exhibit A
SCOPE OF WORK

I. Service Overview

Contractor agrees to provide to the California Department of Health Care Services (DHCS) the following the services described herein:

Provide health care services to eligible Medi-Cal recipients within the scope of Medi-Cal benefits as defined in the contents of the Contract.

II. Service Location

The services must be performed at all contracting and participating facilities of Contractor.

III. Service Hours

The Services must be provided as needed on a 24-hour, seven days a week basis.

IV. Contract Representatives

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

Department of Health Care Services	**Contractor**
Managed Care Operations Division Attention: Chief, Procurement & Contract Development Branch Telephone: (916) 449-5000	Orange County Health Authority, A Public Agency dba: CalOptima Health Attention: Michael Hunn, CEO Telephone: (657) 900-1481 Fax: N/A Email: Michael.hunn@caloptima.org

B. Direct all inquiries to:

Exhibit A
SCOPE OF WORK

Department of Health Care Services	**Contractor**
Managed Care Operations Division Attention: Contracting Officer 1501 Capitol Avenue, Suite 71.4001 P.O. Box Number 997413, Mail Stop 4408 Sacramento, CA 95899-7413 Telephone: (916) 449-5000	Orange County Health Authority, A Public Agency dba: CalOptima Health Attention: Michael Wood, Manager, Regulatory Affairs & Compliance 505 City Parkway West Orange, CA, 92868 Telephone: (714) 246-8415 Fax: (714) 246-6418 Email: mwood@caloptima.org

C. Either party may make changes to the information in provision IV of this Exhibit A by giving written notice to the other party. Said changes must not require an amendment to this Contract.

V. Americans with Disabilities Act

Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement must comply with the accessibility requirements of Section 508 of the Rehabilitation Act of 1973 (29 United States Code (USC) section 794d) and the Americans with Disabilities Act of 1990 (42 USC sections 12101, *et seq.*), as amended, and regulations implementing those statutes as set forth in 36 Code of Federal Regulations (CFR) part 1194 and 28 CFR part 36, as applicable. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their Electronic and Information Technology (EIT) accessible to people with disabilities. California Government Code section 7405 codifies section 508 of the Rehabilitation Act (29 USC section 794d) and the regulations implementing the Rehabilitation Act at 36 CFR part 1194, requiring accessibility of EIT.

The provision of the services is subject to the provisions set forth in the Exhibits and Attachments appended hereto.

Exhibit A, ATTACHMENT I

1.0 Definitions

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms governs the construction of this Contract:

Abuse means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.

Administrative Cost means only those costs that arise out of Contractor's operations as specified in 28 California Code of Regulations (CCR) section 1300.78.

Administrative Subcontractor means a Subcontractor that contractually assumes administrative obligations of Contractor under the Contract. Administrative obligations include functions such as Credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services to Members, such as Care Coordination are not administrative functions.

Adult Day Health Care (ADHC) means an organized day program of therapeutic, social and health activities, and services provided to persons 55 years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care as set forth in 22 CCR section 78007.

Advance Directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under California law, whether statutory or as recognized by the California courts, relating to the provision of health care when a Member is incapacitated.

Adverse Benefit Determination (ABD) means any of the following actions taken by Contractor:

A. The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service;

B. The reduction, suspension, or termination of a previously authorized Covered Service;

C. The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an ABD;

D. The failure to provide Covered Services in a timely manner;

E. The failure to act within the required timeframes for standard resolution of Grievances and Appeals;

F. The denial of the Member's request to obtain services out-of-Network when a Member is in an area with only one Medi-Cal managed care health plan; or

G. The denial of a Member's request to dispute financial liability.

Affiliate means an entity or an individual that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control of Contractor and that provides services to or receives services from Contractor.

All Plan Letter (APL) or **Policy Letter (PL)** means a binding document that has been dated, numbered, and issued by Department of Health Care Services (DHCS) that provides clarification of Contractor's contractual obligations, implementation instructions for Contractor's contractual obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.

Allied Health Personnel means specially trained, licensed, or credentialed health workers other than physicians, podiatrists, and nurses.

Alternative Format Selections (AFS) means the choice a Member or a Member's Authorized Representative (AR) makes to receive information and materials in an alternate format, such as braille, large font, and electronic media, including audio or data compact discs.

American Indian means a Member who meets the criteria for an "Indian" under 42 Code of Federal Regulations (CFR) section 438.14(a).

Appeal means a review by Contractor of an Adverse Benefit Determination (ABD) which includes one of the following actions:

A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service;

B. A reduction, suspension, or termination of a previously authorized service;

C. The denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim;

D. Failure to provide services in a timely manner; or

E. Failure to act within the timeframes provided in 42 CFR section 438.408(b).

Application Programming Interface (API) means a way for two or more computer programs to communicate with each other. The calls that make up the API are also known as subroutines, methods, requests, or endpoints.

Asthma Preventive Service (APS) is defined as information about the basic facts of asthma, proper use of long-term controllers and quick relief medications, evidence-based self-management techniques and self-monitoring skills, and actions to mitigate or control environmental exposures that exacerbate asthma symptoms. APS includes evidence-based asthma self-management education and in-home environmental trigger assessments, consistent with the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma.

Authorized Representative (AR) means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.

Auxiliary Aid means "auxiliary aids and services" as defined in 28 CFR section 36.303(b) that assist disabled Members to communicate, receive and understand information.

Basic Population Health Management (Basic PHM) means an 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.

Behavioral Health means mental health conditions and Substance Use Disorders (SUD).

Behavioral Health Services means Specialty Mental Health Services (SMHS), Non-Specialty Mental Health Services (NSMHS), and Substance Use Disorders (SUD) treatment.

Behavioral Health Treatment (BHT) means services and treatment programs for the treatment of Autism Spectrum Disorder (ASD), as specified in the California Medicaid State Plan, including applied behavioral analysis and other evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member less than 21 years of age who has been diagnosed with ASD, or for whom a licensed physician, surgeon, or psychologist has determined BHT is Medically Necessary.

BHT Provider means a Qualified Autism Services (QAS) Provider, QAS Professional, or QAS Paraprofessional.

Beneficiary Identification Card means a plastic card issued by DHCS to a Member confirming Medi-Cal eligibility.

Bright Futures Periodicity Schedule means the *Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care* and guidelines published by AAP and Bright Futures, in accordance with which all Members less than 21 years of age must receive well child assessments, screenings, and services.

California Advancing and Innovating Medi-Cal (**CalAIM) Terms and Conditions** means those terms and conditions issued and approved by the federal Centers for Medicare & Medicaid Services (CMS), including any attachments, appendices, or similar documents, and subsequent amendments thereto, that govern implementation of the respective components of the CalAIM initiative pursuant to Article 5.1 of Chapter 7 of Part 3 of Division 9 of Welfare and Institutions Code (W&I). CalAIM Terms and Conditions must include, at a minimum, any terms and conditions specified in the following:

A. CalAIM Demonstration, Number 11-W-00193/9, as approved by CMS pursuant to 42 United States Code (USC) section 1315, including for any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

B. Any associated Medicaid waivers as approved by CMS pursuant to 42 USC section 1396n, including but not limited to the CalAIM Section 1915(b) Waiver Control Number CA 17.R10, that are necessary to implement a CalAIM component, including for any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

California Children's Services (CCS)-Eligible Condition means a medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 *et seq*.

CCS Case Manager means an individual identified as a single point-of-contact responsible for the provision of case management services and facilitation of Care Coordination for a Member receiving services under the California Children's Services (CCS) Program.

CCS Program means a State and county program providing Medically Necessary services to treat California Children's Services (CCS)-Eligible Conditions.

Capitation Payment means a regularly scheduled payment made by DHCS to Contractor on behalf of each Member for each month the Member is enrolled with Contractor that is based on the actuarially sound capitation rate for the provision of Covered Services and paid regardless of whether a Member receives services during the period covered by the payment.

Care Coordination means Contractor's coordination of care delivery and services for Members, either within or across delivery systems including:

A. Services the Member receives by Contractor;

B. Services the Member receives from any other managed care health plan;

C. Services the Member receives in Fee-For-Service (FFS);

D. Services the Member receives from out-of-Network Providers;

E. Services that the Member receives through carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and

F. Services the Member receives from community and social support Providers.

Care Management Plan (CMP) means a written plan that is developed with input from the Member and/or their family member(s), parent, legal guardian, Authorized Representative (AR), caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals, and preferences, and make recommendations for clinical and non-clinical service needs.

Center of Excellence means a designation assigned to a transplant program by DHCS upon confirmation that the transplant program meets DHCS' criteria.

Certified Nurse Midwife (**CNM**) means a registered nurse who has successfully completed a program of study and clinical experience meeting the State guidelines or has been certified by an organization recognized by the State.

Child/Children, regardless of whether the term is capitalized or not, means a Member/Members less than 21 years of age unless otherwise specified.

Children with Special Health Care Needs (CSHCN) means Children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional condition and who also require health or related services of a type or amount beyond that required by Children generally. The identification, assessment, treatment, and coordination of care for CSHCN must comply with the requirements of 42 CFR sections 438.208(b)(3), 438.208(b)(4), and 438.208(c)(2) – (4).

Clean Claim means a claim that can be processed without obtaining additional information from the Provider or from a third party, including bills, or invoices that meet DHCS established billing and invoicing requirements.

Cold-Call Marketing means Contractor's or its agent's unsolicited personal contact with a Member or a Potential Member for the purpose of Marketing.

Community Based Adult Services (CBAS) means skilled nursing, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services provided in an outpatient, facility-based program, as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, or as set forth in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS services.

CBAS Discharge Plan of Care means a discharge plan of care based on the Member's Community Based Adult Services (CBAS) assessment that is prepared by the CBAS Provider pursuant to 22 CCR section 78345 before the date of the Member's first reassessment and reviewed and updated at the time of each reassessment and prior to discharge.

CBAS Emergency Remote Services (ERS) means the following services, provided in alternative Service Locations such as a community setting or the Member's home, and/or as appropriate, via Telehealth or live virtual video conferencing, as clinically appropriate: professional nursing care, personal care services, social services, Behavioral Health Services, speech therapy, therapeutic activities, registered dietician-nutrition counseling, physical therapy, occupational therapy, and meals.

CBAS Individual Plan of Care (IPC) means a written plan of care developed by a Community Based Adult Services (CBAS) center's multidisciplinary team, as specified in the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, or as specified in any subsequent demonstration amendment or renewal, or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS.

CBAS Provider means an Adult Day Health Care (ADHC) center that is licensed by the California Department of Public Health (CDPH) to provide ADHC services, is enrolled as a Medi-Cal Provider, and has been certified as a Community Based Adult Services (CBAS) Provider by the California Department of Aging.

Community Health Worker (CHW) means an individual known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, and as set forth in APL 22-016.

Community Reinvestment Plan means a document outlining the reinvestment activities in local communities.

Community Supports means substitute services or settings to those required under the California Medicaid State Plan that Contractor may select and offer to their Members pursuant to 42 CFR section 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

Community Supports Provider means entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees)*.

Complex Care Management (CCM) means an approach to comprehensive care management that meets differing needs of high and medium rising-risk Members, through both ongoing chronic Care Coordination and interventions for episodic, temporary needs. Contractors must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements.

CCM Care Manager means an individual identified as a single point-of-contact responsible for the provision of Complex Care Management (CCM) services for a Member.

Confidential Information means facts, documents, or records in any form that are recognized as "confidential" by any law, regulation, or contract.

Contract means this written agreement between DHCS and Contractor.

Contract Revenues means the amount of Medi-Cal managed health care Capitation Payments, Supplemental Payments, additional payments, and other revenue paid to Contractor by DHCS under this Contract.

Contractor's Representative means an individual appointed by Contractor who is responsible for implementing this Contract, receiving notices on this Contract, and taking actions and making representations related to the compliance with this Contract.

Corrective Actions means specific identifiable activities or undertakings of Contractor which address Contract deficiencies or noncompliance.

Cost Avoid or **Cost Avoidance** means the practice of requiring Providers to bill liable third parties prior to seeking payment from the Medi-Cal program.

County Department means a county agency responsible for determining the initial and continued eligibility of an individual for participation in the Medi-Cal program or for providing services as specified in this Contract.

Covered Services means 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, this Contract, and APLs that are made the responsibility of Contractor 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:

A. Home and Community-Based Services (HCBS) program as specified in 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 this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (*Targeted Case Management Services*), Subsection F4 regarding services for Members less than 21 years of age. Contractor is financially responsible for the payment of all EPSDT services;

B. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), except for Contractors providing Whole Child Model (WCM) services;

C. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*);

D. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*);

E. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (*Services for All Members*);

F. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (*Direct Observed Therapy for Treatment of Tuberculosis*);

G. 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, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (*Dental*) regarding dental services;

H. Prayer or spiritual healing as specified in 22 CCR section 51312;

I. 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, Contractor is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (*School-Based Services*);

J. 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);

K. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services;

L. State Supported Services;

M. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (*Targeted Case Management Services*). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005;

N. Childhood lead poisoning case management provided by county health departments;

O. 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;

P. End of life services as stated in Health and Safety Code (H&S) section 443 *et seq*., and APL 16-006; and

Q. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 22-012.

Credentialing means the process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure, and professional association membership.

Deemed Exhaustion means Contractor's failure to adhere to the notice and timing requirements in responding to a Member's Appeal of an Adverse Benefit Determination (ABD), which allows a Member to immediately request a State Hearing.

Department of Health Care Services (DHCS) or **Department** means the single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health-related programs, as provided by statute and/or regulation.

DHCS Comprehensive Quality Strategy means the federally required written strategy produced by the State, pursuant to 42 CFR section 438.340 that assesses and improves the quality of health care and services furnished by Medi-Cal managed care health plans.

DHCS Contract Manager or **DHCS Program Contract Manager** means the designated DHCS employee who is the primary contact within DHCS for this Contract, and responsible for receiving and sending notices and other documents from/to Contractor relating to this Contract.

DHCS Contracting Officer means the DHCS individual authorized to act on behalf of DHCS to make decisions and direct appropriate actions under this Contract.

Department of Managed Health Care (DMHC) means the California department responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

Developmental Disability (DD) means, as defined by the Lanterman Developmental Disabilities Services Act (1977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy, and autism. This term also includes disabling conditions found to be closely related to intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

Director means the Director of DHCS.

Directed Payment Initiative means a payment arrangement that directs certain expenditures made by Contractor under this Contract and that is either approved by

Centers for Medicare & Medicaid Services (CMS) as described in 42 CFR section 438.6(c) or established pursuant to 42 CFR sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.

Discharge Planning means planning that begins at the time of admission to a hospital or facility to ensure that necessary care, services, and supports are in place in the community before a Member leaves the hospital or facility in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Discrimination Grievance means any complaint or grievance alleging discrimination prohibited by State non-discrimination law, including, without limitation, the Unruh Civil Rights Act and GC section 11135, and federal non-discrimination law, including, without limitation, 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 (29 USC sections 794 and 794d), as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act of 2010 (42 USC section 18116).

Doula means a birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in APL 23-024.

Downstream Subcontractor means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

Downstream Fully Delegated Subcontractor means a Downstream Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A Contractor can operate as a Downstream Fully Delegated Subcontractor.

Downstream Partially Delegated Subcontractor means a Downstream Subcontractor that contractually assumes some, but not all, duties and obligations of a Subcontractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Downstream Partially Delegated Subcontractors.

Downstream Administrative Subcontractor means a Downstream Subcontractor that contractually assumes administrative obligations of a Subcontractor under the Contract. Administrative obligations include functions such as Credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services for Members, such as Utilization Management (UM) or Care Coordination, are not administrative functions.

Downstream Subcontractor Agreement means a written agreement between a Subcontractor and a Downstream Subcontractor or between any Downstream Subcontractors. The Downstream Subcontractor Agreement must include a delegation of Contractor's and Subcontractor's duties and obligations under the Contract.

Drug Medi-Cal (DMC) means the State system wherein Members receive Covered Services from DMC-certified Substance Use Disorder (SUD) treatment Providers.

Drug Medi-Cal Organized Delivery System (DMC-ODS) means a program for the organized delivery of Substance Use Disorder (SUD) services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care.

Durable Medical Equipment (DME) means Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home.

Dyadic Care means to serve both parent(s) or caregiver(s) and Child together as a dyad and is a form of treatment that targets family well-being as a mechanism to support healthy Child development and mental health. It is provided within pediatric Primary Care settings whenever possible and can help identify Behavioral Health interventions and other Behavioral Health issues, provide referrals to services, and help guide the parent-Child or caregiver-Child relationship. Dyadic Care fosters team-based approaches to meeting family needs, including addressing mental health and social support concerns, and it broadens and improves the delivery of pediatric Preventive Care.

Dyadic Service means a family and caregiver-focused Model of Care (MOC) intended to address developmental and Behavioral Health conditions of Children as soon as they are identified. Dyadic Services include Dyadic Behavioral Health (DBH) well-Child visits, Dyadic Comprehensive Community Supports Services, Dyadic Psychoeducational Services, and Dyadic Family Training and Counseling for Child Development.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) means the provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC sections 1396a(a)(43) and 1396d(a)(4)(B) and (r), 42 CFR section 441.50 *et seq*., and as required by W&I sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or Behavioral Health conditions.

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:

A. Placing the Member's health in serious jeopardy;

B. Serious impairment to bodily functions;

C. Serious dysfunction to any bodily organ or part; or

D. Death.

Emergency Medical Transportation (EMT) means transportation services for an Emergency Medical Condition and includes emergency air transportation.

Emergency Preparedness and Response Plan means the plan identified and described in Exhibit A, Attachment III, Section 6.1 (*General Guidance*).

Emergency Services means inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).

Encounter means an instance of direct Provider-to-Member interaction, regardless of the setting, where the Provider is diagnosing, evaluating, or treating the Member's condition.

Encounter Data means the information that describes health care interactions between Members and Providers relating to the receipt of any item(s) or service(s) by a Member under this Contract and subject to the standards of 42 CFR sections 438.242 and 438.818.

Enhanced Care Management (ECM) means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria through a

systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

ECM Lead Care Manager means a Member's designated Enhanced Care Management (ECM) care manager who works for the ECM Provider organization or as staff of Contractor, and is responsible for coordinating all aspects of ECM and any Community Supports as a part of the Member's multi-disciplinary care team, which may include other care managers.

ECM Populations of Focus/Populations of Focus means the populations identified in Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*).

ECM Provider means community-based entities with experience and expertise providing intensive, in-person care management services to Members in one or more of the Populations of Focus for Enhanced Care Management (ECM).

Enrollment means the process by which a Potential Member becomes a Member of Contractor.

Excluded Entities or **Excluded Providers** means entities, Providers, and individuals that are excluded from participation in federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid/Medi-Cal Fraud.

Excluded Service means a service that is covered by the Medi-Cal program but is not a Covered Service, and is carved out of this Contract for the provision of Covered Services.

External Quality Review (EQR) means the analysis and review by the External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that Contractor, its Subcontractor, its Downstream Subcontractor, or its Network Provider furnishes to Members.

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements set forth in 42 CFR section 438.354, and performs EQR and other EQR-related activities as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.

Family Therapy means a type of psychotherapy covered under the Medi-Cal Non-Specialty Mental Health Services (NSMHS) benefit and is composed of at least two family members. Family Therapy sessions address family dynamics as they relate to mental status and behavior(s) and is focused on improving relationships and behaviors in the family and between family members, such as between a Child and parent(s) or caregiver(s).

Federal Financial Participation (FFP) means federal expenditures provided to reimburse allowable State expenditures made under the approved California Medicaid State Plan, waivers, or other similar federal Medicaid authority.

Federally Qualified Health Center (FQHC) means an entity defined in 42 USC section 1396d(l)(2)(B).

Federally Qualified Health Maintenance Organization (FQHMO) means a prepaid health delivery plan that has fulfilled the requirements of the Health Maintenance Organization Act, along with its amendments and regulations, and has obtained the federal government's qualification status under 42 USC section 300e.

Fee-For-Service (FFS) means the Medi-Cal delivery system in which Providers submit claims to and receive payments from DHCS for Medi-Cal Covered Services rendered to Medi-Cal recipients.

File and Use means a submission to DHCS that does not need review and approval prior to use or implementation, but for which DHCS can require edits on or after implementation.

Financial Performance Guarantee means cash or cash equivalents which are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which must not be less than three full months' capitation.

Financial Statements means reports prepared by Contractor to present its financial performance and position at a point in time, and include a balance sheet, income statement, statement of cash flows, statement of equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles (GAAP).

Fiscal Year (FY) means any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30; the federal Fiscal Year (FY) is October 1 through September 30.

Fraud means an intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person and includes any act that constitutes Fraud under applicable federal or State law, including 42 CFR section 455.2 and W&I section 14043.1(i).

Freestanding Birthing Center (FBC) means a health facility that is not a hospital, where childbirth is planned to occur away from the pregnant woman's residence, and that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are in their scope of work as defined in 42 USC section 1396d(l)(3)(B).

Fully Delegated Subcontractor means a Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A Contractor can operate as a Fully Delegated Subcontractor.

Governing Board means Contractor's board of directors or a similar body, and/or its executive management, that has the authority to manage and direct Contractor's affairs and activities, including, but not limited to, approving initiatives and establishing Contractor's policies and procedures.

Grievance means any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to: the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or Contractor's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by Contractor to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other Contractor processes. If Contractor is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.

Health Disparity means differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation, gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.

Health Equity means the reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.

Health Inequity means a systematic difference in the health status of different population groups arising from the social conditions in which Members are born, grow, live, work, and/or age, resulting in significant social and economic costs both to individuals and societies.

Healthcare Effectiveness Data and Information Set (HEDIS®) means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

Implementation Period means the period of time in which Contractor is undertaking any readiness requirements required by DHCS before performance of the Contract begins. The Implementation Period begins with DHCS awarding this Contract and extends to the effective date that begins the Operations Period.

Incentive Arrangement means any payment mechanism approved by Centers for Medicare & Medicaid Services (CMS) in accordance with the requirements of 42 CFR section 438.6(b) under which Contractor may receive incentive payments in addition to Capitation Payments for meeting targets specified in accordance with this Contract, including but not limited to Exhibit B, Subsection 1.1.14.C (*Special Contract Provisions Related to Payment*).

Independent Medical Review (IMR) means a review of Contractor's denial of a Member's request for health care service as not Medically Necessary, experimental, or investigational by an independent physician(s) who is contracted with DMHC. The IMR decision is binding on Contractor but not the Member who may still request a State Hearing after an IMR pursuant to H&S section 1374.30 and 28 CCR section 1300.74.30.

Indian Health Care Provider (IHCP) 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 (IHCIA) at 25 USC section 1603.

Indian Health Service (IHS) means an agency within the United States Department of Health and Human Services responsible for providing federal health services to American Indians and Alaska Natives. The IHS is the principal federal health care provider and health advocate for these populations, and provides them with a comprehensive Indian health care delivery system.

Indian Health Services Memorandum of Agreement Provider (IHS/MOA) means an Indian Health Service (IHS) program funded under the authority of Public Law 93-638 at 25 USC section 5301 et seq. These programs have elected to participate in Medi-Cal as IHS/MOA providers. IHS/MOAs are subject to the payment terms of APL 17-020. The list of eligible IHS/MOA providers is found in APL 17-020, Attachment #1. These providers receive a federally established All-Inclusive Rate that is updated annually by the federal Office of Management and Budgets and published in APL 17-020, Attachment #2.

In-Home Supportive Services (IHSS) means services provided to Members by a county in accordance with the requirements set forth in W&I sections 12300 *et seq.*, 14132.95, 14132.952, and 14132.956.

Initial Health Appointment (IHA), previously called an Initial Health Assessment, means an assessment that must be completed within 120 days of Contractor Enrollment for new Members and must include a history of the Member's physical and Behavioral Health, an identification of risks, an assessment of need for preventive screens or services and health education, and a diagnosis and plan for treatment of any diseases.

Incurred but Not Reported (IBNR) Claim Estimate means a financial accounting of all services that have been performed, but have not been invoiced or recorded, or estimates of costs for medical services provided for which a claim has not yet been filed.

Intermediate Care Facility (ICF) means a residential facility certified and licensed by the State to provide medical services at a lower level of care than is provided at Skilled Nursing Facilities (SNFs), and meets the standards specified in 22 CCR section 51212.

Joint Commission (JC) means the organization that provides health care accreditation and related services that support performance improvement in health care organization and is composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association.

Knox-Keene Health Care Service Plan Act of 1975 (KKA) means the law that regulates health care service plans and is administrated by DMHC, commencing with H&S section 1340 *et seq*.

Laboratory Testing Site means any laboratory and any Provider site, such as a Primary Care Provider (PCP) or Specialist office or clinic, that performs tests or examinations on human biological specimens derived from the human body.

Licensed Midwife (LM) means an individual licensed to practice midwifery and assist a woman in normal childbirth as defined in California Business and Professions Code (B&P) section 2507.

Limited English Proficiency (LEP) means an inability or a limited ability to speak, read, write, or understand the English language at a level that permits the Member to interact effectively with Providers or Contractor's employees.

Local Educational Agency (LEA) means a school district, county office of education, charter school, community college district, California State University campus or University of California campus.

Local Government Agency (LGA) means a local governmental entity including, but not limited to, a county Child welfare agency, county probation department, county Behavioral Health department, county social services department, county public health department, school district, or county office of education.

Long-Term Care (LTC) means specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) homes.

Long-Term Services & Supports (LTSS) means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS) programs and includes carved-in and carved-out services.

Marketing means any activity conducted by or on behalf of Contractor where information regarding the services offered by Contractor is disseminated in order to persuade or influence Potential Members to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of Contractor.

Marketing Materials means materials produced in any medium, by or on behalf of Contractor that can be reasonably interpreted as Marketing to Potential Members. Marketing Materials include, but are not limited to, all printed materials, illustrated materials, digital materials, videos, and media scripts.

Marketing Representative means a person who is engaged in Marketing activities on behalf of Contractor.

Medi-Cal Eligibility Data System (MEDS) means the automated eligibility information processing system operated by DHCS which provides on-line access for Medi-Cal recipient information and update of Medi-Cal recipient eligibility data.

Medi-Cal FFS Rate means the rate that DHCS pays Providers on a per unit or per procedure billing code basis.

Medi-Cal Provider Manual means the multi-part document identifying Medi-Cal benefits and billing codes published and maintained by DHCS at https://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.aspx.

Medical Home means a model of organization of Primary Care that delivers the core functions of primary health care, which is comprised of comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

Medical Records means the record of a Member's medical information, including but not limited to medical history, care or treatments received, test results, diagnoses, and prescribed medications.

Medically Necessary or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary

services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Member or **Enrollee** means a Potential Member who has enrolled with Contractor.

Member Assignment means the written notification and assignment of a Potential Member to the Medi-Cal managed care health plan of the Member's choice, or if as designated by DHCS when the Potential Member fails to make a timely choice.

Member Handbook or **Evidence of Coverage (EOC)** means the document that describes the health care benefits and Covered Services that are available to a Member.

Member Information means documents that are vital, or critical to obtaining benefits or services, and includes, but is not limited to: the Member Handbook, Provider Directory, welcome packets, Marketing information, form letters including Notice of Actions (NOA), notices related to Grievances or Appeals, including Grievance and Appeal acknowledgement and resolution letters, Contractor's preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.

Memorandum of Understanding (MOU) means a formal written agreement between Contractor and Local Government Agencies, county programs, and third-party entities.

Minimum Performance Level (MPL) refers to Contractor's minimum performance requirements for select Quality Performance Measures.

Minor Consent Services means those Covered Services of a sensitive nature which minors do not need parental consent to access, including but not limited to the following situations:

A. Sexual assault, including rape;

B. Drug or alcohol abuse for minors 12 years of age or older;

C. Pregnancy;

D. Family planning;

E. Sexually transmitted diseases (STDs) in minors 12 years of age or older;

F. Diagnosis or treatment of infectious, contagious, or communicable diseases in minors 12 years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and

G. Outpatient mental health care for minors 12 years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the minors are the alleged victims of incest or Child abuse.

Model of Care (MOC) means Contractor's framework for providing Enhanced Care Management (ECM) and Community Supports, including its Policies and Procedures for partnering with ECM and Community Supports Providers.

National Committee for Quality Assurance (NCQA) means an organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.

National Provider Identifier (NPI) means a unique identification number for Providers. Contractor must use the NPIs in the administrative and financial transactions adopted under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Network means Primary Care Providers (PCPs), Specialists, hospitals, ancillary Providers, facilities, and other Providers with whom Contractor enters into a Network Provider Agreement.

Network Provider means any Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

Network Provider Agreement means a written agreement between a Network Provider and Contractor, Subcontractor, or Downstream Subcontractor.

Network Provider Data means information concerning all Network Providers in a Network, regardless of location, which render Covered Services to Members in a Contractor's Service Area and the provider groups, Subcontractors, and/or Downstream

Subcontractors, if any, under which a Network Provider renders those services. This includes, but is not limited to, information about the contractual relationship between Network Providers, provider groups, Subcontractors, and Downstream Subcontractors within the Network, information regarding the facilities where services are rendered, and information about a Network Provider's area(s) of specialization.

No Wrong Door means Members receive timely Behavioral Health Services without delay, regardless of delivery system where they seek care and are able to maintain treatment relationships with trusted Providers without interruption. This includes concurrent service provision, whereby Contractor must cover Medically Necessary Non-Specialty Mental Health Services (NSMHS) for a Member concurrently receiving Specialty Mental Health Services (SMHS) covered by the county Mental Health Plan (MHP), and ensure those services are coordinated and not duplicative. Contractor must ensure compliance with No Wrong Door pursuant to W&I section 14184.402.

Non-Emergency Medical Transportation (NEMT) means ambulance, litter van, wheelchair van, and air medical transportation services. NEMT is used when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, and pursuant to 22 CCR sections 51323, 51231.1, and 51231.2, is rendered by licensed Providers.

Non-Medical Transportation (NMT) means transportation of Members to obtain Covered Services or Excluded Services by passenger car, taxicabs, or other forms of public or private conveyances, and mileage reimbursement when conveyance is in a private vehicle arranged by the Member and not through a transportation broker, bus passes, taxi vouchers, or train tickets. NMT does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with State and local statutes, ordinances, or regulations.

Non-Specialty Mental Health Services (NSMHS) means all of the following services that Contractor must provide when they are Medically Necessary, and is provided by PCPs or by licensed mental health Network Providers within their scope of practice:

A. Mental health evaluation and treatment, including individual, group and family psychotherapy;

B. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;

C. Outpatient services for the purposes of monitoring drug therapy;

D. Psychiatric consultation; and

E. Outpatient laboratory, drugs, supplies, and supplements, excluding separately billable psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.

Operations Period means the period of time between the effective date of the first month of operations and continues on through the last month of Contractor's capitation and provision of services to Members. The Operations Period commences at the conclusion of the Implementation Period upon DHCS' acceptance of Contractor's completion of any readiness requirements required by DHCS.

Other Health Coverage (OHC) means health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-Cal program), federal, or local medical care program, or under other contractual or legal entitlements.

Partially Delegated Subcontractor means a Subcontractor that contractually assumes some, but not all, duties and obligations of Contractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Partially Delegated Subcontractors.

Pass-Through Payment means the "Pass-through payment," as defined in 42 CFR section 438.6(a), that has been documented in a rate certification approved by the federal Centers for Medicare & Medicaid Services (CMS).

Phaseout Period means the period of time after the date the Operations Period or Contract extension ends. The Phaseout Period extends until all activities required during the Phaseout Period for each Service Area are fully completed.

Population Health Management (PHM) means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses Member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.

Population Health Management (PHM) Service means a service that collects and links Medi-Cal beneficiary information from disparate sources and performs Risk Stratification and Segmentation (RSS) and Risk Tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multi-party data access and use in accordance with State and federal laws, regulations, and policies.

Population Health Management Strategy (PHMS) means a comprehensive plan of action for addressing Member needs across the continuum of care, based on annual Population Needs Assessment (PNA) results, data driven risk stratification, predictive analysis, identified gaps in care, standardized assessment processes, and holistic care management interventions. Contractor is required to include, at a minimum, a description of how it will:

A. Keep all Members healthy by focusing on wellness and prevention services;

B. Identify and manage Members with high and rising-risk;

C. Include a separate section on Members less than 21 years of age;

D. Ensure effective transition planning across delivery systems or settings through Care Coordination and other means to minimize patient risk and ensure appropriate clinical outcomes for Member; and

E. Identify and mitigate Member access, experience, and clinical outcome disparities by race, ethnicity, and language to advance Health Equity.

Population Needs Assessment (PNA) means a process for:

A. Identifying Member health needs and Health Disparities;

B. Evaluating health education, Cultural and Linguistic (C&L), delivery system transformation and Quality Improvement (QI) activities and other available resources to address identified health concerns; and

C. Implementing targeted strategies for health education, C&L, and QI programs and services.

Post-Payment Recovery (PPR) means Contractor's efforts to recover the cost of the services from other third-party payors responsible for the payment of a Member's health care services.

Post-Stabilization Care Services means Covered Services related to an Emergency Medical Condition that are provided after a Member's condition is stabilized, in accordance with 42 CFR section 438.114 and 28 CCR section 1300.71.4, to improve or resolve the Member's condition.

Potential Member or **Potential Enrollee** means a Medi-Cal beneficiary who resides in Contractor's Service Area and is subject to mandatory Enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan, and is in one of the following aid codes:

Aid Group	**Mandatory Aid Codes**	**Non-Mandatory Aid Codes** *(all aid codes are Mandatory in County Organized Health Systems (COHS) counties)*
Adult & Family/Optional Targeted Low-Income Child	01, 02, 08, 0A, 0E, 2V, 30, 32, 33, 34, 35, , 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 5C, 5D, 5V, 72, 7A, 7J, 7S, 7W, 7X, 82, 86, 8E, 8P, 8R, 8U, E6, E7, H1, H2, H3, H4, H5, K1, M3, M5, M7, M9, P5, P7, P9, R1, T1, T2, T3, T4, T5	03, 04, 06, 07,2P, 2R, 2S, 2T, 2U, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L, 76
Adult & Family/Optional Targeted Low-Income Child Dual Eligible	0A, 0E, 2C *(applies only in San Francisco, Santa Clara, and San Mateo Counties)*, 2V, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, , 54, 59, 5C, 5D, 5V, 72, 7A, 7J, 7S, 7W, 7X, 82, 8E, 8P, 8R, 8U, E6, E7, H1, H2, H3, H4, H5, K1, M3, M5, M7, M9, P5, P7, P9, R1, T1, T2, T3, T4, T5	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L
SPD Dual	10, 14, 16,1E, 1H, 1X, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6X, L6	
SPD	10, 14, 16, 1E, 1H, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, L6	
Adult Expansion	L1, M1, 7U	
Breast and Cervical Cancer Treatment Program	0M, 0N, 0P, 0R, 0T, 0U, 0W	
Long-Term Care	13, 23, 53, 63	
Long-Term Care Dual	13, 23, 53, 63	

Prescription Drug means a drug or medication that can only be accessed through a Provider's prescription.

Preventive Care means health care designed to prevent disease, illness, injury, and/or its consequences.

Primary Care means health care usually rendered in ambulatory settings by Primary Care Providers (PCP) and mid-level practitioners that emphasizes the Member's general health needs as opposed to Specialists focusing on specific needs.

Primary Care Provider (PCP) means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist. For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

Prior Authorization means a formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.

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 Primary Care Provider (PCP) assignment data as of the last calendar day of the reporting month.

Provider means 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.

Provider Directory means Contractor’s listing of all Network Providers and that includes the Providers’ contact information, whether the Provider is accepting new Members, the hours of operation, what languages are available in the Provider’s office and whether the Provider’s office has accommodations, including offices, exam rooms and equipment, for people with physical disabilities.

Provider Dispute Resolution Mechanism means Contractor’s obligation to include a timely, fair, and cost-effective dispute resolution process where Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers can submit disputes**.**

Provider-Preventable Condition (PPC) means a condition occurring in an inpatient hospital setting, or a condition occurring in any health care setting, that meets the criteria as stated in 42 CFR section 447.26(b).

Qualified Autism Services (QAS) Paraprofessional means an individual who is employed and supervised by a QAS Provider to provide Medically Necessary Behavioral Health Treatment (BHT) services to Members.

QAS Professional means an Associate Behavioral Analyst, Behavior Analyst, Behavior Management Assistant, or Behavior Management Consultant, as defined in the California Medicaid State Plan, who provides Medically Necessary Behavioral Health Treatment (BHT) services to Members.

QAS Provider means a licensed practitioner or Board-Certified Behavior Analyst who designs, supervises, or provides Medically Necessary Behavioral Health Treatment (BHT) services to Members.

Quality Improvement (QI) means systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.

Quality Improvement and Health Equity Committee (QIHEC) means a committee facilitated by Contractor's medical director, or the medical director's designee, in collaboration with the Health Equity officer that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.

Quality Improvement and Health Equity Transformation Program (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 applicable laws, regulations, and this Contract.

Quality Measure Compliance Audit means a thorough assessment of Contractor's information system capabilities and compliance with each Healthcare Effectiveness Data and Information Set (HEDIS®) specification to ensure accurate, reliable, and publicly reportable data.

Quality of Care means the degree to which health services for Members increase the likelihood of desired health outcomes and are consistent with current professional standards of care and knowledge.

Quality Performance Measures means tools that help measure healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

Quantitative Treatment Limitation (QTL) means a limit on the scope or duration of a Covered Service that is expressed numerically.

Rating Period means a period selected by DHCS for which actuarially sound capitation rates are developed and documented in the rate certification submitted to Centers for Medicare & Medicaid Services (CMS) as required by 42 CFR section 438.7(a).

Regional Center (RC) means a non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases, and manages services for Members with Developmental Disabilities and their families.

Restricted Provider Database (RPD) means the database maintained by DHCS that lists Providers who are placed under a Medi-Cal payment suspension while under investigation based upon a credible allegation of Fraud, or Providers who are placed on a temporary or indefinite Medi-Cal suspension while under investigation for Fraud or Abuse, or Enrollment violations.

Retrospective Review means the process of determining Medical Necessity after treatment has been given.

Risk Sharing Mechanism means any payment arrangement, such as reinsurance, risk corridors, or stop-loss limits, documented in the Centers for Medicare & Medicaid Services (CMS) approved rate certification documents for the applicable Rating Period prior to the start of the Rating Period, that is developed in accordance with 42 CFR section 438.4, the rate development standards in 42 CFR section 438.5, and generally accepted actuarial principles and practices.

Risk Stratification and Segmentation (RSS) means the process of separating Member populations into different risk groups and/or meaningful subsets, using information collected through population assessments and other data sources. RSS results in the categorization of Members with care needs at all levels and intensities.

Risk Tiering means the assigning of Members to standard Risk Tiers (low, medium-rising, or high), with the goal of determining appropriate care management programs or specific services.

Rural Health Clinic (RHC) means an entity defined in 42 USC section 1395x(aa)(2) to provide Primary Care and ambulatory services.

Safety-Net Provider means any Provider of comprehensive Primary Care or acute hospital inpatient services that provides services to a significant number of Medi-Cal recipients, patients who receives charity, and/or patients who are medically underinsured, in relation to the total number of patients served by the Provider.

School Site means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. “School Site” also includes a location not owned or operated by a public school, or public school district, if the school or school district provides or arranges for the provision of Medically Necessary treatment of a mental health or Substance Use Disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services means comprehensive, integrated delivery of early intervention and treatment services for Members with Substance Use Disorders (SUD), as well as those who are at risk of developing SUDs.

Senior and Person with Disability (SPD) means a Member who falls under a specific SPD aid code as defined by DHCS.

Service Area means the county or counties that Contractor is approved to operate in under the terms of this Contract. A Service Area may be limited to designated zip codes (under the U.S. Postal Service) within a county.

Service Location means the location where a Member obtains Covered Services under the terms of this Contract.

Significant Change means changes in Covered Services, benefits, geographic Service Area, composition of payments to its Network, or Enrollment of a new population.

Site Review means surveys and reviews conducted by DHCS or Contractor to ensure that Network Provider, Subcontractor, and Downstream Subcontractor sites have sufficient capacity to provide appropriate health care services, carry out processes that support continuity and coordination of care, maintain Member safety standards and practices, and operate in compliance with all applicable federal, State, and local laws and regulations.

Skilled Nursing Care means Covered Services provided by nurses, technicians, and/or therapists during a stay in a Skilled Nursing Facility or in a Member's home.

Skilled Nursing Facility (SNF) means any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program.

Social Drivers of Health (SDOH) means the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health Related Social Needs.

Special Care Center means a center that provides comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions.

Specialist means a Provider who has completed advanced education and clinical training in a specific area of medicine or surgery. Specialists include, but are not limited to, those Specialists listed in W&I section 14197.

Specialty Mental Health Provider means a person or entity who is licensed, certified, otherwise recognized, or authorized under the California law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.

Specialty Mental Health Service (SMHS) means a Medi-Cal covered mental health service provided or arranged by county Mental Health Plans (MHP) for Members in their counties that need Medically Necessary Specialty Mental Health Services.

Standing Referral means a referral by a Primary Care Provider (PCP) to a Specialist for more than one visit to the Specialist, as indicated in the treatment plan, if any, without the Primary Care Provider having to provide a specific referral for each visit.

State means the State of California.

State Hearing means a hearing with a State Administrative Law Judge to resolve a Member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.

State Supported Services means Medi-Cal services that are funded entirely by the State, and for which the State does not receive matching federal funds. These services are covered by Contractor through their Secondary Contract with DHCS for State Supported Services.

Street Medicine means a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment that Contractor may offer to their Members. The fundamental approach of Street Medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Street Medicine utilizes a whole person, patient-centered approach to provide Medically Necessary health care services, as well as address Social Drivers of Health that impede health care access.

Street Medicine Provider means a Provider that renders Street Medicine services as offered by Contractor to their Members. Street Medicine Providers may provide services in various roles, such as the Member's assigned Primary Care Provider (PCP), through a direct contract with Contractor, as an Enhanced Care Managed (ECM) Provider, as a Community Supports Provider, or as a referring or treating contracted Provider as set forth in APL 22-023.

Subacute Care means a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed Skilled Nursing Care than is provided to the majority of Members in a Skilled Nursing Facility (SNF), as defined in 22 CCR section 51124.5.

Subcontractor means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Subcontractor Agreement means a written agreement between Contractor and a Subcontractor. The Subcontractor Agreement must include a delegation of Contractor's duties and obligations under the Contract.

Subcontractor Network means a Network of a Subcontractor or Downstream Subcontractor, wherein the Subcontractor or Downstream Subcontractor is delegated risk and is responsible for arranging for the provision of and paying for Covered Services as stated in their Subcontractor or Downstream Subcontractor Agreement.

Substance Use Disorder (SUD) means those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

Supplemental Payment means a payment, in addition to the Capitation Payment, made by DHCS to Contractor in accordance with Exhibit B, Subsection 1.1.7 (*Supplemental Payments*) of this Contract.

Suspended and Ineligible Provider List means the list containing the names of former Medi-Cal Providers suspended from or ineligible for participation in the Medi-Cal program. The Suspended and Ineligible Provider List is available online at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx.

Targeted Case Management (TCM) means services which assist Members within specified target groups to gain access to needed medical, social, educational, and other services, as set forth in 42 USC section 1396n(g). In prescribed circumstances, TCM is available as a Medi-Cal benefit and a discrete service through State or local government entities and their contractors.

Telehealth means a method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.

Template Data means data reports submitted to DHCS by Contractors, which includes, but is not limited to, data of Member populations, health care benefit categories, or program initiatives.

Third Party Tort Liability (TPTL) means the contractual responsibility or tort liability of an individual or entity other than Contractor or the Member for the payment of claims for injuries, or trauma sustained by a Member.

Threshold Languages/Threshold or Concentration Standard Languages means the non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS.

Transitional Care Service means a service provided to all Members transferring from one institutional care setting, or level of care, to another institution or lower level of care, including home settings.

Treatment Authorization Request (TAR) means certain Fee-For-Service (FFS) procedures and services that are subject to authorization by Medi-Cal field offices before reimbursement can be approved.

Tribal Federally Qualified Health Center (Tribal FQHC) means a Tribal Health Program funded under the authority of Public Law 93-638 at 25 USC sections 5301 et seq. These Health Programs have elected to participate in the Medi-Cal Tribal FQHCs and are subject to the payment terms of APL 21-008. Reimbursement of Tribal FQHCs is through an Alternative Payment Methodology (APM), which is set at the federal Indian Health Service All-Inclusive Rate. The APM rate is updated annually and published in APL 21-008, Attachment #1. A list of Tribal FQHCs is published in APL 21-008, Attachment #2.

Tribal Health Program means an American Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Health Service under the Indian Self-Determination and Education Assistance Act and is defined in 25 USC section 1603(25).

United States Department of Health and Human Services (U.S. DHHS) means the federal agency that oversees Centers for Medicare & Medicaid Services (CMS) that works in partnership with state governments to administer the Medicaid program, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

Urban Indian Organization means a nonprofit corporate body situated in an urban center, governed by an urban American Indian controlled board of directors, as defined in 25 USC section 1603(29). Urban Indian Organizations participate in Medi-Cal as

Tribal Federally Qualified Health Centers (Tribal FQHCs) or community clinics and are reimbursed via the Prospective Payment System or at Fee-For-Service rates.

Urgent Care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

Utilization Management (UM) or **Utilization Review** means the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

Vaccines for Children (VFC) Program means the federally funded program that provides free vaccines for eligible Children age 18 or younger (including all Medi-Cal eligible Children age 18 or younger) and distributes immunization updates and related information to participating Providers.

Waste means the overutilization or inappropriate utilization of services and misuse of resources.

Working Capital Ratio means a liquidity ratio, calculated as current assets divided by current liabilities, that measures Contractor's ability to pay its current liabilities with current assets. Working Capital Ratio is computed in accordance with Generally Accepted Accounting Principles (GAAP).

Working Day(s) means Monday through Friday, except for State holidays as identified at the California Department of Human Resources State Holidays page.

"Your Rights" Attachment means Contractor's written notice sent to the Member that explains the Member's rights to challenge, free of charge, Contractor's action, and the Member's right to file an Appeal with Contractor, a Deemed Exhaustion, and the right to request a State Hearing or an Independent Medical Review (IMR).

2.0 Acronyms

Medi-Cal Managed Care Contract Acronyms List

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following acronyms are abbreviations for the corresponding terms. This Acronyms List is provided for the convenience of the parties and must not be deemed as an exhaustive or exclusive list of all acronyms in this Contract. In the event that the acronyms contained in this list are inconsistent with the provisions in the Contract, the Contract provisions will prevail.

Acronyms	Corresponding Terms
AAP	American Academy of Pediatrics
ABD	Adverse Benefit Determination
ACE	Adverse Childhood Experience
ACIP	Advisory Committee on Immunization Practices
ACOG	American College of Obstetricians and Gynecologists
ADA	Americans with Disabilities Act of 1990
ADHC	Adult Day Health Care
ADO	Alternate Dispute Officer
AFS	Alternative Format Selections
AIDS	Acquired Immune Deficiency Syndrome
APL	All Plan Letter
API	Application Programming Interface
APS	Asthma Preventive Service
AR	Authorized Representative
ASAM	American Society of Addiction Medicine
ASD	Autism Spectrum Disorder
Basic PHM	Basic Population Health Management
BHT	Behavioral Health Treatment
C&L	Cultural and Linguistic
CalAIM	California Advancing and Innovating Medi-Cal
CBAS	Community Based Adult Services
CCM	Complex Care Management
CCR	California Code of Regulations
CCS	California Children's Services
CDPH	California Department of Public Health
CFR	Code of Federal Regulations
CHW	Community Health Worker
CLIA	Clinical Laboratory Improvement Act
CLPPB	Childhood Lead Poisoning Prevention Branch
CMP	Care Management Plan

Acronyms	Corresponding Terms
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
COBA	Coordination of Benefits Agreement
COHS	County Organized Health Systems
CPSP	Comprehensive Perinatal Services Program
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CRC	Caregiver Resource Center
CSHCN	Children with Special Health Care Needs
DDS	Department of Developmental Services
DF	Disclosure Form
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DME	Durable Medical Equipment
DMFEA	Division of Medi-Cal Fraud and Elder Abuse
DMHC	Department of Managed Health Care
DOT	Direct Observed Therapy
D-SNP	Dual-Eligible Special Needs Plan
DUR	Drug Use Review
DVBE	Disabled Veteran Business Enterprises
ECM	Enhanced Care Management
EMT	Emergency Medical Transportation
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQRO	External Quality Review Organization
ERS	CBAS Emergency Remote Services
FBC	Freestanding Birthing Center
FDA	United States Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
FSR	Facility Site Review
GAAP	Generally Accepted Accounting Principles
GC	California Government Code
H&S	Health and Safety Code
HCBS	Home and Community-Based Services
HEDIS®	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	The Health Insurance Portability and Accountability Act of 1996

Acronyms	Corresponding Terms
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPA	Health Plan Accreditation
ICD-10	International Classification of Diseases, Tenth Revision
ICF/DD	Intermediate Care Facility/Developmentally Disabled
ICF/DD-H	Intermediate Care Facility/Developmentally Disabled Habilitative
ICF/DD-N	Intermediate Care Facility/Developmentally Disabled Nursing
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
IHA	Initial Health Appointment
IHCP	Indian Health Care Provider
IHS	Indian Health Service
IHSP	Individualized Health and Support Plan
IHSS	In-Home Supportive Services
IMD	Institution for Mental Diseases
IMR	Independent Medical Review
IPA	Independent Physician/Provider Associations
IPC	Individual Plan of Care
IT	Information Technology
JC	Joint Commission
KKA	Knox-Keene Health Care Service Plan Act of 1975
LEA	Local Education Agency
LEP	Limited English Proficiency
LGA	Local Government Agency
LHD	Local Health Department
LM	Licensed Midwife
LTC	Long-Term Care
LTSS	Long-Term Services and Support
MAT	Medications for Addiction Treatment (or Medication-Assisted Treatment)
MCH	Maternal and Child Health
MEDS	Medi-Cal Eligibility Data System
MFTP	Money Follows the Person
MHP	Mental Health Plan
MIS	Management Information System
MLR	Medical Loss Ratio
MOC	Model of Care
MOU	Memorandum of Understanding

Acronyms	Corresponding Terms
MPL	Minimum Performance Level
MSSP	Multipurpose Senior Service Program
NABD	Notice of Adverse Benefit Determination
NAR	Notice of Appeal Resolution
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
NISTSP	National Institute of Standards and Technology Special Publication
NMT	Non-Medical Transportation
NOA	Notice of Action
NP	Nurse Practitioner
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limitation
NSMHS	Non-Specialty Mental Health Services
OHC	Other Health Coverage
PACE	Program for All-Inclusive Care for the Elderly
PCC	Public Contract Code
PCP	Primary Care Provider
PHI	Protected Health Information
PHM	Population Health Management
PHMS	Population Health Management Strategy
PI	Personal Information
PIA	Prison Industry Authority
PIP	Performance Improvement Project
PIR	Privacy Incident Reporting
PIU	Program Integrity Unit
PL	Policy Letter
PNA	Population Needs Assessment
PPC	Provider-Preventable Condition
PPR	Post-Payment Recovery
PSCI	Personal, Sensitive, and/or Confidential Information
QAS	Qualified Autism Services
QI	Quality Improvement
QIHEC	Quality Improvement and Health Equity Committee
QIHETP	Quality Improvement and Health Equity Transformation Program
QSO	Qualified Service Organization
QTL	Quantitative Treatment Limitation
RC	Regional Center

Acronyms	Corresponding Terms
RHC	Rural Health Clinic
RPD	Restricted Provider Database
RSS	Risk Stratification and Segmentation
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDOH	Social Drivers of Health
SED	Serious Emotional Disturbance
SFTP	Secure File Transfer Protocol
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SPD	Senior and Person with Disability
STC	Special Terms and Conditions
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder
TAR	Treatment Authorization Request
TB	Tuberculosis
TCM	Targeted Case Management
TDD	Telecommunication Devices for the Deaf
TNE	Tangible Net Equity
TPTL	Third Party Tort Liability
TTY	Telephone Typewriters
U.S. DHHS	United States Department of Health and Human Services
UM	Utilization Management
US DOJ	United States Department of Justice
USC	United States Code
USPSTF	United States Preventive Services Task Force
VFC	Vaccines for Children
W&I	Welfare and Institutions Code
WCM	Whole Child Model
WIC	Women, Infants and Children Supplemental Nutrition Program

Exhibit A, ATTACHMENT II

1.0 Operational Readiness Deliverables and Requirements

This Article describes a non-exhaustive list of Contractor deliverables, activities, and timeframes to be completed during the Implementation Period before beginning the Operations Period.

Upon successful completion of operational readiness deliverables and requirements, DHCS will provide Contractor a written authorization to begin its Operations Period. The Implementation Period begins with the effective date of the Contract and extends to the beginning of the Operations Period.

Once the Contract is awarded, DHCS will provide Contractor with a timeline to complete Implementation Period deliverables and requirements. The table in this Article must not be deemed as exhaustive, exclusive, or limiting. Contractor must submit all required operational deliverables consistent with all requirements set forth in this Contract on a schedule, form, and manner specified by the DHCS. Contractor may be responsible for additional deliverable requirements or activities during the Implementation Period based on changes in State and federal law and/or DHCS program needs. Contractor must comply with any additional requirements, not listed in the tables below, upon DHCS' request and in the form and manner specified by DHCS.

In the event Contractor fails to submit all deliverables in accordance with the milestones and timeframes required by DHCS, DHCS may impose Liquidated Damages and Sanctions in accordance with Exhibit E, Subsections 1.1.19 (*Sanctions*) and 1.1.20 (*Liquidated Damages*).

Dual Special Needs Plan

Contractors in Coordinated Care Initiative counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties) must have a Dual Special Needs Plan (D-SNP) available to dual eligible Members for contract year 2024 and must provide documentation of the Centers for Medicare & Medicaid approval of the D-SNP by December 2, 2023.

EXHIBIT A, ATTACHMENT I – 1.0 DEFINITIONS

No deliverables listed for this Article.

EXHIBIT A, ATTACHMENT I – 2.0 ACRONYMS

No deliverables listed for this Article.

EXHIBIT A, ATTACHMENT II –1.0 OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

See specific contract Sections below for details.

EXHIBIT A, ATTACHMENT III – 1.1 PLAN ORGANIZATION AND ADMINISTRATION

Identifier	Operational Readiness Requirement
R.0001	Submit documentation of State employees (current and former) who may present a conflict of interest as defined in Exhibit A, Attachment III, Subsection 1.1.3 (*Conflict of Interest – Current and Former State Employees)*.
R.0002	Submit a complete organizational chart.
R.0003	If Contractor is a subsidiary organization, submit an attestation by the parent organization that this Contract will be a high priority to the parent organization.
R.0004	Submit an attestation that the medical decisions made by the medical director will not be unduly influenced by fiscal or administrative management.
R.0005	Submit policies and procedures describing the representation and participation of Medi-Cal Members on Contractor's public policy advisory committee.
R.0006	Submit the Knox-Keene license exhibits and forms reflecting current operation status, as specified in Exhibit A, Attachment III, Section 1.1 (*Plan Organization and Administration*) and 28 California Code of Regulations (CCR) section 1300.51.
R.0007	Submit supporting documentation if Contractor is not currently licensed to operate in an awarded Service Area, as specified in Exhibit A, Attachment III, Section 1.1 (*Plan Organization and Administration*).
R.0008	If, within the last five years, Contractor has had a contract terminated or not renewed for poor performance, nonperformance, or any other reason, Contractor must submit a summary of the circumstances surrounding the termination or non-renewal, a description of the parties involved, including address(es) and telephone number(s). Describe Contractor's Corrective Actions to prevent future occurrences of any problems identified.
R.0009	Identify the composition and meeting frequency of any committee participating in establishing Contractor's public policy including the percent of patient/Member consumers. Describe Contractor's Governing Board, including the percent of patient/Member consumers, the frequency of the committee's report submission to Contractor's Governing Board, and the Governing Board's process for handling reports and recommendations after receipt.

Identifier	Operational Readiness Requirement
R.0010	Contractor must submit policies and procedures for ensuring that all appropriate staff and Network Providers receive annual diversity, Health Equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency/humility training) relating to Members including completion of required Continuing Medical Education on cultural competency/humility and implicit bias.

EXHIBIT A, ATTACHMENT III – 1.2 FINANCIAL INFORMATION

Identifier	Operational Readiness Requirement
R.0012	Submit most recent audited annual financial reports.
R.0013	Submit quarterly Financial Statements with the most recent quarter prior to execution of the Contract.
R.0014	Submit the Knox-Keene license exhibits reflecting projected financial viability as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and 28 CCR section 1300.76.
R.0015	Submit Knox-Keene license Exhibit HH-6 as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and 28 CCR section 1300.51(d)(HH).
R.0016	1) Describe any risk sharing or Incentive Arrangements. 2) Explain any intent to enter into a stop loss option with DHCS. 3) Describe any reinsurance and risk-sharing arrangements with any Subcontractors and Downstream Subcontractors shown in this Contract. 4) Submit copies of all policies and agreements. 5) Comply with assumption of financial risk and reinsurance requirements pursuant to 22 CCR sections 53863 and 53868. Comply with directed payments requirements pursuant to 42 Code of Federal Regulations (CFR) section 438.6.
R.0017	Fiscal Arrangements: Submit the Knox-Keene license exhibits as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and in 28 CCR section 1300.51.
R.0018	Describe systems for ensuring that Subcontractors, Downstream Subcontractors, and Network Providers who are providing services to Medi-Cal Members, have the administrative and financial capacity to meet its contractual obligations and requirements, as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*) and in 22 CCR section 53250 and 28 CCR section 1300.70.

Identifier	Operational Readiness Requirement
R.0019	Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures.
R.0020	Describe process to ensure timely filing of required financial reports as described in Exhibit A, Attachment III, Section 1.2 (*Financial Information*). Contractor must also describe how it will comply with the Administrative Cost requirements referenced in 22 CCR section 53864(b).
R.0021	Provide letters of financial support, credit, bond, or loan guarantee or other financial guarantees, if any, in at least the same amount that the obligations to Members will be performed.

EXHIBIT A, ATTACHMENT III – 1.3 PROGRAM INTEGRITY AND COMPLIANCE PROGRAM

Identifier	Operational Readiness Requirement
R.0022	Submit a Compliance Program, Standard of conduct or code of conduct, related policies and procedures, and training materials.
R.0023	Organizational chart for the Compliance Program showing key personnel.
R.0024	Submit a Fraud Prevention Program and related policies and procedures, training materials, and an organizational chart showing key personnel.
R.0025	Submit policies and procedures for the screening, Enrollment of Network Providers, if Contractor elects to screen and enroll.

EXHIBIT A, ATTACHMENT III – 2.1 MANAGEMENT INFORMATION SYSTEM

Identifier	Operational Readiness Requirement
R.0026	Submit a completed MCO Baseline Assessment Form.

Identifier	Operational Readiness Requirement
R.0027	If procuring a new Management Information System (MIS) or modifying a current system, Contractor must provide a detailed implementation plan that includes the following: 1) Outline of the tasks required; 2) The major milestones; and 3) The responsible party for all related tasks. In addition, the implementation plan must also include: 1) A full description of the acquisition of software and hardware, including the schedule for implementation; 2) Full documentation of support for software and hardware by the manufacturer or other contracted party; 3) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results; and 4) Documentation of system changes related to Exhibit G, (*Business Associate Addendum*) requirements.
R.0028	Submit a detailed description, including a diagram and/or flow chart, of how Contractor will monitor the flow of Encounter Data, Network Provider Data, Program Data, Template Data, and all other data required by this Contract from origination at the Provider level to Contractor, through submission to DHCS as well as how Contractor will transmit information regarding general and specific data quality issues identified by DHCS from origination to Providers for correction.
R.0029	Submit Encounter Data, Provider data, Program Data, and Template Data test files as required by DHCS, produced using real or proxy data processed by a new or modified MIS to DHCS. Production data submissions from a new or modified MIS may not take place until this test has been successfully reviewed and approved by DHCS.
R.0030	Submit policies and procedures for the submission of complete, accurate, reasonable, and timely Encounter Data, Provider data, Program Data, Template Data, and all other data required by this Contract, including how Contractor will correct data quality issues identified by DHCS.
R.0032	Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.
R.0033	Submit a detailed description, including details regarding interoperability, of the proposed and/or existing MIS as it relates to each of the subsystems described in Exhibit A, Attachment III, Section 2.1 (*Management Information System*).

Identifier	Operational Readiness Requirement
R.0246	Submit policies and procedures to demonstrate how Contractor will conduct routine testing and monitoring, and update their systems as appropriate to ensure the Application Programming Interfaces (APIs) are functioning properly and complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements.

EXHIBIT A, ATTACHMENT III – 2.2 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

Identifier	Operational Readiness Requirement
R.0035	Submit a flow chart and/or organization chart identifying all components of the Quality Improvement and Health Equity Transformation Program (QIHETP) including who is involved and responsible for each activity.
R.0036	Submit a flow chart and/or organization chart identifying all components of the QIHETP including who is involved and responsible for each activity, for each Fully Delegated Subcontractor, and each Contractor downstream Subcontractor.
R.0037	Submit policies that specify the responsibility of the Governing Board in the QIHETP.
R.0038	Submit policies for the Quality Improvement and Health Equity Committee (QIHEC) including membership, activities, roles and responsibilities and reporting relationships to other committees within the organization.
R.0039	Submit policies for each Fully Delegated Subcontractor's and Contractor Downstream Subcontractor's QIHEC including membership, activities, roles and responsibilities, and reporting relationships to other committees within the organization.
R.0040	Submit procedures outlining how Providers, Contractor Subcontractors, and Contractor Downstream Subcontractors will participate in the QIHETP and Population Needs Assessment (PNA) and how the findings from both will be shared with Providers, Contractor Subcontractors and Contractor Downstream Subcontractors.
R.0041	Submit policies and procedures related to the oversight of Subcontractors and Downstream Subcontractors for any delegated QIHETP activities, including a complete list of all Subcontractors, Downstream Subcontractors, and their delegated QIHETP activities.
R.0042	Submit policies and procedures that describe how Contractor will develop and submit an annual QIHETP Plan that provides a comprehensive assessment of all Quality Improvement (QI) and Health Equity activities undertaken, including an evaluation of the effectiveness of QI and Health Equity interventions, and an assessment of all Subcontractors' performance for any delegated QI and/or Health Equity activities.

Identifier	Operational Readiness Requirement
R.0043	Submit policies and procedures to address how Contractor will meet each of the following requirements: 1) Quality and Health Equity Performance Measure annual reporting requirements; 2) Exceed DHCS established Quality and Health Equity Performance measure benchmarks; 3) Ensure all Fully Delegated Subcontractors exceed DHCS established Quality and Health Equity Performance measure benchmarks; 4) Performance Improvement Projects (PIPs); 5) Consumer Satisfaction Survey; 6) Network Adequacy Validation; 7) Encounter Data Validation; 8) Focused Studies; and 9) Technical Assistance Recommendations.
R.0044	Submit policies and procedures for reporting any disease or condition to public health authorities.
R.0045	Submit policies and procedures for Credentialing and recredentialing that ensure all Network Providers who deliver Covered Services to Members are qualified in accordance with applicable standards, and are licensed, certified, or registered, as appropriate.
R.0046	No later than January 1, 2024, submit either (A) or (B and C): 1) Evidence of National Committee for Quality Assurance (NCQA) Health Plan Accreditation (HPA). 2) Timeline that demonstrates the NCQA HPA process will be started no later than January 1, 2024, and full NCQA HPA will be received no later than January 1, 2026. 3) Evidence of interim NCQA HPA approval within five Working Days of receipt.
R.0047	No later than January 1, 2024, submit either (A) or (B): 1) Evidence of NCQA Health Equity Accreditation. 2) Timeline that demonstrates the NCQA Health Equity Accreditation process will be started no later than January 1, 2024, and completed no later than January 1, 2026.
R.0048	Submit policies and procedures for identifying, evaluating, and reducing Health Disparities.
R.0049	Submit policies and procedures that describe how Contractor ensures the adoption, dissemination and monitoring of the use of clinical practice guidelines.
R.0050	Submit policies and procedures that describe the integration of Utilization Management (UM) into the QIHETP.

Identifier	Operational Readiness Requirement
R.0051	Submit policies and procedures that describe how Contractor will detect both over- and under-utilization of services, including outpatient Prescription Drugs.
R.0052	Submit policies and procedures that describe how Contractor will ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services provided for Members less than 21 years of age, and how Contractor will identify and address underutilization of preventive services for such Members.
R.0053	Submit policies and procedures that describe how Contractor will promote Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and preventive services to Members less than 21 years of age, as well as outreach to Members less than 21 years of age overdue for such services.
R.0054	Submit policies and procedures that describe how Contractor will ensure that Members less than 21 years of age are fully addressed in the Population Health Management Strategy (PHMS), including Basic Population Health Management (Basic PHM), EPSDT, Case Management Services, Early Intervention and a Wellness and Prevention Program.
R.0055	Submit a description of a comprehensive wellness program for Members less than 21 years of age.
R.0056	Submit policies and procedures that describe how Contractor will maintain and continually monitor, evaluate, and improve Cultural and Linguistic (C&L) services that support the delivery of Covered Services to Members less than 21 years of age.
R.0057	Submit policies and procedures that describe how Contractor will develop and maintain a school-linked statewide Network of School Site Behavioral Health counselors.
R.0058	Submit policies and procedures that describe how Contractor will inform its Network Providers about the Vaccines for Children (VFC) program and how they will promote and support Enrollment of appropriate Providers in VFC.
R.0059	Submit policies and procedures that describe Contractor's Member and family engagement strategy and how Members and/or parents and caregivers are engaged in the development of QI and Health Equity activities and interventions.
R.0060	Submit policies and procedures that describe how Contractor will engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to Members less than 21 years of age.
R.0061	Submit policies and procedures that describe how Contractor will ensure the provision of all Medically Necessary mental health and Substance Use Disorder (SUD) services to Members less than 21 years of age.

EXHIBIT A, ATTACHMENT III – 2.3 UTILIZATION MANAGEMENT PROGRAM

Identifier	Operational Readiness Requirement
R.0062	Submit written description of UM program that describes appropriate processes to be used to review, approve, modify, deny, and delay the provision of medical, mental health, and SUD services to demonstrate compliance with mental health parity.
R.0063	Submit written description of procedures for reviews and annual updates of UM program.
R.0064	Submit written description of Grievances and Appeals procedures for Providers and Members that will be published on Contractor's website.
R.0065	Submit policies and procedures for Standing Referrals.
R.0066	Submit policies and procedures on Standing Referrals when a Member condition requires a specialized medical care over a prolonged period of time.
R.0067	Submit policies and procedures for Prior Authorization, concurrent review, and Retrospective Review.
R.0068	Submit a list of services requiring Prior Authorization and the Utilization Review criteria.
R.0069	Submit policies and procedures for the Utilization Review Appeals process for Providers and Members.
R.0070	Submit policies and procedures that specify timeframes for medical authorization.
R.0072	Submit policies and procedures to detect both under- and over-utilization of health care services.
R.0073	Submit policies and procedures showing how UM functions which may be delegated to a Subcontractor or Downstream Subcontractor will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved; and that UM activities are properly documented and reported.
R.0074	Submit policies and procedures to refer Members who are potentially eligible for Multipurpose Senior Service Program (MSSP) services to MSSP services Providers for authorization.

EXHIBIT A, ATTACHMENT III – 3.1 NETWORK PROVIDER AGREEMENTS, SUBCONTRACTOR AGREEMENTS, DOWNSTREAM SUBCONTRACTOR AGREEMENTS, AND CONTRACTOR'S OVERSIGHT DUTIES

Identifier	Operational Readiness Requirement
R.0075	Submit policies and procedures for a system to evaluate and monitor the financial viability of all Network Providers, Subcontractors, and Downstream Subcontractors.

Identifier	Operational Readiness Requirement
R.0076	Submit executed Network Provider Agreements/Subcontractor Agreements/Downstream Subcontractor Agreements or documentation substantiating Contractor's efforts to enter into these agreements with the Local Health Department (LHD) for each of the following public health services: 1) Family Planning Services; 2) Sexually Transmitted Disease (STD) Services; 3) Human Immunodeficiency Virus (HIV) testing and counseling; and 4) Immunizations.
R.0244	Submit all Network Provider, Subcontractor, and Downstream Subcontractor Agreements templates.
R.0245	Submit Subcontractor and Downstream Subcontractor Agreement templates language showing accountability of any delegated QIHETP functions and responsibilities.

EXHIBIT A, ATTACHMENT III – 3.2 PROVIDER RELATIONS

Identifier	Operational Readiness Requirement
R.0077	Submit policies and procedures for the Provider Dispute Resolution Mechanism.
R.0078	Submit a written description of how Contractor will communicate the Provider Dispute Resolution Mechanism to Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors.
R.0079	Submit protocols for payment and communication with out-of-Network Providers.
R.0080	Submit policies and procedures for ensuring out-of-Network Providers receive Contractor's clinical protocols and evidence-based practice guidelines.
R.0081	Submit copy of Contractor's Provider manual.
R.0082	Submit a schedule of Network Provider training to be conducted during year one of operation. Include date, time and location, and complete curriculum.
R.0083	Submit policies and procedures for ensuring Network Providers receive training within the required timeframes, regarding clinical protocols, evidenced-based practice guidelines, and DHCS developed cultural awareness and sensitivity instruction for Senior and Person with Disability (SPD) Members.
R.0084	Submit protocols for communicating and interacting with emergency departments in and out of Contractor's Service Area.

EXHIBIT A, ATTACHMENT III – 3.3 PROVIDER COMPENSATION ARRANGEMENTS

Identifier	Operational Readiness Requirement
R.0085	Submit policies and procedures regarding timing of Capitation Payments to Primary Care Providers (PCP) or clinics.
R.0086	Submit description of any Provider financial incentive programs (including but not limited to Physician incentive plans as defined in 42 CFR section 422.208).
R.0087	Submit description of efforts to promote value-based models and investments in Primary Care using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) Framework as outlined in the Alternative Payment Model (APM) Framework White Paper, https://hcp-lan.org/workproducts/apm-whitepaper.pdf.
R.0088	Submit policies and procedures for processing and payment of claims.
R.0089	Submit policies regarding the prohibition of a claim or demand for services provided under the Medi-Cal managed care contract to any Member.
R.0090	Submit any Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Network Provider Agreements to DHCS for approval.
R.0091	Submit policies and procedures for the reimbursement of non-contracting Certified Nurse Midwives (CNMs) and Nurse Practitioners (NPs).
R.0092	Submit policies and procedures for the reimbursement of Skilled Nursing Facilities and Nursing Facilities (SNF/NF).
R.0093	Submit policies and procedures for the reimbursement to LHDs and non-contracting family planning Providers for the provision of family planning services, STD episode, and HIV testing and counseling.
R.0094	Submit policies and procedures for the reimbursement of immunization services to LHD.
R.0095	Submit policies and procedures regarding payment to non-contracting Emergency Services Providers. Include reimbursement schedules for all non-contracting Emergency Service Providers, including any schedule of per diem rates and/or Fee-for-Service (FFS) Rates for each of the following Provider types: 1) PCPs; 2) Medical Groups and Independent Practice Associations; 3) Specialists; and 4) Hospitals.
R.0096	Submit policies and procedures for reporting Provider-Preventable Conditions (PPCs).
R.0247	Submit policies and procedures for pre-payment and post-payment claims review.

EXHIBIT A, ATTACHMENT III – 4.1 MARKETING

Identifier	Operational Readiness Requirement
R.0097	Submit policies and procedures for training and certification of Marketing Representatives.
R.0098	Submit a description of training program, including the Marketing Representative's training/certification manual.
R.0099	Submit Contractor's Marketing plan.
R.0100	Submit copy of boilerplate request form used to obtain DHCS approval of participation in a Marketing event.

EXHIBIT A, ATTACHMENT III – 4.2 ENROLLMENTS AND DISENROLLMENTS

Identifier	Operational Readiness Requirement
R.0101	Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting Providers.
R.0102	Submit policies and procedures for how Contractor will access and utilize Enrollment data from DHCS.
R.0103	Submit policies and procedures relating to Member disenrollment.

EXHIBIT A, ATTACHMENT III – 4.3 POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE

Identifier	Operational Readiness Requirement
R.0108	Submit evidence illustrating Contractor's MIS has the capacity to meet DHCS data integration and exchange requirements as outlined in Exhibit A, Attachment III, Subsection 4.3.3 (*Data Integration and Exchange*).
R.0110	Submit policies and procedures for complying with the Risk Stratification/Segmentation (RSS) requirements in Exhibit A, Attachment III, Subsection 4.3.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*).
R.0111	Submit Contractor's process(es) describing how Contractor identifies Significant Changes in Members' health status or level of care and how Contractor monitors to ensure appropriate re-stratification.
R.0112	Submit a list of the data used by Contractor's RSS approach that includes the required sources in Exhibit A, Attachment III, Subsection 4.3.5.A.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*) at a minimum. For each type of data listed, Contractor must include a description of the data and its origin, and how the data will be incorporated into the RSS approach.
R.0113	Submit a description of Contractor's population RSS and Risk Tiering approach, as well as the processes for how RSS and Risk Tiers are used to connect Members to appropriate services.

Identifier	Operational Readiness Requirement
R.0114	Submit the method of bias analysis used to analyze Contractor's RSS and Risk Tiering approach, and the analysis of whether any biases were identified and if so, how they were corrected.
R.0115	Submit policies and procedures for conducting an initial screening or assessment of each Member's needs within 90 days of Enrollment, for sharing that information with DHCS, other Contractors, or Providers on behalf of Members, as appropriate, and for monitoring the completion of the assessments.
R.0116	Submit a description of Contractor's Complex Care Management (CCM) program outlining the types of Members, populations and/or program criteria established, the CCM program's approach for both long-term chronic conditions and episodic, temporary interventions, and processes for fulfilling all the other CCM program requirements outlined in Exhibit A, Attachment III, Subsection 4.3.7.A.2 (*Care Management Programs*).
R.0117	Submit policies and procedures for handling care management, and the non-duplication of services when multiple Subcontractors, Downstream Subcontractors, and/or Providers are involved in a Member's care.
R.0118	Submit policies and procedures for assigning Care Managers to Members, and monitoring to ensure all Care Managers' responsibilities are fulfilled.
R.0119	Submit policies and procedures for documenting and maintaining Care Management Plans (CMPs).
R.0120	Submit policies and procedures that meet the Basic PHM requirements outlined in Exhibit A, Attachment III, Subsection 4.3.8.A (*Basic Population Health Management*). Contractor's policies and procedures should address core Basic PHM, Care Coordination, care navigation and referral needs of all Members. Contractor's policies and procedures must also address requirements regarding wellness and prevention programs and chronic disease management programs.
R.0121	Submit evidence that Contractor is providing the Provider resources as required by Exhibit A, Attachment III, Subsection 4.3.8.B (*Basic Population Health Management*).
R.0122	Submit policies and procedures for identifying, referring, and providing EPSDT case management services for Members less than 21 years of age.
R.0123	Submit policies and procedures for identifying and providing care management services for Children with Special Health Care Needs (CSHCN).
R.0124	Submit policies and procedures for identifying, referring, and providing care management services for Members at risk of developmental delay and eligible to receive services from the local Early Start Program.

Identifier	Operational Readiness Requirement
R.0125	Submit policies and procedures for the provision of comprehensive wellness and prevention programs to all Members.
R.0126	Submit policies and procedures for providing Transitional Care Services as outlined in Exhibit A, Attachment III, Subsection 4.3.11.A (*Targeted Case Management Services*).
R.0127	Submit Contractor's standardized discharge risk assessment that identifies Members' risk for re-hospitalization, re-institutionalization, and substance use recidivism.
R.0128	Submit Contractor's strategy for developing policies and procedures for Discharge Planning and Transitional Care Services with each Network and out-of-Network Provider hospital within its Service Area.
R.0129	Submit policies and procedures for ensuring Discharge Planning documents are completed, and that the documents fulfill the requirements outlined in Exhibit A, Attachment III, Subsection 4.3.11.B (*Targeted Case Management Services*), and are provided to Members, parents, legal guardians, or Authorized Representatives when being discharged from a hospital, institution, or facility.
R.0131	Submit policies and procedures for coordinating care for Members who may need or are receiving services and/or programs from out-of-Network Providers.
R.0132	Submit policies and procedures for identifying and referring the target populations for Targeted Case Management (TCM) programs within Contractor's Service Area and for reaching out to Local Government Agencies (LGAs) to coordinate care, as appropriate, upon notification from DHCS that Members are receiving TCM services. Policies and procedures must include processes for ensuring non-duplicative services.
R.0133	Submit policies and procedures for identifying, referring, and coordinating care for Members in need of Non-Specialty Mental Health Services (NSMHS), Specialty Mental Health Services (SMHS) and/or SUD treatment services with Contractor's Network, the county Mental Health Plan (MHP), Drug Medi-Cal Organized Delivery System (DMC-ODS) or Drug Medi-Cal, or other community resources. Contractor is required to use the State-approved screening and transition tools.
R.0134	Submit policies and procedures for identifying, referring, and coordinating care for Members requiring alcohol or SUD treatment services from both within and, if necessary, outside Contractor's Service Area in partnership with the LGAs responsible for such services.
R.0135	Submit policies and procedures for identifying, referring, and coordinating care for Members with the local California Children's Services (CCS) Program.

Identifier	Operational Readiness Requirement
R.0136	Submit policies and procedures for the identifying, referring, and coordinating care for Members with Developmental Disabilities (DD) in need of non-medical services from the local Regional Center (RC) that includes the duties of the RC liaison.
R.0137	Submit policies and procedures for ensuring Care Coordination of Local Education Agency (LEA) services, including PCP involvement in the development of the Member's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP).
R.0138	Submit policies and procedures for identifying, referring, and ensuring Care Coordination and non-duplication of services for Members who are eligible for or who are already receiving contracted school-based services, such as EPSDT and Behavioral Health Services, from either LEAs, FQHCs or community-based organizations.
R.0139	Submit policies and procedures for providing required dental services and dental-related services that includes the duties of Contractor's dental liaison.
R.0140	Submit policies and procedures for ensuring case management and Care Coordination of Members with the LHD Tuberculosis (TB) Control Officer. Policies and procedures must include assessing and referring Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.
R.0141	Submit policies and procedures for identifying and referring eligible Members for Women, Infants and Children Supplemental Nutrition Program (WIC) services.
R.0142	Submit policies and procedures for identifying and referring eligible Members to Home and Community-Based Services (HCBS) programs. Policies and procedures must include processes for ensuring non-duplicative services.
R.0143	Submit policies and procedures for identifying and referring eligible Members to the county In-Home Supportive Services (IHSS) program, the duties of Contractor's IHSS liaison. and ensure compliance with the requirements outlined in Exhibit A, Attachment III, Subsection 4.3.21 (*In-Home Supportive Services*).
R.0144	Submit policies and procedures that described the duties and responsibilities of Contractor's Indian Health Care Provider (IHCP) tribal liaison in working with IHCPs within Contractor's Service Area.

Identifier	Operational Readiness Requirement
R.0248	Submit policies and procedures that describe the duties and responsibilities of Contractor's managed care liaisons, including training and notification requirements for each of the following required liaisons: 1) Long-Term Services and Supports (LTSS) Liaison; 2) Transportation Liaison; 3) CCS Liaison; and 4) Foster Care Liaison.

EXHIBIT A, ATTACHMENT III – 4.4 ENHANCED CARE MANAGEMENT

Identifier	Operational Readiness Requirement
R.0145	Submit an Enhanced Care Management (ECM) Model of Care (MOC) using the DHCS approved template. If Contractor has a previously approved MOC for implementation of ECM effective January 1, 2022, or July 1, 2022, Contractor may submit an attestation stating that there are no changes to the previously approved MOC. If Contractor has changes to a previously approved MOC, Contractor must submit an updated MOC with all changes in track-edits for DHCS review and approval. Contractor must submit to DHCS any Significant Changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, pursuant to Exhibit A, Attachment III, Subsection 4.4.5.D (*Enhanced Care Management Model of Care*) and in accordance with DHCS policies and guidance, including All Plan Letters (APLs). Significant Changes may include, but are not limited to, changes to Contractor's approach to administer or deliver ECM services, approved policies and procedures, and Subcontractor Agreements and Downstream Subcontractor Agreements boilerplates.

EXHIBIT A, ATTACHMENT III – 4.5 COMMUNITY SUPPORTS

Identifier	Operational Readiness Requirement

R.0146	Submit a Community Supports MOC using the DHCS approved template. If Contractor has a previously approved MOC for implementation of Community Supports effective January 1, 2022, or July 1, 2022, Contractor may submit an attestation stating that there are no changes to the previously approved MOC. If Contractor has changes to a previously approved MOC, Contractor must submit an updated MOC with all changes in track-edits for DHCS review and approval. Contractor must submit to DHCS any changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, pursuant to Exhibit A, Attachment III, Subsection 4.5.5.D (*Community Supports Model of Care*) and in accordance with DHCS policies and guidance, and APLs. Substantial changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services; approved policies and procedures; and Network Provider Agreement, Subcontractor Agreements, or Downstream Subcontractor Agreements boilerplates, as appropriate.

EXHIBIT A, ATTACHMENT III – 4.6 MEMBER GRIEVANCE AND APPEAL SYSTEM

Identifier	Operational Readiness Requirement
R.0147	Submit policies and procedures relating to Contractor's Member Grievance and Appeal system including compiling, aggregating, and reviewing Grievance and Appeal data.
R.0148	Submit policies and procedures for Contractor's oversight of the Member Grievance and Appeal system for the receipt, processing and distribution of Grievance and Appeals, including the expedited review of Appeals. Include a flow chart to demonstrate the process.
R.0149	Submit policies and procedures relating to Contractor's Grievances and the expedited review of Grievances as required by 42 CFR sections 438.402, 438.406, and 438.408, 28 CCR sections 1300.68 and 1300.68.01, and 22 CCR section 53858.
R.0150	Submit policies and procedures relating to the resolution of Discrimination Grievances.
R.0151	Submit policies and procedures relating to Contractor's Appeals process. Include Contractor's responsibilities in State Hearings, Independent Medical Review, and expedited Appeals.
R.0152	Submit format for monthly Grievance and Appeal report.

EXHIBIT A, ATTACHMENT III – 5.1 MEMBER SERVICES

Identifier	Operational Readiness Requirement
R.0153	Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and Providers.

Identifier	Operational Readiness Requirement
R.0154	Submit policies and procedures for training Contractor's Member Services staff on Member rights, responsibilities, and services available under this Contract.
R.0155	Submit policies and procedures for training Contractor's Network Providers, Subcontractors, and Downstream Subcontractors on Member rights, Covered Services, and other responsibilities.
R.0156	Submit policies and procedures for handling Member Grievances not related to an Adverse Benefit Determination (ABD).
R.0157	Submit policies and procedures for providing communication access to Members in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, written communication, electronic format, plain language or written translations and oral interpreters, including Limited English Proficiency (LEP) Members, or non-English speaking.
R.0158	Submit policies and procedures regarding compliance with the Americans with Disabilities Act of 1990 (42 United States Code (USC) section 12101 et seq.), Section 504 of the Rehabilitation Act of 1973 (29 USC section 794), Section 1557 of the Patient Protection and Affordable Care Act (42 USC section 18116), SB 223 (Atkins, Chapter 771, Statutes of 2017), and SB 1423 (Hernandez, Chapter 568, Statutes of 2018), and California Government Code(GC) section 11135, as required in APL 21-011.
R.0159	Submit the following consistent with the requirements of Exhibit E, Subsection 1.1.23 (*Confidentiality of Information*). Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information and the right to amend or correct Medical Records pursuant to 45 CFR sections 164.524 and 164.526.
R.0160	Submit policies and procedures for addressing Advance Directives.
R.0161	Submit policies and procedures for the training of Member services staff.
R.0162	Submit policies and procedures regarding the development content and distribution of Member information. Address appropriate reading level and translation of materials.
R.0163	Submit final approved Member Identification Card and Member Handbook.
R.0164	For non-County Organized Health Systems (COHS) Contractors, submit policies and procedures explaining the Member's right to an Independent Medical Review (IMR) including when an expedited IMR is available to the Member.

Identifier	Operational Readiness Requirement
R.0165	Submit policies and procedures explaining the Member's right to a State Hearing after receiving a Notice of Appeal Resolution (NAR) or in cases of Deemed Exhaustion. These policies and procedures must also include the information on the Member's right to an expedited State Hearing if his/her health condition is in jeopardy.
R.0166	Submit policies and procedures and live notice Contractor will send to Members advising them of how to obtain Member informing materials including the Member Handbook, and Provider Directory.
R.0167	Submit policies and procedures on the Member's right to disenroll at any time to enroll in another Medi-Cal managed care plan pursuant to 22 CCR section 53891(c).
R.0168	Submit policies and procedures for notifying Members of changes in availability or location of Covered Services.
R.0169	Submit policies and procedures for Member selection of a PCP or non-physician medical practitioner. Include the mechanism used for allowing SPD Members to request a Specialist to serve as their PCP.
R.0170	Submit policies and procedures for Member Assignment to a PCP. Include the use of FFS utilization data and other data in linking a SPD to a PCP, or Specialist acting as the SPD's PCP.
R.0171	Submit policies and procedures for notifying the PCP that a Member has selected or has been assigned to within ten calendar days from the selection or assignment.
R.0172	Submit policies and procedures demonstrating how, upon entry into Contractor's Network, the relationship between Traditional and Safety-Net Providers and the Member is not disrupted, to the maximum extent possible.
R.0173	Submit policies and procedures for notifying Members of an ABD for denial, deferral, or modification of requests for Prior Authorization, including explanation of Deemed Exhaustion to the Member.
R.0249	Submit policies and procedures to demonstrate how, for dates of service on or after January 1, 2016, Contractor will make the data it maintains available within one Working Day of receipt data or information, or one Working Day after a claim is adjudicated or Encounter Data is received.
R.0250	Submit policies and procedures to demonstrate how Contractor will update its Provider Directory API at least weekly after receiving updated Provider information or being notified of any information that affects the content or accuracy of the Provider Directory.
R.0251	Submit website mock-ups showing where a third-party applicant can easily access Contractor's patient access and Provider Directory APIs.

Identifier	Operational Readiness Requirement
R.0252	Submit a link to Contractor's publicly accessible Member educational resources that will achieve the following: 1) Demonstrate the steps Member may consider taking to help protect the privacy and security of their health information and the importance of understanding the security and privacy practices of any application to which they entrust their health information; and 2) Provide an overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities, the oversight responsibilities of the Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to OCR and FTC.

EXHIBIT A, ATTACHMENT III – 5.2 NETWORK AND ACCESS TO CARE

Identifier	Operational Readiness Requirement
R.0174	Submit policies and procedures on how Contractor will assist Members in selecting PCPs who are accepting new patients and how it will afford access to Primary Care and specialty care.
R.0175	Submit complete 274 Provider File demonstrating the ability to serve 60 percent of Potential Members, including SPD Members, in each of the counties that Contractor serves pursuant to this Contract.
R.0176	Submit policies and procedures for how Contractor will meet federal requirements for access and reimbursement Network and/or out-of-Network FQHC, RHC, Freestanding Birthing Center (FBC) services, CNMs, and Licensed Midwives (LMs).
R.0177	Submit policies and procedures that establish traditional and Safety-Net Provider participation standards.
R.0178	Submit policies and procedures describing how Contractor will monitor Provider to Member ratios to ensure they are within specified standards.
R.0179	Submit policies and procedures regarding Physician supervision of non-physician medical practitioners.
R.0180	Submit policies and procedures to monitor and ensure how Contractor, Network Providers, Subcontractors and Downstream Subcontractors comply with timely access requirements for each of the following: 1) Standards for timely appointments; 2) Appropriate clinical timeframes; 3) Shortening or expanding timeframes; 4) Follow up appointments; 5) Triaging Member calls; 6) Telephone interpreters; and 7) Contractor's customer service line.

Identifier	Operational Readiness Requirement
R.0181	Submit policies and procedures for how Contractor will ensure Network Provider hours of operation are no less than the hours of operation offered to other commercial or FFS recipients.
R.0182	Submit a policy regarding the availability of Contractor's Medi-Cal director or licensed physician 24-hours-a-day, 7-days-a-week, and procedures for communicating with emergency room personnel.
R.0183	Submit all documents outlined for the Network certification demonstrating that the proposed Network meets the appropriate Network adequacy standards set forth in this Contract and Welfare and Institutions Code (W&I) section 14197. See APL 23-001 for document specification and submission guidelines. Network certification must be submitted in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e).
R.0184	Submit policies and procedures for providing Emergency Services including 24-hr./day access without Prior Authorization, follow-up, and coordination of emergency care services.
R.0185	Submit policies and procedures for authorizing and arranging for out-of-Network access, including arranging transportation services for Members to access the out-of-Network Providers.
R.0186	Submit policies and procedures for the provision of and access to each of the following: 1) Family planning services; 2) STD services; 3) HIV testing and counseling services; 4) COVID therapeutics (see APL 22-009); 5) Pregnancy termination; 6) Minor Consent Services; 7) Immunizations; 8) IHCP services; 9) CNM and CNP services; 10) NSMHS for minors; and 11) Medication for Addiction Treatment (MAT).
R.0187	Submit policies and procedures for the timely referral and coordination of Covered Services to which Contractor, Subcontractor, or Downstream Subcontractor has moral objections to perform or otherwise support.
R.0188	Submit policies and procedures for the provision of 24-hour interpreter services at key points of contact.
R.0189	Submit policies and procedures regarding Contractor, Subcontractor, and Downstream Subcontractor compliance with State and federal language and communication assistance requirements.

Identifier	Operational Readiness Requirement
R.0190	Submit policies and procedures regarding Contractor, Subcontractor, and Downstream Subcontractor compliance with civil rights laws requiring access for Members with disabilities.
R.0191	Submit a written description of the C&L services program and policies and procedures for monitoring and evaluation of the C&L services program.
R.0192	Submit an analysis demonstrating the ability of Contractor's Network to meet the ethnic, cultural, and linguistic needs of Contractor's Members.
R.0193	Submit policies and procedures for providing cultural competency/humility, sensitivity or diversity training for staff, Network Providers, Subcontractors, and Downstream Subcontractors at key points of contact.
R.0194	Submit policies and procedures describing Contractor's Member and family engagement strategy and how Contractor will ensure Member and/or parent and caregiver input into appropriate policies and decision-making.
R.0195	Submit policies and procedures describing how Contractor will ensure the following with regards to the Community Advisory Committee (CAC): 1) How Contractor will ensure a diverse membership on the CAC that is reflective of Contractor's Service Area and includes adolescents and/or parents/caregivers of Members less than 21 years of age; 2) How Contractor will support Member participation in the CAC; 3) How Contractor will ensure the CAC will be involved in appropriate policies and decision-making; 4) How Contractor will actively facilitate communication and connection between the CAC and Contractor leadership; and 5) How Contractor will ensure that one Member of the CAC participates in the DHCS Statewide CAC and how Contractor will support Member's attendance and participation in that Committee.
R.0196	Submit policies and procedures for providing continuity of care including the completion of Covered Services by Providers and out-of-Network Providers.
R.0197	Submit policies and procedures for performance of Facility Site Reviews (FSR) and Medical Record reviews (FSR Attachments A and B), and for performance of Facility Site physical accessibility reviews (FSR Attachment C).
R.0198	Submit the aggregate results of pre-operational Site Reviews to DHCS at the request of DHCS. The aggregate results must include all data elements specified by DHCS.

EXHIBIT A, ATTACHMENT III – 5.3 SCOPE OF SERVICES

Identifier	Operational Readiness Requirement
R.0199	Submit policies and procedures, including standards, for the provision of each of the following services for Members less than 21 years of age: 1) Children's preventive services; 2) Immunizations; 3) Blood Lead screens; and 4) EPSDT services.
R.0200	Submit policies and procedures for the provision of adult preventive services, including immunizations.
R.0201	Submit policies and procedures for the provision of each of the following services to pregnant Members: 1) Prenatal and postpartum care; 2) Use of American College of Obstetricians and Gynecologists standards and guidelines; 3) Comprehensive risk assessment tool for all pregnant Members; and 4) Referral to Specialists.
R.0202	Submit a list of appropriate hospitals available within the Network that provide necessary high-risk pregnancy services.
R.0203	Provide a detailed description of health education system including policies and procedures regarding delivery of services, administration, and oversight.
R.0204	Provide a list and schedule of all health education classes and/or programs.
R.0205	Submit policies and procedures for the provision of Emergency Medical Transportation (EMT), Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).
R.0206	Submit policies and procedures that define and describe what mental health services are to be provided by a licensed mental health care Provider.
R.0208	Submit policies and procedures for the provision of Major Organ Transplants as Covered Services.
R.0209	Submit policies and procedures for the provision of Long-Term Care (LTC) as Covered Services.
R.0210	Submit policies and procedures for the provision of services at non-contracted LTC facilities.
R.0211	Submit policies and procedures for conducting a Drug Use Review (DUR).
R.0212	Submit policies and procedures for the UM of covered pharmaceutical services, demonstrating compliance with mental health parity requirements set forth in 42 CFR section 438.900 *et seq.*

EXHIBIT A, ATTACHMENT III – 5.4 COMMUNITY BASED ADULT SERVICES

Identifier	Operational Readiness Requirement
R.0215	Submit policies and procedures for referring a Member to a Community Based Adult Services (CBAS) Provider.
R.0216	Submit policies and procedures on arranging for the provision of CBAS unbundled services.
R.0217	Submit all policies and procedures required by the California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, Section V.A.23.
R.0218	Submit policies and procedures for the initial assessment and reassessment of Members for eligibility to receive CBAS, including circumstances where Contractor may forgo a face-to-face review if eligibility has already been determined through another process.
R.0219	Submit policies and procedures for an expedited assessment process.
R.0220	Submit final draft of the written notice to be sent to Members after a CBAS assessment determination that results in a change to the Member's CBAS benefit.
R.0253	Submit all policies and procedures on providing CBAS Emergency Remote Services (ERS).
R.0254	Submit policies and procedures for community participation for Members receiving CBAS.
R.0255	Submit policies and procedures for notifying DHCS of payments made to a CBAS Provider involved in a credible allegation of Fraud.

EXHIBIT A, ATTACHMENT III – 5.5 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Identifier	Operational Readiness Requirement
R.0207	Submit policies and procedures for when a Member becomes eligible for SMHS and/or SUD treatment services during the course of receiving NSMHS, including how Contractor will use required State-approved transition of care tool for coordinating care between Contractor and MHPs.
R.0213	Submit policies and procedures for handling of psychiatric emergencies during non-business hours.
R.0214	Submit policies and procedures for verifying the credentials of licensed mental health Providers of NSMHS.
R.0222	Submit policies and procedures for entering into agreements with MHPs, NSMHS Providers, county DMC-ODS plans, counties administering California Medicaid State Plan benefits, and SUD treatment Providers in order to comply with access standards and Care Coordination requirements, including those concerning the concurrent provision of covered NSMHS and SMHS consistent with WI section 14184.402(f)(1).

Identifier	Operational Readiness Requirement
R.0223	Submit policies and procedures for the provision of SUD services including drug and alcohol Screening, Brief Intervention, and Referral to Treatment (SBIRT) services, including: 1) Provision of SBIRT by a Member's PCP to identify, reduce, and prevent problematic substance use; 2) Referral, without requiring Prior Authorization, for SBIRT services for Members whose PCPs do not offer SBIRT services; and 3) Referral of Members to SUD treatment without requiring Prior Authorization, when there is a need beyond SBIRT services.

EXHIBIT A, ATTACHMENT III – 5.6 MOUs WITH LOCAL GOVERNMENT AGENCIES, COUNTY PROGRAMS, AND THIRD PARTIES

Identifier	Operational Readiness Requirement
R.0224	Submit executed Memorandum of Understandings (MOUs), or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities and county programs in Contractor's Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including, but not limited to: 1) LHDs in each County within Contractor's Services Area for the following programs and services: a) CCS; b) Maternal and Child Health (MCH); c) TB Direct Observed Therapy (DOT); and d) Community Health Workers (CHWs). 2) WIC agencies in each county within Contractors' Service Area. 3) LGAs such as the County Behavioral Health Department and County Social Services Department, in each county within Contractors' Service Area to assist with coordinating the following programs and services: a) SMHS; b) Alcohol and SUD treatment services, including counties administering State plan Drug Medi-Cal benefits and counties participating in DMC-ODS; c) TCM; and d) IHSS. 4) LGAs to coordinate programs and services for Members in each county within Contractor's Service Area at a minimum: a) Social Services; and b) Child welfare departments. 5) RCs for persons with DDs.

Identifier	Operational Readiness Requirement
R.0225	Submit executed MOUs, or documentation substantiating Contractor's efforts to negotiate MOUs to coordinate programs and services for Members with LGAs, third-party entities, and county programs in Contractor's Service Area, even if Contractor is coordinating care and not financially responsible, to ensure Care Coordination, data sharing, and non-duplicative services for Members, including at a minimum: 1) LEAs for IEPs or IFSPs; 2) Jails, juvenile facilities, and probation departments; and 3) Third-party entities in each county within Contractor's Service Area, at a minimum: a) HCBS program agencies; b) Continuums of Care; c) First 5 programs; d) Area Agencies on Aging; and e) Caregiver Resource Center.
R.0226	Submit policies and procedures for exchanging Member Information with MHPs and DMC-ODS or county Drug Medi-Cal Programs in compliance with State and federal privacy laws and regulations.
R.0227	Submit policies and procedures for maintaining collaboration among the parties to the MOU and monitoring and assessing the effectiveness of MOUs. Policies and procedures should include the requirement to review its MOUs annually for any needed modifications or renewal of responsibilities and obligations.

EXHIBIT A, ATTACHMENT III – 6.0 EMERGENCY PREPAREDNESS AND RESPONSE

No deliverables listed for this Article. (To Become Effective on January 1, 2025)

EXHIBIT B, BUDGET DETAIL AND PAYMENT PROVISIONS

Identifier	Operational Readiness Requirement
R.0233	Submit documentation of the Coordination of Benefits Agreement that Contractor has entered into with Medicare.

EXHIBIT C, GENERAL TERMS AND CONDITIONS

No deliverables listed for this Exhibit.

EXHIBIT D(f), SPECIAL TERMS AND CONDITIONS

No deliverables listed for this Exhibit.

EXHIBIT E, PROGRAM TERMS AND CONDITIONS

Identifier	Operational Readiness Requirement
R.0234	Submit policies and procedures explaining Contractor's data certification reporting method. Policies and procedures must include a template certification statement.
R.0235	Submit policies and procedures for the treatment of recoveries, including retention policies, process, timeframes, and documentation for reporting, for all recovery of overpayments.
R.0236	Submit policies and procedures for how Contractor will comply with Cost Avoidance and Post-Payment Recovery for Members with Other Healthcare Coverage (OHC).
R.0237	Submit policies and procedures for how Contractor will comply with Third-Party Tort and Worker's Compensation Liability.
R.0238	Submit policies and procedures for how Contractor will comply with an investigation or a prosecution conducted by the Division of Medi-Cal Fraud and Elder Abuse (DMFEA) and/or the United States Department of Justice (US DOJ), including communicating requirements with Subcontractors and Downstream Subcontractors.

EXHIBIT F, CONTRACTOR'S RELEASE

No deliverables listed for this Exhibit.

EXHIBIT G, BUSINESS ASSOCIATE ADDENDUM

No deliverables listed for this Exhibit.

EXHIBIT H, CONFLICT OF INTEREST AVOIDANCE REQUIREMENTS

Identifier	Operational Readiness Requirement
R.0241	Submit updated report on any conflicts of interest and/or conflict avoidance plan, if requested by DHCS.

EXHIBIT I, CONTRACTOR'S PARENT GUARANTY REQUIREMENTS

Identifier	Operational Readiness Requirement
R.0242	Submit parent guaranty, if applicable.

EXHIBIT J, DELEGATION REPORTING AND COMPLIANCE PLAN

Identifier	Operational Readiness Requirement
R.0243	Submit delegation reporting and compliance plan (Template A, B, and C).

EXHIBIT K, EXCLUDED PROVISIONS AS TO CONTRACTORS NOT LICENSED PURSUANT TO THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

No deliverables listed for this Exhibit.

EXHIBIT L, REQUIREMENTS SPECIFIC TO CONTRACTOR

Any deliverables for Contractor-specific requirements will be stated in Exhibit L.

Exhibit A, ATTACHMENT III

1.0 Organization

The Department of Health Care Services (DHCS) seeks to ensure that only those managed care plans that have the organizational capacity, leadership, financial well-being, commitment to invest in our communities, and demonstrated ability to ensure program integrity and compliance with all applicable federal and State requirements and standards under this Contract, may be Contractors.

Article 1.0 outlines DHCS' requirements for plan organization and administration including key leadership roles, including the designation of a Chief Health Equity Officer having the authority to design and implement policies that ensure Health Equity is prioritized and addressed. Key personnel changes, including those relevant to Contractor, Subcontractors, and Downstream Subcontractors, must be reported to DHCS in a timely fashion. The financial health and well-being of Contractors are vital to ensuring access to Medi-Cal Covered Services, and as such, DHCS requires reporting of financial data for review. In addition, DHCS will ensure minimum loss ratios are in place for Contractors, Subcontractors, and Downstream Subcontractors who take financial risk to provide services for Members. Additionally, requiring that a portion of profits invested back into the community will help ensure that Contractors are seeking opportunities to work at a local level to further efforts to address Social Drivers of Health (SDOH) and drive improvements in quality, equity, and access to care.

Article 1.0 also outlines requirements for Contractors to ensure that they have a clear compliance plan to meet the requisite personnel, processes, and capacity as outlined in the Contract.

1.1 Plan Organization and Administration

1.1.1 Legal Capacity
1.1.2 Key Personnel Disclosure Form
1.1.3 Conflict of Interest – Current and Former State Employees
1.1.4 Contract Performance
1.1.5 Medical Decisions
1.1.6 Medical Director
1.1.7 Chief Health Equity Officer
1.1.8 Key Personnel Changes
1.1.9 Administrative Duties/Responsibilities
1.1.10 Member Representation
1.1.11 Diversity, Equity, and Inclusion Training

Exhibit A, ATTACHMENT III

1.1 Plan Organization and Administration

1.1.1 Legal Capacity

Contractor must maintain the legal capacity to contract with Department of Health Care Services (DHCS) and, if required, maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (KKA) as amended (Health and Safety Code (H&S) section 1340 *et seq.*). If Contractor is not currently licensed to operate in an awarded Service Area, within 30 Working Days of award of Contract, it must submit a material modification to its license to the Department of Managed Health Care (DMHC) requesting authorization to operate in the Service Area. Contractor must submit proof of its material modification submission to DHCS concurrently. Operations Period will not begin until the material modification is approved by DMHC. Within three Working Days of approval, Contractor must submit a copy of its approved and amended Knox-Keene license to DHCS.

1.1.2 Key Personnel Disclosure Form

A. Contractor must file an annual statement with DHCS disclosing any purchases or leases of services, equipment, supplies, or real property from an entity in which any of the following persons have a substantial financial interest:

1) Any person or corporation having five percent or more ownership or controlling interest in Contractor;

2) Any director, officer, partner, trustee, or employee of Contractor; and

3) Any member of the immediate family of any person designated in 1) or 2) above.

B. Comply with 42 Code of Federal Regulations (CFR) sections 455.104 (Disclosure by Medicaid providers and fiscal agents: Information on ownership and control), 455.105 (Disclosure by providers: Information related to business transactions), 455.106 (Disclosure by providers: Information on persons convicted of crimes), and 438.610 (Prohibited affiliations).

1.1.3 Conflict of Interest – Current and Former State Employees

A. This Contract will be governed by the conflict of interest provisions of 42 CFR sections 438.3(f)(2) and 438.58 and 22 California Code of Regulations (CCR) sections 53874 and 53600.

B. In the performance of this Contract, Contractor will not utilize any State officer, employee in State civil service, other appointed State official, intermittent State employee, or contracting consultant for DHCS, unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment.

1.1.4 Contract Performance

Contractor must maintain the necessary organization and level of staffing to implement and operate this Contract in accordance with 28 CCR section 1300.67.3 and 22 CCR sections 53800, 53851, and 53857. Contractor must ensure the following:

A. Contractor has an accountable Governing Board;

B. Compliance with this Contract is a high priority, and that Contractor is committed to supplying any necessary resources to assure full performance of the Contract;

C. If Contractor is a subsidiary organization, its parent organization provides an attestation confirming that this Contract will be a high priority to the parent organization and committing to supply any necessary resources to assure full performance of the Contract;

D. Adequate staffing in medical and other health services, fiscal and administrative capacity sufficient to effectively conduct Contractor’s business; and

E. Written procedures are developed and maintained for conducting Contractor’s business, including the provision of health care services, in compliance with federal and State Medicaid law.

1.1.5 Medical Decisions

Contractor must ensure that medical decisions, including those by Subcontractors, Downstream Subcontractors, Network Providers, and other Providers, are not unduly influenced by fiscal and administrative management.

1.1.6 Medical Director

Contractor must appoint a physician as a full-time medical director pursuant to 22 CCR section 53857 whose responsibilities must include, but should not be limited to, the following:

A. Ensuring that medical and other health services decisions are:

   1) Rendered by qualified medical personnel; and

   2) Not influenced by fiscal or administrative management considerations.

B. Ensuring that the medical and other health care provided meets acceptable standards of care;

C. Ensuring that Contractor's medical personnel follow medical protocols and rules of conduct;

D. Developing and implementing medical policy consistent with applicable standards of care;

E. Resolving Grievances related to Quality of Care;

F. Participating directly in the implementation of Quality Improvement and Health Equity activities;

G. Participating directly in the design and implementation of the Population Health Management Strategy (PHMS) and initiatives;

H. Participating actively in the execution of Grievance and Appeal procedures;

I. Ensuring that Contractor engages with local health departments; and

J. Posting medical director contact information in an easily accessible location on their provider portal website.

1.1.7 Chief Health Equity Officer

Contractor must maintain a full-time Chief Health Equity Officer who has the necessary qualifications or training at the time of hire or within one year of hire to meet the requirements of the position. The Chief Health Equity Officer responsibilities must include, but should not be limited to, the following:

A. Provide leadership in the design and implementation of Contractor's strategies and programs to ensure Health Equity is prioritized and addressed;

B. Ensure all Contractor policy and procedures consider Health Inequities and are designed to promote Health Equity where possible, including, but not limited to:

1) Marketing strategy;

2) Medical and other health services policies;

3) Member and provider outreach;

4) Community Advisory Committee;

5) Quality Improvement (QI) activities, including delivery system reforms;

6) Grievance and Appeals; and

7) Utilization Management (UM).

C. Develop and implement policies and procedures aimed at improving Health Equity and reducing Health Disparities;

D. Engage and collaborate with Contractor staff, Subcontractors, Downstream Subcontractors, Network Providers, and entities including, but not limited to, local community-based organizations, local health departments, Behavioral Health and social services, Child welfare systems and Members in Health Equity efforts and initiatives;

E. Implement strategies designed to identify and address root causes of Health Inequities, which includes but is not limited to systemic racism, Social Drivers of Health (SDOH), and infrastructure barriers;

F. Develop targeted interventions designed to eliminate Health Inequities;

G. Develop quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate Health Inequities;

H. Ensure all Contractor, Subcontractor, Downstream Subcontractor, and Network Provider staff receive mandatory diversity, equity, and inclusion training (sensitivity, diversity, communication skills, and cultural

competency/humility training) as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*) annually. This includes, but is not limited to:

1) Reviewing training materials to ensure the materials are up to date with current standards of practice; and

2) Maintaining records of training completion.

1.1.8 Key Personnel Changes

Contractor must report to DHCS Contract Manager any changes in the status of the executive-level personnel including, but not limited to, the chief executive officer, chief financial officer, chief operations officer, the chief medical director, the chief Health Equity officer, the compliance officer, and government relations persons within ten calendar days. Contractor must also report to DHCS Contract Manager any changes in the status of the executive-level personnel for Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors including, but not limited to, the chief executive officer, chief financial officer, chief operations officer, the medical director, the chief Health Equity officer, the compliance officer, and government relations persons within 20 calendar days.

1.1.9 Administrative Duties/Responsibilities

Contractor must maintain the organizational and administrative capabilities to carry out Contractor's duties and responsibilities under the Contract. At a minimum, Contractors' responsibilities must include the following:

A. Comply with all requirements and deliverables as described in Exhibit A, Attachment II, Article 1.0 (*Operational Readiness Deliverables and Requirements*);

B. Maintain financial records and books of account on an accrual basis, in accordance with Generally Accepted Accounting Principles (GAAP), which fully disclose the disposition of all Medi-Cal program funds received, as specified in Exhibit A, Attachment III, Section 1.2 (*Financial Information*);

C. Maintain a Member and Enrollment reporting system as specified in Exhibit A, Attachment III, Section 2.1 (*Management Information System*), Section 4.6 (*Member Grievance and Appeal System*), and Section 5.1 (*Member Services*);

D. Maintain data reporting capabilities sufficient to provide necessary and timely reports to DHCS, as required by Exhibit A, Attachment III, Section 2.1 (*Management Information System*);

E. Maintain data and information exchange capabilities as needed to meet Contractor's obligation under the Contract and to support DHCS administration of the Medi-Cal program through data sharing with other trading partners. This includes, but is not limited to, Encounter Data, Medical Record information, Network Provider and Provider information, Member demographics, and case notes;

F. Maintain QI activities and Population Health Management (PHM) activities. Comply with all National Committee for Quality Assurance (NCQA) and accreditation requirements by calendar year 2026 as described in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program*);

G. Maintain a UM program, as described in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*);

H. Maintain Network adequacy as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*);

I. Comply with requirements, as described in Exhibit A, Attachment III, Section 3.2 (*Provider Relations*);

J. Maintain claims processing capabilities as described in Exhibit A, Attachment III, Section 3.3 (*Provider Compensation Arrangements*);

K. Maintain adequate access and availability of Primary Care Providers (PCP) and Specialists for all Medically Necessary Covered Services for Members, as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*);

L. Form a Community Advisory Committee (CAC) and meet expectations, as described in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*), including CAC's active participation in addressing Quality of Care, Health Equity, Health Disparities, PHM, Children services, and other ongoing Contractor functions;

M. Provide or arrange for all Medically Necessary Covered Services for Members, as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Exhibit A, Attachment III, Section 5.4 (*Community Based Adult*

Services), and Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*);

N. Provide Care Coordination including, but not limited to, all Medically Necessary services delivered both within and outside Contractor's Network, as described in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*);

O. Negotiate in good faith and execute Network Provider Agreements, Subcontractor Agreements, or Memorandums of Understanding (MOUs), as appropriate, with third party entities, including county programs, and local health jurisdictions covered by this Contract, as described in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) and Exhibit A, Attachment III, Subsection 3.1.9 *(Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments)*;

P. Comply with the requirements described in Exhibit A, Attachment III, Section 5.1 (*Member Services*);

Q. Maintain Member Grievance procedures, as specified in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

R. Develop training and certification for Marketing activity, if Contractor conducts Marketing, as described in Exhibit A, Attachment III, Section 4.1 (*Marketing*);

S. Cooperate with the DHCS Enrollment program, as described in Exhibit A, Attachment III, Section 4.2 (*Enrollments and Disenrollments*); and

T. Comply with all requirements and deliverables, as described in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*).

1.1.10 Member Representation

Contractor must ensure that Medi-Cal Members, including Seniors and Persons with Disabilities (SPD), persons with chronic conditions (such as asthma, diabetes, congestive heart failure), Limited English Proficient (LEP) Members, and Members from diverse cultural and ethnic backgrounds or their representatives are included and invited to participate in establishing public policy within Contractor's advisory committee and CAC, as specified in Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees*), or other similar committees or groups.

1.1.11 Diversity, Equity, and Inclusion Training

Contractor must ensure that all staff who interact with, or may potentially interact with, Members and any other staff deemed appropriate by Contractor or DHCS, receive annual sensitivity, diversity, communication skills, and cultural competency/humility training as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*).

Exhibit A, ATTACHMENT III

1.2 Financial Information

1.2.1 Financial Viability and Standards Compliance
1.2.2 Contractor's Financial Reporting Obligations
1.2.3 Independent Financial Audit Reports
1.2.4 Cooperation with DHCS' Financial Audits
1.2.5 Medical Loss Ratio
1.2.6 Contractor's Obligations
1.2.7 Community Reinvestment Plan and Report

1.2 Financial Information

1.2.1 Financial Viability and Standards Compliance

Contractor must meet and maintain financial viability and standards compliance to DHCS' satisfaction for each of the following elements:

A. Tangible Net Equity (TNE).

Contractor at all times must be in compliance with the TNE requirements set forth in 28 CCR section 1300.76, even in circumstances where Contractor is not otherwise legally required to comply with this provision.

B. Administrative Costs.

Contractor's Administrative Costs must comply with the standards set forth in 22 CCR section 53864(b) and 28 CCR section 1300.78.

C. Standards of organization and financial soundness.

Contractor must maintain an organizational structure sufficient to conduct the operations required by this Contract and ensure that its financial resources are sufficient for sound business operations in accordance with 28 CCR sections 1300.67, 1300.67.3, 1300.75.1, 1300.75.4.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, and 1300.77.4.

D. Working Capital Ratio of one of the following:

1) Contractor must maintain a Working Capital Ratio of current assets to current liabilities of at least 1:1 in accordance with Health & Safety Code (H&S) section 1375.4(b)(1)(A)(iv); or

2) Contractor must demonstrate to DHCS that Contractor is meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or

3) Contractor must provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent Working Capital Ratio of 1:1, if the noncurrent assets are considered current.

E. In the event DHCS finds Contractor non-compliant with any of the elements or obligations set forth in this provision, DHCS may impose a Corrective Action plan or sanctions in accordance with Exhibit E (*Program*

Terms and Conditions) and Welfare and Institutions Code (W&I) section 14197.7, as set forth in All Plan Letter (APL) 23-012. See Exhibit E, Subsection 1.1.19 (*Sanctions*).

1.2.2 Contractor's Financial Reporting Obligations

A. Form and Standards for Financial Reporting

Contractor must provide financial information and reports, including, but not limited to, Financial Statements, to DHCS in the form and manner specified by DHCS. Unless otherwise specified by DHCS, Contractor must prepare all financial information requested by DHCS in accordance with Generally Accepted Accounting Principles (GAAP) and the 1989 Health Maintenance Organization (HMO) Financial Report of Affairs and Conditions format. Any Department of Managed Health Care (DMHC) required reports must be prepared in DMHC-required financial reporting format, and in accordance with 28 CCR section 1300.84. Information submitted by Contractor must be based on current operations. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 (KKA) rules found under 28 CCR sections 1300.51 *et seq*.

Unless otherwise specified by DHCS, all Financial Statements must include, at a minimum, the following reports/schedules unless explicitly excluded in this Attachment:

1) Jurat;

2) Report 1A and 1B: Balance Sheet;

3) Report 2: Statement of Contract Revenue, Expenses, and Net Worth;

4) Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 in lieu of Report 3: Statement of Changes in Financial Position for GAAP compliance;

5) Report 4: Enrollment and Utilization Table;

6) Schedule G: Unpaid Claims Analysis;

7) Appropriate footnote disclosures in accordance with GAAP; and

8) Schedule H: Aging of All Claims.

In addition, Contractor must prepare and submit a stand-alone Medi-Cal line of business income statement and Enrollment table on each financial reporting period required. Contractor must prepare this income statement and Enrollment table in the DMHC required financial reporting format for each specific county or rating region of operation, as specified by DHCS and must include, at a minimum, the following reports/schedules:

1) Report 2: Statement of Contract Revenue and Expenses; and

2) Report 4: Enrollment and Utilization Table by County/Rating Region.

Medi-Cal line of business Financial Statements are to include expenses, Contract Revenues, and Enrollment only for Medi-Cal Members enrolled through direct contract with DHCS.

Contactor must submit the Medi-Cal line of business Financial Statements within the same timeframe as indicated for each required Financial Statement.

B. Monthly Reporting Obligations

Contractor must submit to DHCS, no later than 30 calendar days after the close of Contractor's fiscal month, an exact copy of any reports required be filed in accordance with 28 CCR section 1300.84.3.

C. Quarterly Reporting Obligations

Contractor must submit to DHCS, no later than 45 calendar days after the close of Contractor's fiscal quarter, an exact copy of any reports required to be filed in accordance with 28 CCR section 1300.84.2.

D. Annual Reporting Obligations

Contractor must prepare and submit to DHCS, no later than 120 calendar days after the close of Contractor's Fiscal Year, an exact copy of any reports required to be filed in accordance with 28 CCR section 1300.84.06. Contractor must also submit Medi-Cal line of business Financial Statements no later than 120 calendar days of after the close of the applicable Rating Period.

E. Annual Forecasts

Contractor must submit to DHCS annual forecasts of Contractor's next Fiscal Year no later than 60 calendar days prior to the beginning of each Fiscal Year. Contractor's annual forecast must be prepared using DMHC required financial reporting forms and must include, at a minimum, the following reports/schedules:

1) Report 2: Statement of Contract Revenue and Expenses (Medi-Cal line-of-business);

2) Report 4: Enrollment and Utilization Table by County/Rating Region (Medi-Cal line-of-business);

3) TNE (All lines of business); and

4) A detailed explanation of all underlying assumptions used to develop the forecast.

F. Publication of Financial Reports

Financial Reports submitted in accordance with this Section 1.2 are public records and may be made public by DHCS.

1.2.3 Independent Financial Audit Reports

Contractor must ensure that an annual audit is performed by an independent Certified Public Accountant in accordance with 42 CFR section 438.3(m) and W&I section 14459. Except as indicated in Paragraph B of this provision, a copy of the resulting independent financial audit report must be submitted to DHCS no later than 120 calendar days after the close of Contractor's Fiscal Year.

When the delivery of care or other services is dependent upon Affiliates of Contractor, Contractor must submit combined, annual Financial Statements that reflect the financial position of Contractor's overall health care delivery system in accordance with 28 CCR section 1300.84(c). Such combined, annual Financial Statements must be presented in a form that clearly shows the financial position of Contractor separately from the combined totals set forth in the combined Financial Statements. Intra-entity or related party transactions and profits must be eliminated if consolidated Financial Statements are prepared and submitted by Contractor. Contractor also must submit to DHCS any financial audit conducted by DMHC pursuant to H&S section 1382 within 30 calendar days of Contractor's receipt thereof.

In the event that Contractor's retained independent Certified Public Accountant determines that preparation of combined, annual Financial Statements is inappropriate or impracticable under the circumstances, separate certified Financial Statements must be prepared for each entity involved in the delivery of health care services by Contractor, and such separate, annual Financial Statements must be submitted to DHCS, along with the following:

A. Contractor must provide the independent Certified Public Accountant's written statement of the reasons for not preparing combined Financial Statements;

B. Contractor must provide supplemental schedules that clearly reflect all intra-entity or related party transactions and eliminations necessary to enable DHCS to analyze the overall financial position of Contractor's entire health care delivery system. If Contractor is a public entity or a political subdivision of the State and a county grand jury conducts Contractor's financial audits, Contractor must submit its Financial Statements within 180 calendar days after the close of Contractor's Fiscal Year in accordance with H&S section 1384;

C. Contractor must authorize its independent Certified Public Accountant to allow DHCS' designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report;

D. Contractor must submit to DHCS all financial reports relevant to Affiliates as specified in 28 CCR section 1300.84(c); and

E. Contractor must submit to DHCS copies of any financial reports submitted to any other public or private organization within ten calendar days of submission to such other public or private organization.

1.2.4 Cooperation with DHCS' Financial Audits

DHCS must conduct, or contract for the conduct of, periodic audits of the accuracy, truthfulness, and completeness of the financial data submitted by, or on behalf of, Contractor in accordance with 42 CFR section 438.602(e). Contractor must cooperate with these audits and provide all information and materials requested by DHCS, or its contracted auditor, for this purpose. Please see Exhibit A, Attachment III, Section 2.1 (*Management Information System*) for related requirements.

1.2.5 Medical Loss Ratio

Contractor must annually report a Medical Loss Ratio (MLR) as described in this provision and in accordance with 42 CFR section 438.8. For Rating Periods during which the State mandates a minimum MLR remittance in accordance with 42 CFR section 438.8(j), Contractor must impose equivalent MLR reporting requirements on Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors. Starting January 1, 2025, Contractor must impose equivalent remittance requirements on Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

A. Contractor must calculate and report a MLR as stated in 42 CFR sections 438.8 and 438.604(a)(3) in a form and manner specified by DHCS.

   1) Contractor must ensure that revenues, expenditures, and other amounts are appropriately identified and classified including by distinguishing 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.

   2) Contractor must, in compliance with 42 CFR section 438.230(c)(1) and California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions, in particular Paragraph 11 of the 1915(b) Waiver, require all Subcontractors and Downstream Subcontractors to comply with the MLR reporting responsibilities in this Section, including the requirement to distinguish which amounts are 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 Centers for Medicare & Medicaid Services (CMS) Informational Bulletin published May 15, 2019 with the subject “Medical Loss Ratio Requirements Related to Third-Party Vendors.” Payments to a Subcontractor or Downstream Subcontractor that are not the amount actually paid to a Provider or supplier for furnishing Covered Services must not be included in incurred claims.

B. The MLR experienced by Contractor in a MLR reporting year is the ratio of the numerator, as stated in Paragraph C of this Section, to the denominator, as stated in Paragraph D of this Section. A MLR may be increased by a credibility adjustment in accordance with Paragraph F of this provision.

C. The numerator of Contractor's MLR for a MLR reporting year is the sum of Contractor's incurred claims, expenditures for activities that improve health care quality, and Fraud prevention activities.

1) Contractor's Incurred Claims

a) Incurred claims must include the following:

i. Direct claims that Contractor paid to Providers, including under capitated contracts with Network Providers, for Covered Services or supplies under this Contract and meeting the requirements of 42 CFR section 438.3(e);

ii. Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims Incurred but Not Reported;

iii. Withholds from payments made to Network Providers;

iv. Claims that are recoverable for anticipated coordination of benefits;

v. Claims payments recoveries received due to subrogation;

vi. Incurred but Not Reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity;

vii. Changes in other claims-related reserves; and

viii. Reserves for contingent benefits and the medical claim portion of lawsuits.

b) Amounts that must be deducted from incurred claims include the following:

i. Overpayment recoveries received from Network Providers;

ii. Prescription Drug rebates received and accrued; and

iii. Amounts received as remittances from Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors in accordance with Paragraph K of this provision and Exhibit B of this Contract.

c) Expenditures that must be included in incurred claims include the following:

i. The amount of incentive and bonus payments made, or expected to be made, to Network Providers; and

ii. The amount of claims payments recovered through Fraud reduction efforts, not to exceed the amount of Fraud reduction expenses. The amount of Fraud reduction expenses must not include activities specified in Paragraph C.2.c. of this provision.

d) Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to solvency funds mandated by DHCS.

e) The following amounts must be excluded from incurred claims.

i. Non-claims costs, which include (1) the amounts paid to third-party vendors for secondary network savings; (2) amounts paid to third-party vendors for network development, administrative fees, claims processing, and Utilization Management (UM); (3) amounts paid for professional or administrative services, including amounts paid to a Provider, that do not represent compensation or reimbursement for California Medicaid State Plan services or services defined in 42 CFR section 438.3(e) and provided to Members; and (4) amounts paid for fines and penalties assessed by regulatory authorities; and

ii. Amounts paid to DHCS as remittances in accordance with Paragraph K of this provision and Exhibit B of this Contract; and

iii. Amounts paid to Network Providers under 42 CFR section 438.6(d).

f) Incurred claims paid by an entity that is later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by the ceding entity.

2) Activities that improve health care quality must be in one of the following categories:

a) Contractor's activity that meets the requirements of 45 CFR section 158.150(b) and is not excluded under 45 CFR section 158.150(c);

b) Contractor's activity related to any External Quality Review-related activity as described in 42 CFR sections 438.358(b) and (c); or

c) Any Contractor expenditure that is related to Health Information Technology (HIT) and meaningful use, meets the requirements placed on issuers set forth in 45 CFR section 158.151, and is not considered incurred claims, as defined in this provision.

3) Contractor's expenditures on activities related to Fraud prevention as described in 45 CFR part 158, and not including expenses for Fraud reduction efforts as stated in Paragraph C.1.c.ii of this provision.

D. The denominator of Contractor's MLR for a MLR reporting year must equal the adjusted premium revenue for Contractor's Medi-Cal line of business. The adjusted premium revenue is Contractor's premium revenue minus Contractor's federal, State, and local taxes and licensing and regulatory fees, and is aggregated in accordance with this provision.

1) Premium revenue includes the following for the MLR reporting year:

a) Capitation Payments, developed in accordance with 42 CFR section 438.4, and excluding payments made per 42 CFR section 438.6(d);

b) One-time payments for Member life events as specified in this Contract, including, but not limited to, Supplemental

Payments and Additional Payments as set forth in provisions 1.7 and 1.8 of Exhibit B, respectively;

c) Other payments to Contractor approved under 42 CFR section 438.6(b)(3);

d) All changes to unearned premium reserves; and

e) Net payments or receipts related to Risk Sharing Mechanisms developed in accordance with 42 CFR sections 438.5 or 438.6.

2) Taxes, licensing, and regulatory fees for the MLR reporting year must include:

a) Statutory assessments to defray the operating expenses of any State or federal department;

b) Examination fees in lieu of premium taxes as specified by State law;

c) Federal taxes and assessments allocated to Contractor, excluding federal income taxes on investment income, capital gains, and federal employment taxes;

d) State and local taxes and assessments including:

i. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State or a locality directly.

ii. Guaranty fund assessments.

iii. Assessments of State or local industrial boards or other boards for operating expenses, or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by the State.

iv. State or local income, excise, and business taxes, other than premium taxes and State employment and similar taxes and assessments.

v. State or local premium taxes, plus State or local taxes based on reserves, if in lieu of premium taxes.

e) Payments made by Contractor that are otherwise exempt from federal income taxes, for community benefit expenditures as defined in 45 CFR section 158.162(c), limited to the higher of either:

i. 3 percent of earned premium; or

ii. The highest premium tax rate in the State, multiplied by Contractor's earned premium in the State.

3) If Contractor is later assumed by another entity that becomes the new Contractor under this Contract, the new Contractor must report the total amount of the denominator for the entire MLR reporting year, and no amount under this Paragraph for that year may be reported by the ceding Contractor.

E. In the allocation of expense, Contractor must include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis. Contractor must use the following methods to allocate expenses:

1) Allocation to each category must be based on a GAAP method that is expected to yield the most accurate results;

2) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense; and

3) Expenses that relate solely to the operation of a reporting entity, such as staff costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

F. Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible to account for a difference between the actual and target MLRs that may be due to random statistical variation. The credibility adjustment is added to the reported MLR calculation before calculating any remittance.

1) Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

2) If a Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards in this provision.

3) Contractor must fulfill these requirements by using the base credibility factors that CMS publishes annually in accordance with 42 CFR section 438.8(h)(4).

G. Contractor must aggregate data by Member groups as defined in this Contract, or as otherwise directed by DHCS. This may require separate reporting and MLR calculations for specific populations.

H. MLR Reporting requirements.

1) Contractor must submit a report to DHCS that includes at least the following information for each MLR reporting year:

a) Total incurred claims;

b) Expenditures on Quality Improvement (QI) activities;

c) Expenditures related to activities compliant with 42 CFR sections 438.608(a) – (5), (7), (8), and (b);

d) Non-claims costs;

e) Premium revenue;

f) Taxes, licensing, and regulatory fees;

g) Methodology(ies) for allocation of expenditures;

h) Any credibility adjustment applied;

i) The calculated MLR;

j) Any remittance owed to DHCS, if applicable;

k) A comparison of the information reported with the audited financial report required under 42 CFR section 438.3(m);

l) A description of the method used to aggregate data; and

m) The number of Member months.

2) Contractor must submit this report in a timeframe and manner determined by DHCS, but no longer than 12 months after the end of the MLR reporting year.

3) Contractor must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 calendar days from the end of the MLR reporting year, or within 30 calendar days of being requested by Contractor, whichever is sooner, regardless of current contracting limitations, to calculate and validate the accuracy of MLR reporting.

4) Contractor must attest to the accuracy of the MLR calculation in accordance with requirements of this provision when submitting the MLR report.

I. Contractor may be excluded from the requirements in this provision in the first MLR reporting year of its operation. Contractor then must comply with these requirements beginning with the next MLR reporting year in which it contracts with DHCS, even if the first MLR reporting year was not a full 12 months.

J. In any instance where there is a retroactive change to the Capitation Payments for a MLR reporting year and the MLR report has already been submitted to DHCS, Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the reporting requirements in this provision.

K. Contractor must, if applicable, provide a remittance for a MLR reporting year in accordance with W&I section 14197.2(c)(1) and Exhibit B of this Contract. Starting January 1, 2025, Contractor must impose equivalent remittance requirements on its Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

1.2.6 Contractor's Obligations

A. Contractor is required to provide any other financial reports, data, or information not listed above as requested by DHCS to evaluate or monitor Contractor's financial condition.

B. If Contractor's incurred claims reported in accordance with Exhibit A, Attachment III, Subsection 1.2.5, Paragraph C.1.a.iii above includes withholds from payments made to Network Providers, Contractor must provide to DHCS a report, in a form and manner specified by DHCS, detailing the basis for those withholds.

1.2.7 Community Reinvestment Plan and Report

A. Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must annually submit a Community Reinvestment Plan for DHCS' approval that details its anticipated community reinvestment activities, pursuant to Exhibit B, Subsection 1.1.17 (*Community Reinvestment*), in a form and manner specified by DHCS through APLs or similar guidance. The Community Reinvestment Plan must detail the expected Members of Contractor's community reinvestment, how they will benefit, and any additional information requested by DHCS. DHCS will make available the parameters for allowable community reinvestment activities through APLs or similar guidance.

B. If Contractor has a Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor, Contractor must require the Fully Delegated Subcontractor and Downstream Fully Delegated Subcontractor to annually submit a Community Reinvestment Plan for approval that details its anticipated community reinvestment activities, pursuant to Exhibit B, Subsection 1.1.17 (*Community Reinvestment*), in a form and manner specified by DHCS through APLs or similar guidance. Contractor must submit the Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's Community Reinvestment Plan to DHCS.

C. Contractor must annually submit a Community Reinvestment Report, including information related to any Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's Community Reinvestment Plan, to DHCS in a form and manner specified by DHCS through APLs or similar guidance. The Community Reinvestment Report must detail Contractor's community reinvestment activities in accordance with the Community Reinvestment Plan, and the outcomes thereof. DHCS will make available the minimum information requirements for the report through APLs or similar guidance.

Exhibit A, ATTACHMENT III

1.3 Program Integrity and Compliance Program

1.3.1 Compliance Program
1.3.2 Fraud Prevention Program
1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing
1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers
1.3.5 Disclosures
1.3.6 Treatment of Overpayment Recoveries
1.3.7 Federal False Claims Act Compliance and Support

1.3 Program Integrity and Compliance Program

Contractor must establish administrative and management policies and procedures which are designed to prevent and detect Fraud, Waste, and Abuse. In furtherance of this goal, Contractor must establish a Compliance program, a Fraud, Waste, and Abuse prevention program, and other program integrity processes, as set forth in this Exhibit A, Attachment III, Section 1.3 (*Program Integrity and Compliance Program*). In establishing these policies, procedures, and programs, Contractor must meet the requirements of 42 CFR section 438.608.

While Contractor may contract with entities to support Contractor on compliance activities (such as training and auditing), Contractor may not delegate program integrity and compliance program functions to Subcontractors or Downstream Subcontractors.

Contractors must ensure that all Subcontractors and Downstream Subcontractors also have a robust program integrity and compliance program in place. This requirement may be fulfilled by Contractor maintaining all program integrity and compliance program functions on behalf of Subcontractor or Downstream Subcontractor.

1.3.1 Compliance Program

Contractor must have a compliance program that includes, at a minimum, the following elements:

A. A compliance plan which:

1) Outlines the key elements of the compliance program;

2) Includes reference to the standards of conduct or code of conduct;

3) Allows the compliance program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance;

4) Details how it will implement and maintain elements of the compliance program;

5) Includes the compliance reporting structure and positions of key personnel involved in ensuring compliance, including the compliance officer;

6) References the delegation reporting and compliance plan

7) References policies and procedures operationalizing the compliance program;

8) Is reviewed and approved by the board of director's compliance and oversight committee routinely, but not less than annually; and

9) Is publicly posted on Contractor's website.

B. Standard of conduct or code of conduct must clearly articulate Contractor's commitment to comply with all applicable requirements and standards under this Contract, and all applicable federal and State requirements. It must describe the organizational expectations that all employees, officers, board of directors, Network Providers, Subcontractors, and Downstream Contractors act ethically and have a responsibility in ensuring compliance. Standard of conduct must be approved by Contractor's full board of directors annually.

C. Written policies and procedures which address the following:

1) Detail how elements of the compliance program are operationalized, including the titles of persons responsible for specific activities;

2) Describe how Contractor will oversee all Network Providers, Subcontractors, Downstream Subcontractors, and third-party entities compliance with all applicable terms and conditions of the Contract. See also, Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*); and

3) Outline Contractor's process to ensure policies and procedures are reviewed at least annually and how changes are disseminated to impacted operational areas. Contractor must update the policies and procedures to incorporate changes in applicable laws, regulations, and requirements.

D. A delegation reporting and compliance plan as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*) and Exhibit J *(Delegation Reporting and Compliance Plan)*;

E. The designation of a compliance officer who is responsible for developing, implementing, and ensuring compliance with the requirements and standards under the Contract and who reports directly to the chief executive officer and the board of directors. Contractor's policies and procedures must include the criteria for selecting a compliance officer and a job description, including responsibilities and the authority of this position. The compliance officer must be a full-time employee and must be independent, which means they must not serve in both a compliance and operational role, for example, when the compliance officer is the chief operating officer, finance officer or general counsel.

F. The establishment of a regulatory compliance and oversight committee of the board of directors and at the senior management level charged with overseeing Contractor's compliance program and compliance with the requirements under this Contract. Contractor's policies and procedures must include the criteria for selecting members to the committee. The committee must review the compliance plan on an annual basis. The committee must meet at least quarterly to oversee the compliance program, including, reviewing areas of non-compliance and implementation and monitoring of Corrective Actions.

G. A system for training and educating the compliance officer, senior management, and employees on federal and State standards and requirements of this Contract. Trainings must address Contractor's standards of conduct, compliance plan, and compliance policies and procedures compliance training completion must be verified such as through a certification or attestation upon training completion and review of the standard of conduct, compliance program, and compliance policies and procedures. Contractor must ensure that training for the compliance officer, senior management, and employees on the compliance program is completed within 90 days of employment and annually thereafter.

H. A system for board members, officers, senior management, and employees to receive training on policies and procedures related to compliance for specific job functions including but not limited to:

1) Compliance officer, senior management, and employees training and education on the overall compliance program, Fraud, Waste, and Abuse, and code of conduct in accordance with Exhibit A, Attachment III, Section 1.3 (*Program Integrity and Compliance Plan*);

2) Network Providers completion of required initial and ongoing Network Provider training within the established timeframes in

accordance with Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*), Members' rights as required under Exhibit A, Attachment III, Section 3.2 (*Provider Relations*), and Advanced Directives in accordance with 42 CFR sections 422.128 and 438.3(j) set forth in Exhibit A, Attachment III, Subsection 5.1.1 (*Members Rights and Responsibilities*);

3) Member Services staff completion of required training as set forth in Exhibit A, Attachment III, Subsection 5.1.2 (*Member Services Staff*) and include diversity, equity and inclusion training in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*); and

4) For staff carrying out obligations under Memorandum of Understandings (MOUs), the training required under Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*)

I. Effective lines of communication between the compliance officer and employees. For example, Contractor must establish a consistent process for distributing and communicating new regulations, regulatory changes, or changes relevant to this Contract. Contractor will communicate this process to all Subcontractors, Downstream Subcontractors, and Network Providers, as applicable. Lines of communication must be accessible to all employees and include a mechanism to enable anonymous and confidential good faith reporting of potential compliance issues by any employee, Member, Network Provider, Subcontractor, or other person or entity, as they are identified.

J. Enforcement of standards through well-publicized disciplinary guidelines. This includes, but is not limited to:

1) Establishment and implementation of disciplinary policies and procedures that reflect clear and specific disciplinary standards as well as Contractor's expectation for reporting of issues related to noncompliance or illegality; training expectations and disciplinary or enforcement standards when noncompliant activity is found.

2) To demonstrate that disciplinary guidelines are enforced, Contractor must maintain records of disciplinary actions for a period of ten years at a minimum, including date of and description of violation, date of investigation, findings and date and description disciplinary action.

K. Contractor must develop and maintain effective systems for routine monitoring and auditing, and identification of compliance risks including but not limited to:

1) Dedicated staff for routine internal monitoring and auditing of compliance risks;

2) Methods and tools for assessing whether Contractor activities required under this Contract comply with State and federal law and this Contract. This includes having methods and tools to evaluate and trend an activity over time to assess noncompliance;

3) Routine and periodic reporting of internal monitoring and auditing activities and results to compliance and oversight committee of the board; and

4) Unannounced audits of Subcontractors and Downstream Subcontractors to assess the compliance with requirements set forth in this Contract as relevant to delegated functions.

L. Contractor must develop and maintain effective systems for prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract (42 CFR section 438.608(a)).

1) This includes policies and procedures for constructing and implementing effective Corrective Action plans, including root cause analysis and tailoring Corrective Action plans to address specific compliance concerns;

2) Corrective action plans must be reviewed and signed by the compliance officer and the executive officer responsible for the area subject to the Corrective Action plan;

To demonstrate effective systems to address compliance concerns and implement effective corrective action, Contractor must maintain and publicly post records of Corrective Action plans and the rectifying actions to close out the findings, including but not limited to, committee meeting minutes detailing discussion of Corrective Action plans and description of outcomes; and

3) Contractor must ensure contractual provisions are in place through Subcontractor Agreements and Downstream Subcontractor Agreements, as relevant, to enforce compliance with Corrective Action plans when they are not met, such as financial sanctions, payment withholds, or liquidated damages.

1.3.2 Fraud Prevention Program

Contractor must have a Fraud prevention program that at a minimum sets forth policies and procedures for the elements identified in this Exhibit A, Attachment III, Subsection 1.3.2 (*Fraud Prevention Program*).

A. Fraud Prevention Officer

Contractor must designate a Fraud prevention officer who is responsible for developing, implementing, and ensuring compliance with Contractor's Fraud prevention program and who reports directly to the chief executive officer and the board of directors. The Fraud prevention officer must attend and participate in DHCS' quarterly program integrity meetings, as scheduled. The same individual may serve as both the compliance officer and the Fraud prevention officer.

B. Notification of Changes in Member's Circumstances

Contractor must promptly notify DHCS when Contractor receives information about changes in a Member's circumstances that may affect the Member's eligibility including changes in the Member's residence, income, insurance status, and death (42 CFR section 438.608(a)(3)). This notification will be in a form and manner specified by DHCS through All Plan Letters (APLs), or other similar instructions.

C. Method to Verify Services Received

Contractor must have a regular method to verify, by sampling or other methods, confirming that services that have been represented to have been delivered by Network Providers were received by Members (42 CFR section 438.608(a)(5)). Contractor must provide proof of compliance with this requirement when requested by DHCS, in a form and manner specified by DHCS through APLs, or other similar instruction.

D. Contractor's Reporting Obligations

In accordance with 42 CFR section 438.608(a)(7), Contractor must refer, investigate, and report all Fraud, Waste, and Abuse activities that

Contractor identifies to DHCS' Program Integrity Unit (PIU), in a manner prescribed by PIU, as follows:

1) Preliminary Fraud, Waste, and Abuse Reports

Contractor must file a preliminary report with DHCS' PIU detailing any suspected Fraud, Waste, or Abuse identified by or reported to Contractor, its Subcontractors, its Downstream Subcontractors, and/or its Network Providers within ten Working Days of Contractor's discovery or notice of such Fraud, Waste, or Abuse. Contractor must submit a preliminary report in accordance with requirements set forth in APLs or other similar instructions. Subsequent to the filing of the preliminary report, Contractor must promptly conduct a complete investigation of all reported or suspected Fraud, Waste, and Abuse activities.

2) Completed Investigation Report

Within ten Working Days of completing its Fraud, Waste, or Abuse investigation (including both Contractor-initiated and DHCS-initiated referrals), Contractor must submit a completed report to DHCS' PIU. This report must include Contractor's findings, actions taken, and include all documentation necessary to support any action taken by Contractor, and any additional documentation as requested by DHCS or other State and federal agencies.

3) Quarterly Fraud, Waste, Abuse Status Report

Contractor must submit a quarterly report to DHCS' PIU on all Fraud, Waste, and Abuse investigative activities ten Working Days after the close of every calendar quarter. The quarterly report must contain the status of all preliminary, active, and completed investigations and must include both Contractor-initiated and DHCS-initiated referrals. In addition to quarterly reports, Contractor must provide updates and available documentation as DHCS may request from time to time.

4) Manner of Report Submission

Contractor must electronically submit each Fraud, Waste, and Abuse report required under the Contract in a manner prescribed by DHCS' PIU. The required reports must include but not be limited to the preliminary Fraud report, the completed investigation report, and the quarterly status report, including all supporting documents,

and any additional documents requested by DHCS, in a form and manner specified by DHCS through APLs, or other similar instructions.

5) Contractor's Obligation to Investigate State, federal, and other Medi-Cal managed care plans' Referrals of Fraud, Waste, and Abuse.

DHCS may, from time to time, share with Contractor relevant Fraud, Waste, and Abuse referrals received from State and federal agencies and other Medi-Cal managed care plans. Contractor may also receive Fraud, Waste, and Abuse referrals directly from other federal agencies, State agencies (other than DHCS), and Medi-Cal managed care plans.

Contractor must conduct a complete investigation of all Fraud, Waste, and Abuse referrals received from DHCS, other State and federal agencies, and other Medi-Cal managed care plans, relating to Contractor's Subcontractors, Downstream Subcontractors, and Network Providers. Contractor must submit a completed investigation report and a quarterly status report, as set forth above in this Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*), in connection with all DHCS, State and federal agency, and Medi-Cal managed care plan referrals of Fraud, Waste, and Abuse.

6) Confidentiality

Contractor acknowledges that information shared by DHCS, other State and federal agencies, and other Medi-Cal managed care plans in connection with any Fraud, Waste, or Abuse referral must be considered confidential, until formal criminal proceedings are made public. Contractor further acknowledges that it is receiving this Confidential Information as a DHCS business associate in order to facilitate Contractor's contractual obligations to maintain a Fraud, Waste, and Abuse prevention program. Contractor must receive and maintain this Confidential Information in its capacity as a Medi-Cal managed care plan and will use the Confidential Information only for conducting an investigation into any potential Fraud, Waste, or Abuse activities and in furtherance of any other program integrity activities.

In the event Contractor is required to share this Confidential Information with a Subcontractor, Downstream Subcontractor, or

Network Provider, Contractor must ensure that Subcontractor, Downstream Subcontractor and Network Provider acknowledge that such information must be kept confidential by Subcontractor, Downstream Subcontractor, and Network Provider, and a similar provision of confidentiality must be included in all Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements.

1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing

A. Screening and Enrolling

All Network Providers must be screened and enrolled in accordance with this Contract, applicable State and federal law, including 42 CFR section 438.602(b), and APL 22-013.

1) If Contractor chooses not to utilize the State level Enrollment pathway, Contractor must notify DHCS and send to DHCS its policies and procedures for review and approval before conducting its own Enrollment process.

2) Contractor may allow Network Providers to participate in their Network for up to 120 calendar days if the Network Provider has a pending Enrollment application in review with DHCS or with Contractor in accordance with 42 CFR section 438.602(b)(2).

3) Contractor must terminate its contract with the provider no later than 15 calendar days of the provider receiving notification from DHCS that the provider has been denied enrollment in the Medi-Cal program, or upon the expiration of the first 120-day period. Contractor cannot continue to contract with providers during the period in which the provider resubmits its enrollment application to DHCS or Contractor and can only re-initiate a contract upon the provider's successful enrollment.

B. Credentialing/Recredentialing

Contractor has an on-going obligation to credential and recredential Providers and Network Providers in accordance with this Contract (Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*)), applicable State and federal law, including 42 CFR section 438.602(b), and APL 22-013.

1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers

Contractor has a continuing obligation to verify that Contractor's Network Providers are enrolled and remain enrolled in the Medi-Cal program. Contractor is responsible for knowledge of all ineligible Providers and individuals on these lists.

A. Tracking Suspended, Excluded, and Ineligible Providers

Contractor must review the following exclusionary databases and lists no less frequently than monthly and take appropriate action in accordance with APL 15-026 and APL 21-003.

1) List of Suspended and Ineligible Providers located at https://www.medi-cal.ca.gov;

2) List of excluded individuals and entities maintained by the U.S. Department of Health and Human Services (U.S. DHHS), Office of Inspector General located at https://oig.hhs.gov;

3) The System of Award Management (SAM);

4) The Social Security Administration Death Master File (SSADMF);

5) To the extent applicable, National Plan and Provider Enumeration System (NPPES); and

6) Restricted Provider Database (RPD)

Contractor must notify DHCS' PIU within ten Working Days of removing a suspended, excluded, or ineligible Providers or individual from its Network and confirm that the ineligible Provider is no longer receiving payments, either directly or indirectly, in connection with the Medi-Cal program. A suspended, excluded, and ineligible Provider report must be sent to DHCS PIU in a manner prescribed by DHCS' PIU.

B. No Contracts with Excluded, Suspended, or Ineligible Providers

Contractor is prohibited from employing, paying, contracting, or maintaining a Medi-Cal contract with Providers that are excluded, suspended, or ineligible to participate, either directly or indirectly, in the

Medicare or Medi-Cal programs (42 CFR section 438.610(a)-(c) and APL 21-003).

C. Notification and Termination of Contracts

Contractor must promptly notify DHCS when Contractor receives information about a change in a Network Provider's, Subcontractor's, or Downstream Subcontractor's circumstances that may affect the Network Provider's, Subcontractor's, or Downstream Subcontractor's eligibility to participate in the Medi-Cal managed care program, including the termination of their Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement with Contractor in accordance with this Contract, State and federal law, including 42 CFR section 438.608(a)(4), and APL 21-003.

D. Actions to be taken where Credible Allegation of Fraud

If DHCS, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or United States Department of Justice (US DOJ), or any other authorized State or federal agency, determines there is a credible allegation of Fraud against Contractor's Subcontractor, Downstream Subcontractor, or Network Provider, Contractor must comply with this Contract, all applicable State and federal laws, APL 15-026, and APL 21-003. Contractor must have procedures in place to immediately suspend payments to Subcontractors, Downstream Subcontractors, and Network Providers for which a State or federal agency determines there is a credible allegation of Fraud (42 CFR section 438.608(a)(8)). In addition, Contractor may conduct additional monitoring, temporarily suspend, and/or terminate the Network Provider, Subcontractor, or Downstream Subcontractor.

1.3.5 Disclosures

In accordance with 42 CFR section 438.608(c), Contractor, its Subcontractors, and its Downstream Subcontractors must:

A. Provide written disclosure of any prohibited affiliation under 42 CFR section 438.610; and

B. Provide written disclosures of information on ownership and control as required under 42 CFR section 455.104.

C. Report and return any payment to DHCS within 60 calendar days of when it has identified any Capitation Payments or other payments it has received or paid in excess of the amounts specified in this Contract.

1.3.6 Treatment of Overpayment Recoveries

A. Retention, Reporting, and Payment of Recoveries

Contractor must comply with guidelines issued by DHCS pertaining to retention policies for the treatment of recoveries of all overpayments from Contractor to a Provider, including for the treatment of recoveries of overpayments due to Fraud, Waste, or Abuse. Contractor must also comply with the process, timeframes, and documentation required for reporting and paying to DHCS the recovery of overpayments, as set forth in APL 23-011.

Contractor must split equally overpayment recoveries of $25 million or more with DHCS. Contractor must report an overpayment of $25 million or more to DHCS through their assigned Managed Care Operations Division (MCOD) Contract Manager (CM) within 60 calendar days of the date that the overpayment. In addition, Contractor must comply with this Contract, and all applicable State and federal law regarding overpayment recoveries, including 42 CFR sections 438.608(a)(2) and (d).

A Contractor can retain each overpayment recovery that is less than $25 million. Contractor is required to report all overpayments in their annual report to DHCS, using the rate development template, including recoveries that are less than $25 million. Contractor does not need to report overpayments that are less than $25 million within 60 calendar days of when the overpayment was identified.

B. Annual Report

Contractor must annually report to DHCS its recoveries of overpayments using the rate development (42 CFR section 438.608(d)(3)).

1.3.7 Federal False Claims Act Compliance and Support

A. Employee Education about False Claims Recovery

Contractor must provide to all its employees, Subcontractors, Downstream Subcontractors, and Network Providers written policies containing detailed information about the False Claims Act and other federal and State laws described in 42 United States Code (USC) section 1396a(a)(68), including information about rights of employees to be protected as whistleblowers (See also 42 CFR section 438.608(a)(6)).

Upon request by DHCS, Contractor must demonstrate compliance with this Exhibit A, Attachment III, Subsection 1.3.7.A (*Employee Education about False Claims Recovery*), which may include providing DHCS with copies of Contractor's applicable written policies and procedures and any relevant employee handbook excerpts.

B. Cooperation with the Office of the Attorney General, DMFEA, or the US DOJ Investigations and Prosecutions.

Contractor must fully cooperate in any investigation or prosecution conducted by the Office of the Attorney General, DMFEA, or the US DOJ. Contractor's cooperation must include, but is not limited to, providing upon request, information, and access to records. Contractor is also responsible for making their staff available for in-person interviews, consultation, grand jury proceedings, pre-trial conference, depositions, and hearings at DHCS headquarters in Sacramento.

C. Money Recovered from State Action Belongs to the State

In the event that DHCS receives a monetary recovery from the Office of the Attorney General, DMFEA, or the US DOJ, as a result of DMFEA's or US DOJ's prosecution of a Subcontractor, Downstream Subcontractor, or Network Provider under the California False Claims Act (California Government Code (GC) section 12650 *et seq.*), the Federal False Claims Act (31 USC section 3729 *et seq.*), or any other applicable laws, the entirety of such monetary recovery belongs exclusively to DHCS, and Contractor waives any claim to any portion of the recovery, except as determined by DHCS in its sole discretion.

D. Payment to Contractor is from Government Funds

Medi-Cal payments to Contractor, Subcontractors, Downstream Subcontractors, Network Providers, and Providers are made from federal and State government funds. DHCS retains the right to recover overpayments made to Contractor, Subcontractors, Downstream Subcontractors, Network Providers, and/or Providers of Medi-Cal services, medical supplies, or drugs as set forth in part in Exhibit B, Subsection 1.1.9 (*Recovery of Amounts Paid to Contractor*). In addition to DHCS' recovery rights, DMFEA and US DOJ may prosecute any act of health care Fraud involving such government funds under the California False Claims Act (GC § 12650 *et seq.*), the Federal False Claims Act (31 USC section 3729 *et seq.*), or any other applicable laws.

E. Contractor's Settlements with Subcontractors, Downstream Subcontractors, and Network Providers do not bind DHCS, DMFEA, or the US DOJ.

Any settlement or resolution of a disputed matter involving Fraud, Waste, or Abuse between Contractor and its Subcontractor, Downstream Subcontractor, or Network Provider must include a written provision that provides notice to the Subcontractor, Downstream Subcontractor, or Network Provider that the settlement and/or resolution is not binding on DHCS, DMFEA, or the US DOJ and does not preclude DHCS, DMFEA, or the US DOJ from taking further action against Contractor or its Subcontractor, Downstream Subcontractor, or Network Provider.

Exhibit A, ATTACHMENT III

2.0 Systems and Processes

DHCS is committed to ensuring Contractor has the capabilities, systems, and processes that enable delivery of high-quality health care. The provisions in this Article lay out DHCS' expectations of Contractor to have Management Information Systems (MIS) to collect, report, and analyze data to identify Members' needs and support Population Health Management (PHM). Contractor must be able to not only submit Encounter Data, but have systems to ensure the data are complete, accurate, reasonable, and timely, including for Subcontractors, Downstream Subcontractors, and Network Providers.

The provisions of this Article are also intended to ensure that Medi-Cal systems and processes are innovative and adapting to the way in which Members seek and access care. DHCS expects Contractor to build upon their MIS capabilities to enable interoperability for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) Networks. Further, Contractor must comply with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access Final Rule set forth at CMS-9115-F and ensure their Subcontractors, Downstream Subcontractors, and Network Providers have the system capabilities to comply with the California Health and Human Services Data Exchange Framework set forth in Health and Safety Code (H&S) section 130290. These requirements will enable the delivery system to have information for Members where and when they need care.

To further drive standards of high-quality care and Health Equity, this Article includes provisions requiring Contractor to have both National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation by January 1, 2026. Further, DHCS specifies alignment of Quality Improvement and Health Equity activities that align in principle with the DHCS Comprehensive Quality Strategy and imposes requirements for Contractor to exceed minimum performance standards.

DHCS is committed to transparency to demonstrate accountability to the public and community it serves. Consequently, DHCS requires public reporting of information related to access, quality, delegation, Quality Improvement (QI), and Health Equity activities. Specific to public posting, this Article includes provisions requiring Contractor to make available on their websites their annual Quality Improvement and Health Equity Transformation Plan, meeting minutes from their Quality Improvement and Health Equity Committee (QIHEC), and Utilization Management (UM) policies and procedures.

2.1 Management Information System

2.1.1 Management Information System Capability
2.1.2 Encounter Data Reporting
2.1.3 Participation in the State Drug Rebate Program
2.1.4 Network Provider Data Reporting
2.1.5 Program Data Reporting
2.1.6 Template Data Reporting
2.1.7 Management Information System/Data Audits
2.1.8 Management Information System/Data Correspondence
2.1.9. Tracking and Submitting Alternative Format Selections
2.1.10 Interoperability Application Programming Interface System Requirements

2.1 Management Information System

2.1.1 Management Information System Capability

Contractor's Management Information System (MIS) must be fully compliant with 42 CFR section 438.242 requirements and must have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's Encounter Data submission. Contractor must make available to DHCS, and to the Centers for Medicare & Medicaid Services (CMS) upon request, all data related to this Contract.

A. Contractor must have and maintain a MIS that supports, at a minimum:

1) All Medi-Cal eligibility data;

2) Information on Members enrolled with Contractor,

3) Provider claims status and payment data;

4) Health care services delivery Encounter Data;

5) Network Provider Data;

6) Program Data;

7) Template Data;

8) Screening and assessment data;

9) Referrals including tracking of referred services to follow up with Members to ensure that services were rendered;

10) Electronic health records;

11) Prior Authorization requests and a specialty referral system as specified in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*);

12) Complex Care Management Care Manager assignment as specified in Exhibit A, Attachment III, Subsection 4.3.7 *(Care Management Programs*);

13) Financial information as specified in Exhibit A, Attachment III, Subsection 1.2.2 (*Contractor's Financial Reporting Obligations*);

14) Social Drivers of Health (SDOH) data per All Plan Letter (APL) 21-009;

15) Member and Member's Authorized Representative Alternative Format Selections (AFS); and

16) Data sources specified in DHCS policies and guidance, including APLs, the Enhanced Care Management (ECM) Policy Guide, Community Supports Policy Guide, and the Population Health Management (PHM) Policy Guide.

B. Contractor's MIS must have processes that support the interactions between financial data, Member/eligibility data, Network Provider Data, Encounter Data, claims data, Program Data, Template Data, quality management/Quality Improvement (QI)/Utilization Management (UM) data, and report generation subsystems. The interactions of Contractor's MIS subsystems must be interoperable, efficient, and successful with Contractor's other MIS subsystems and DHCS' systems and processes.

C. Contractor's MIS must have the capability to transmit and consume data files with and from DHCS, Subcontractors, Downstream Subcontractors, Network Providers, other State, federal, and local governmental agencies, and other sources as needed to support Care Coordination and overall administration of the Medi-Cal program. Data that must be able to be transmitted and consumed include, but are not limited to:

1) Encounter Data;

2) Fee-For-Service (FFS) claims data; including carved-out claims data, such as Medically Necessary services carved out of this Contract and data available from partner organizations, including but not limited to the Local Education Agency Medi-Cal Billing Option Program (LEA BOP) and incarceration in-reach services;

3) Dental claims data;

4) Specialty mental health data;

5) Substance Use Disorder (SUD) data;

6) Medi-Cal FFS Treatment Authorization Request (TAR) data;

7) California Children's Services Program data;

8) Targeted Case Management (TCM) data;

9) Pharmacy claims data;

10) Risk Tier assignment data;

11) Authorization and referral data; and

12) Medical record information including case notes.

Contractor must have processes in place for utilizing all data made available in order to meet the requirements for and in support of Care Coordination, other administrative functions of this Contract with DHCS, and Operational Readiness Requirements and Deliverables as described in Exhibit A, Attachment II.

D. Contractor must implement and maintain a publicly accessible, standards-based Patient Access Application Programming Interface (API), and a Provider Directory API, as described in 42 CFR sections 431.60 and 431.70, and in APL 22-026. Contractor must operate the API in the manner specified in 45 CFR section 170.215 and include information per 42 CFR section 438.242(b)(5) and (6).

2.1.2 Encounter Data Reporting

A. Contractor must maintain a MIS that consumes Encounter Data and/or claims data and transmits Encounter Data, including allowed amounts and paid amounts as required, to DHCS in compliance with 42 CFR sections 438.242 and 438.818, and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Encounter Data to DHCS, as defined in State and federal law, APLs, and this Contract, for all items and services furnished to a Member under this Contract, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers to submit claims and Encounter Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including edit and reporting

systems, sufficient to ensure Encounter Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, Downstream Subcontractor, and out-of-Network Provider Encounter Data regardless of contracting arrangements or whether the Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider is reimbursed on a FFS or capitated basis.

D. Contractor must submit complete, accurate, reasonable, and timely Encounter Data within six Working Days of the end of each month following the month of payment, under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS.

E. DHCS will review and validate Contractor's Encounter Data, including Encounter Data submitted by Contractor on behalf of its Subcontractors, Downstream Subcontractors, and Network Providers, for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Encounter Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Encounter Data, Contractor must ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Encounter Data.

G. DHCS or its agent will periodically, but not less frequently than once every three years, conduct an independent audit of the Encounter Data submitted by, or on behalf of, Contractor, in accordance with 42 CFR section 438.602(e). Contractor must comply with the requirements set forth in Exhibit A, Attachment III, Subsection 2.2.9.E (*Encounter Data Validation*).

2.1.3 Participation in the State Drug Rebate Program

A. Contractor must participate in the federal and State drug rebate program by including all utilization data for both current and retroactive outpatient drugs in its Encounter Data as necessary to meet federal requirements in 42 USC section 1396r - 8(k)(2).

1) Encounter Data for outpatient drugs must comply with 42 USC section 1396r - 8(b)(1)(A); and

2) All outpatient drug Encounter Data must include, at a minimum, the total number of units of each dosage form, strength, and package size, by 11 numeric digit National Drug Code (NDC), for each claim, including eligible Physician administered drug claims.

B. Pursuant to 42 CFR section 438.3(s), Contractor must ensure that Encounter Data for outpatient drugs from participating organizations or covered entities in the federal 340B program contains DHCS-required identifiers to maintain compliance with the requirements of 42 USC section 256b(a)(5)(A)(i). Contractor must also comply with the provisions of W&I section 14105.46.

C. Contractor must assist DHCS in resolving manufacturer rebate disputes related to Network Provider Data or Encounter Data submissions. Encounter Data identified by DHCS or Contractor as having inaccurate or incomplete units, NDCs, procedure codes, 340B identifiers, or other data elements necessary to resolve manufacturer drug rebate disputes are required to be corrected and resubmitted in compliance with APLs.

2.1.4 Network Provider Data Reporting

A. Contractor must maintain a MIS that collects and transmits Network Provider Data to DHCS in compliance with 42 CFR sections 438.207, 438.604(a)(5), and 438.606, and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Network Provider Data, Subcontractor data, and Downstream Subcontractor data to DHCS, as defined in State and federal law, APLs, DHCS 274 companion guide, and this Contract, that accurately represents Contractor's Network, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, and Downstream Subcontractors to submit Network Provider Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms, including editing and reporting systems, sufficient to ensure Network Provider Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, and Downstream

Subcontractor Network Provider Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Network Provider Data within ten calendar days following the end of each month, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Network Provider Data as set forth in 42 CFR section 438.606. Subcontractors, Downstream Subcontractors and Network Providers must comply with this Section for submission of Network Provider Data to Contractor.

E. DHCS will review and validate Contractor's Network Provider Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Network Provider Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Network Provider Data, Contractor must ensure that corrected Network Provider Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Network Provider Data.

2.1.5 Program Data Reporting

A. Contractor must maintain a MIS that consumes and transmits Program Data to DHCS in compliance with Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Program Data to DHCS, as defined in State and federal law, APLs, and this Contract, including, but not limited to, all Grievances, Appeals, referrals, out-of-Network requests, medical exemption request denial reports and other continuity of care requests, and Primary Care Provider (PCP) and Risk Tier assignments received or determined by Contractor, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers to submit Program Data to Contractor to ensure compliance with this Contract.

Contractor must have mechanisms, including editing and reporting systems, sufficient to ensure Program Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, Downstream Subcontractor, and out-of-Network Provider Program Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Program Data within ten calendar days following the end of each month, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Program Data as set forth in 42 CFR section 438.606. Network Providers, Subcontractors, Downstream Subcontractors, and out-of-Network Providers must comply with this Subsection for submission of Program Data to Contractor.

E. DHCS will review and validate Contractor's Program Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Program Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Program Data, Contractor must ensure that corrected Program Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Program Data.

2.1.6 Template Data Reporting

A. Contractor must maintain a MIS that collects and reports Template Data to DHCS in compliance with Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) and in accordance with APLs.

B. Contractor must implement policies and procedures for ensuring the complete, accurate, reasonable, and timely submission of Template Data to DHCS, as defined in State and federal law, APLs, and this Contract, for all items and services furnished to a Member under this Contract, whether directly or through Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements.

C. Contractor must require all Network Providers, Subcontractors, and Downstream Subcontractors to submit Template Data to Contractor to ensure compliance with this Contract. Contractor must have mechanisms,

including editing and reporting systems, sufficient to ensure Template Data is complete, accurate, reasonable, and timely, as defined in State and federal law and APLs, prior to submission to DHCS. Contractor must ensure the completeness, accuracy, reasonableness, and timeliness of all Network Provider, Subcontractor, and Downstream Subcontractor Template Data regardless of contracting arrangements.

D. Contractor must submit complete, accurate, reasonable, and timely Template Data on a regular basis, or as mandated through federal law, and in a form and manner specified by DHCS. Contractor must certify all Template Data as set forth in 42 CFR section 438.606. Subcontractors, Downstream Subcontractors, and Network Providers must comply with this Subsection for submission of Template Data to Contractor.

E. DHCS will review and validate Contractor's Template Data for completeness, accuracy, reasonableness, and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, reasonableness, or timeliness of Contractor's Template Data and notifies Contractor in writing of the deficiencies and requests correction and resubmission of the relevant Template Data, Contractor must ensure that corrected Template Data is resubmitted within 15 calendar days of the date of DHCS' notice, or as mandated through federal law. Upon Contractor's written request, DHCS may, in its sole discretion, grant an extension for submission of corrected Template Data.

2.1.7 Management Information System/Data Audits

Contractor must conduct MIS and data audits to the extent directed by DHCS, in accordance with this Contract, APLs, or other similar instructions which will be no less frequently than once every three years.

2.1.8 Management Information System/Data Correspondence

When DHCS provides Contractor with written notice of any problems or deficiencies related to the submittal of data to DHCS, or of any changes or clarifications related to Contractor's MIS system, Contractor must submit to DHCS a Corrective Action plan with measurable benchmarks within 15 calendar days from the date of DHCS' written notice to Contractor. DHCS will approve Contractor's Corrective Action plan or request revisions within 30 calendar days of receipt of Contractor's Corrective Action plan. If DHCS requests revisions, Contractor must submit a revised Corrective Action plan for DHCS' approval within 15 calendar days after receipt of the request. Contractor's failure to complete the Corrective Action plan as approved by DHCS will subject it to

sanctions, pursuant to Exhibit E, Subsection 1.1.19 (*Sanctions*). DHCS may publicly disclose on the DHCS website if Contractor has entered into a Corrective Action plan or has been subject to sanctions due to non-compliance under this Section.

2.1.9. Tracking and Submitting Alternative Format Selections

A. Contractor must have and maintain systems that are able to, at a minimum, perform the following functions:

1) Collect and store Member AFS, as well as the AFS of a Member's AR;

2) Share Member AFS data with DHCS as specified in the Alternative Format Data Process Guide included in APL 22-002; and

3) Track Member's AR AFS data and submit to DHCS when requested.

B. Contractor must submit all Member AFS data that has been collected in a one-time file upload to the DHCS Alternate Formats database, in the time and manner specified in APL 22-002.

C. After Contractor's one-time file upload is completed, Contractor must submit to DHCS all new Member AFS at the time of the Member's request. Contractor must send submissions online through the AFS application system, or by calling the AFS Helpline at (833) 284-0040.

D. DHCS will share Member AFS data with Contractor on an ongoing basis. DHCS will send Contractor a weekly AFS file from the DHCS Alternative Format Database. The DHCS weekly file data elements and file path are included in the APL 22-002 AFS Technical Guidance attachment. Contractor must utilize the weekly DHCS AFS file data to update their records and provide Member materials in the requested alternative formats.

E. Contractor must submit to DHCS policies and procedures for collecting and sharing AFS data in accordance with the requirements in APL 22-002.

2.1.10 Interoperability Application Programming Interface System Requirements

A. In order to ensure Contractor applies the same standards for Encounter Data contained in Exhibit A, Attachment III, Subsection 2.1.2 (*Encounter Data Reporting*), to data collected and made available through its API,

Contractor must verify that data collected from Network Providers, Subcontractors, and Downstream Subcontractors to be made available through the API are complete, accurate, reasonable, and timely, and collected in accordance with the oversight and monitoring requirements in APL 22-026. Contractor must make all collected data available to DHCS and CMS, upon request.

B. Contractor must conduct routine testing and monitoring of its API functions, and applying system updates as appropriate, to ensure that the API is compliant and functional.

C. Contractor may deny or discontinue any third-party application connection to its API if Contractor determines that continued access presents an unacceptable level of risk to the security of Protected Health Information (PHI) on its systems. Contractor's determination must be made in accordance with the requirements provided in APL 22-026.

Exhibit A, ATTACHMENT III

2.2 Quality Improvement and Health Equity Transformation Program

2.2.1 Quality Improvement and Health Equity Transformation Program Overview
2.2.2 Governing Board
2.2.3 Quality Improvement and Health Equity Committee
2.2.4 Provider Participation
2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities
2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures
2.2.7 Quality Improvement and Health Equity Annual Plan
2.2.8 National Committee for Quality Assurance Accreditation
2.2.9 External Quality Review Requirements
2.2.10 Quality Care for Children
2.2.11 Quality Monitoring for Skilled Nursing Facilities – Long-Term Care
2.2.12 Disease Surveillance
2.2.13 Credentialing and Recredentialing

2.2 Quality Improvement and Health Equity Transformation Program

Contractor must implement a Quality Improvement and Health Equity Transformation Program (QIHETP) that includes, at a minimum, the standards set forth in 42 CFR sections 438.330 and 438.340, and 28 CCR section 1300.70, and be consistent with the principles outlined in the DHCS Comprehensive Quality Strategy and a forthcoming All Plan Letter (APL). Contractor must monitor, evaluate, and take timely action to address necessary improvements in the Quality of Care delivered by all its Providers in any setting, and take appropriate action to improve upon Health Equity. Contractor is responsible for the quality and Health Equity of all Covered Services regardless of whether or not those services have been delegated to a Subcontractor, Downstream Subcontractor, or Network Provider.

A. Contractor must deliver quality care that enables all its Members to maintain health and improve or manage a chronic illness or disability. Contractor must ensure quality care in each of the following areas:

   1) Clinical quality of physical health care;

   2) Clinical quality of Behavioral Health care focusing on prevention, recovery, resiliency, and rehabilitation;

   3) Access to primary and specialty health care Providers and services;

   4) Availability and regular engagement with Primary Care Providers (PCP);

   5) Continuity of care and Care Coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent Provider-patient relationships; and

   6) Member experience with respect to clinical quality, access and availability, culturally and linguistically competent health care and services, continuity of care, and Care Coordination.

B. Contractor must apply the principles of Continuous Quality Improvement (CQI) to all aspects of Contractor's service delivery system through analysis, evaluation, and systematic enhancements of the following:

   1) Quantitative and qualitative data collection and data-driven decision-making;

2) Up-to-date, evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals, or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

3) Feedback provided by Members, community partners, and Network Providers in the design, planning, and implementation of its CQI activities; and

4) Other issues identified by Contractor or DHCS.

C. Contractor must develop Population Health Management (PHM) interventions designed to address Social Drivers of Health (SDOH), reduce disparities in health outcomes experienced by different subpopulations of Members, and work towards achieving Health Equity by:

1) Developing equity-focused interventions intended to address disparities in the utilization and outcomes of physical and Behavioral Health care services; and

2) Engaging in a Member and family-centric approach in the development of interventions and strategies, and in the delivery of all health care services.

D. Contractor must ensure that the QIHETP requirements of this Contract are applied to the delivery of both physical and Behavioral Health Services.

2.2.1 Quality Improvement and Health Equity Transformation Program Overview

Contractor must maintain a QIHETP which includes the following, at a minimum:

A. Oversight and participation of Contractor's Governing Board;

B. Creation and designation of a Quality Improvement and Health Equity Committee (QIHEC) whose activities are supervised by Contractor's medical director or the medical director's designee, in collaboration with Contractor's Chief Health Equity Officer;

C. Supervision of QIHETP activities by Contractor's medical director and the Chief Health Equity Officer; and

D. The participation of a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Community Health

Workers, and other non-clinical Providers in the process of QIHETP development and performance review.

2.2.2 Governing Board

Contractor must implement and maintain written policies and procedures that specify the responsibilities of its Governing Board, which include the following, at a minimum:

A. Approving the overall QIHETP and the annual plan of the QIHETP;

B. Appointing an accountable entity or entities within Contractor's organization responsible for the oversight of the QIHETP;

C. Receiving written QIHEC progress reports that describe actions taken, progress in meeting QIHETP objectives, and improvements made; and

D. Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the Quality Improvement (QI) and Health Equity standards in this Contract and the DHCS Comprehensive Quality Strategy.

2.2.3 Quality Improvement and Health Equity Committee

A. Contractor must implement and maintain a QIHEC designated and overseen by its Governing Board. Contractor's medical director or the medical director's designee must head the QIHEC in collaboration with Contractor's Chief Health Equity Officer. Contractor must ensure that a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, Subcontractors, Downstream Subcontractors, Network Providers, and Members, actively participate in the QIHEC or in any sub-committee that reports to the QIHEC. The Subcontractors, Downstream Subcontractors, and Network Providers that are part of QIHEC must be representative of the composition of Contractor's Network and include, at a minimum, Network Providers who provide health care services to Members affected by Health Disparities, Limited English Proficiency (LEP) Members, Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions.

The QIHEC's responsibilities include the following:

1) Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures,

utilization data, consumer satisfaction surveys, and the findings and activities of other Contractor committees such as the Community Advisory Committee (CAC);

2) Institute actions to address performance deficiencies, including policy recommendations; and

3) Ensure appropriate follow-up of identified performance deficiencies.

B. Contractor must ensure Member confidentiality is maintained in QI discussions and ensure avoidance of conflict of interest among the QIHEC members.

C. Contractor must ensure that the QIHEC meets at least quarterly, and more frequently if needed. A written summary of QIHEC activities, as well as QIHEC activities of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, findings, recommendations, and actions must be prepared after each meeting and submitted to Contractor's Governing Board. Contractor must also submit the written summary to DHCS upon request.

D. Contractor must make the written summary of the QIHEC activities publicly available on Contractor's website at least on a quarterly basis.

E. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain a QIHEC that meets the requirements set forth in this Section. Contractor must also ensure that they report to Contractor's QIHEC quarterly, at a minimum.

2.2.4 Provider Participation

Contractor must ensure that its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors participate in the QIHETP and Population Needs Assessment (PNA) as described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*). Contractor must incorporate its Fully Delegated Subcontractor and Downstream Fully Delegated Subcontractor data and results into the development of its PNA, as described in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*). Contractor must regularly update its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors on activities, findings, and recommendations of the QIHEC's QIHETP and PNA results.

2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities

A. Contractor is accountable for all QI and Health Equity functions and responsibilities that are delegated to Subcontractors and any Downstream Subcontractors, in accordance with Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*). Contractor must, at a minimum, specify the following requirements in its Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable:

1) QI or Health Equity responsibilities, and specific subcontracted functions and activities of Subcontractor and Downstream Subcontractor;

2) The schedule for Contractor's ongoing oversight, monitoring, and evaluation of Subcontractor and Downstream Subcontractor, including quarterly reporting and an annual review of Subcontractor's and Downstream Subcontractor's performance;

3) Subcontractor's and Downstream Subcontractor's reporting requirements and Contractor's approval procedure of Subcontractor's and Downstream Subcontractor's reports;

4) Subcontractor's and Downstream Subcontractor's obligation to report findings and actions of QI or Health Equity activities at least quarterly to Contractor; and

5) Contractor's actions and remedies if Subcontractor's and Downstream Subcontractor's obligations are not satisfactorily performed.

B. Contractor must maintain an adequate oversight procedure to ensure Subcontractor's and Downstream Subcontractor's compliance with all QI or Health Equity delegated activities that, at a minimum:

1) Evaluates Subcontractor's and Downstream Subcontractor's ability to perform the delegated activities, including an initial determination that Subcontractor and Downstream Subcontractor have the administrative capacity, experience, and budgetary resources to fulfill their contractual obligations;

2) Ensures Subcontractor and Downstream Subcontractor meet QI and Health Equity standards set forth in this Contract; and

3) Includes Contractor's continuous monitoring, evaluation and approval of its delegated functions to Subcontractor and Downstream Subcontractor. Contractor must make the findings of its continuous monitoring and evaluation of the Subcontractor and Downstream Subcontractor available to DHCS at least annually, but more frequently when directed by DHCS.

2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures

Contractor must develop, implement, maintain, and periodically update its QIHETP policies and procedures that include, at a minimum, the following:

A. Contractor's commitment to the delivery of quality and equitable health care services;

B. Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's organizational chart, listing the key staff and the committees responsible for QI and Health Equity activities, including reporting relationships of QIHEC to executive staff;

C. Qualification and identification of staff who are responsible for QI and Health Equity activities;

D. A process for sharing QIHETP findings with its Subcontractors, Downstream Subcontractors, and Network Providers;

E. The role, structure, and function of the QIHEC;

F. The policies and procedures to ensure that all Covered Services are available and accessible to all Members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, health status, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner;

G. The policies and procedures designed to identify, evaluate, and reduce Health Disparities, by performing the following:

1) Analyzing data to identify differences in Quality of Care and utilization, as well as the underlying reasons for variations in the provision of care to its Members;

2) Developing equity-focused interventions to address the underlying factors of identified Health Disparities, including SDOH; and

3) Meeting disparity reduction targets for specific populations and/or measures as identified by DHCS and as directed under Exhibit A, Attachment III, Subsection 2.2.9.A (*Quality Performance Measures*).

H. Description of the integration of Utilization Management (UM) activities into the QIHETP as specified in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or the medical director's designee;

I. Policies and procedures to adopt, disseminate, and monitor the use of clinical practice guidelines that:

1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field;

2) Consider the needs of Members;

3) Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified Providers from appropriate specialties;

4) Have been reviewed by Contractor's medical director, as well as Subcontractors, Downstream Subcontractors, and Network Providers, as appropriate; and

5) Are reviewed and updated at least every two years;

J. The inclusion of PHM activities, including the findings of the annual PNA, as required in Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*);

K. Policies and procedures that ensure the delivery of Medically Necessary non-specialty and Specialty Mental Health Services (SMHS) as outlined in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*);

L. Policies and procedures that ensure that Contractor and its Subcontractors, Downstream Subcontractors, Network Providers, and other entities with which Contractor contracts for the delivery of health care services comply with all mental health parity requirements in 42 CFR section 438.900 *et seq*.;

M. Mechanisms to detect both over- and under-utilization of services including, but not limited to, outpatient Prescription Drugs;

N. Mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all Covered Services. The mechanisms must include oversight processes that ensure Members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with APL 23-001, and W&I sections 14197 and 14197.04;

O. Mechanisms to continuously monitor, review, evaluate, and improve quality and Health Equity of clinical care services provided, including, but not limited to, preventive services for Children and adults, perinatal care, Primary Care, specialty, emergency, inpatient, Behavioral Health and ancillary care services; and

P. Mechanisms to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all Members, including SPDs, CSHCNs, Members with chronic conditions, including Behavioral Health, Members experiencing homelessness, Members recently released from incarceration, Members who use Long-Term Services & Supports (LTSS), and Children receiving Child welfare services.

2.2.7 Quality Improvement and Health Equity Annual Plan

Contractor must develop and submit an annual QI and Health Equity plan to DHCS, as directed below and in and a forthcoming APL.

A. Develop a QI and Health Equity plan annually for submission to DHCS that includes the following, at a minimum:

1) A comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions;

2) A written analysis of required Quality Performance Measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor’s and Downstream

Fully Delegated Subcontractor's performance measure results and actions to address any deficiencies;

3) An analysis of actions taken to address any Contractor-specific recommendations in the annual External Quality Review (EQR) technical report and Contractor's specific evaluation reports;

4) An analysis of the delivery of services and Quality of Care of Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review and the results of consumer satisfaction surveys;

5) Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and Behavioral Health care services;

6) A description of Contractor's commitment to Member and/or family focused care through Member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how Contractor utilizes the information from this engagement to inform Contractor policies and decision-making;

7) PHM activities and findings as outlined in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*); and

8) Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

To the extent that Contractor delegates its QI and Health Equity activities to its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, Contractor's QI and Health Equity annual plan must include evaluation and findings specific to the Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance.

B. Provide annual copies of all final reports of independent private accrediting agencies (e.g. the National Committee for Quality Assurance (NCQA)) relevant to Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's Medi-Cal line of business, including:

1) Accreditation status, survey type, and level, as applicable;

2) Accreditation agency results, including recommended actions or improvements, Corrective Action plans, and summaries of findings; and

3) Expiration date of the accreditation.

In addition, pursuant to 42 CFR section 438.332, Contractor must authorize independent private accrediting agencies to provide DHCS a copy of Contractor's most recent accreditation review annually.

C. Provide an annual report to DHCS that includes an assessment of all Subcontractors' and Downstream Subcontractors' performance of its delegated QI or Health Equity activities.

D. Contractor must make the QI and Health Equity plan publicly available on its website on an annual basis.

2.2.8 National Committee for Quality Assurance Accreditation

A. Contractor must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by no later than January 1, 2026. Contractor must maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract and submit every three years NCQA HPA and Health Equity Accreditation results. Contractor must also complete additional NCQA accreditation programs as directed by DHCS.

B. In accordance with W&I section 14184.203, Contractor must also ensure that all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors have full NCQA HPA and Health Equity Accreditation by no later than January 1, 2026. Contractor must also ensure all its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain full NCQA HPA and Health Equity Accreditation throughout the term of this Contract. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also complete additional NCQA accreditation programs as directed by DHCS.

C. Contractor must provide DHCS with the following components of Contractor's, Fully Delegated Subcontractor's, and Downstream Fully Delegated Subcontractor's NCQA HPA and Health Equity Accreditation

status and reviews within 30 calendar days of the receipt of the completed report from NCQA:

1) Accreditation status;

2) Survey type;

3) Results of the review;

4) Healthcare Effectiveness Data and Information Set (HEDIS ®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS ®) summary level data;

5) Recommended actions or improvements;

6) Corrective Action plans and summaries of findings; and

7) Expiration date of the accreditation.

D. Contractor must notify DHCS of the date of its NCQA site visit within 15 calendar days of confirmation of the site visit by NCQA. Contractor must make available all written materials submitted to NCQA available to DHCS and allow DHCS representative(s) to participate in the NCQA audit activities, including but not limited to, the NCQA site visit.

E. Contractor must notify DHCS of any change in NCQA HPA and Health Equity Accreditation status within 30 calendar days of receipt of the final NCQA report. In addition to complying with the Corrective Actions imposed by NCQA, Contractor must also comply with any additional Corrective Actions imposed by DHCS to address a change in Contractor's accreditation status.

F. If Contractor fails to obtain or maintain its HPA or Health Equity Accreditation status within the timeframe described above and anytime thereafter, Contractor will be subject to Corrective Actions by DHCS, including but not limited to, the actions set forth in Exhibit E, Subsections 1.1.16 (*Termination*), 1.1.19 (*Sanctions*), and 1.1.20 (*Liquidated Damages*).

G. Contractor must have policies and procedures in place to oversee the HPA and Health Equity Accreditation status of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors throughout the term of this Contract. Contractor must have policies and procedures in place to subject its Fully Delegated Subcontractors and

Downstream Fully Delegated Subcontractors to Corrective Actions if Contractor's Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to maintain its HPA and Health Equity Accreditation status, including, but not limited to, termination of Subcontractor Agreements or Downstream Subcontractor Agreements with Fully Delegated Subcontractors or Downstream Fully Delegated Subcontractors, sanctions, and damages.

2.2.9 External Quality Review Requirements

At least annually or more frequently as directed by DHCS, Contractor must cooperate with and assist the External Quality Review Organization (EQRO) designated by DHCS in conducting its EQR reviews of Contractor in accordance with 42 USC section 1396u-2(c)(2), 42 CFR section 438.310 *et seq.*, and 22 CCR section 53860(d).

Contractor must comply with all requirements set forth in 42 CFR section 438.310 *et seq*., the forthcoming APL, and the Centers for Medicare & Medicaid Services (CMS) EQR protocols, which provide detailed instructions on how to complete the EQR activities.

In addition, Contractor must also comply with the following requirements:

A. Quality Performance Measures

On an annual basis, Contractor must track and report on a set of Quality Performance Measures and Health Equity measures identified by DHCS in accordance with all of the following requirements:

1) Contractor must work with the EQRO to conduct an onsite assessment of the Quality Measure Compliance Audit and DHCS-required Quality Performance Measures;

2) Contractor must calculate and report all required Quality Performance Measures and Health Equity measures at the county or regional reporting unit level and possibly Skilled Nursing Facility (SNF) level as directed by DHCS. Contractor must separately report to DHCS all required performance measure results at the reporting unit level and SNF level for certain measures for its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors;

a) Contractor must calculate performance measure rates, to be verified by the EQRO;

b) Contractor must report audited results on the required performance measures to DHCS no later than June 15 of each year or on another date as established by DHCS. Contractor must initiate reporting on required Quality Performance Measures for the reporting cycle following the first year of this Contract operation;

3) Contractor must exceed the DHCS-established Minimum Performance Level (MPL) for each required Quality Performance Measure and Health Equity measure selected by DHCS. Contractor must ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors whose rates Contractor separately reports to DHCS also exceed the DHCS-established MPL for each required Quality Performance Measure and Health Equity measure selected by DHCS.

4) Contractor must meet Health Disparity reduction targets for specific populations and measures as identified by DHCS.

5) In accordance with 42 CFR section 438.700 *et seq.*, W&I section 14197.7, and Exhibit E of this Contract, DHCS may impose financial sanctions, administrative sanctions, and/or Corrective Actions on Contractor for failure to meet required MPLs as detailed in APL 23-012. DHCS may require Contractor to make changes to its executive personnel if Contractor has persistent and pervasive poor performance as evidenced by multiple performance measures consistently below the MPL over multiple years. DHCS may also limit Contractor's Service Area expansion or suspend Member Enrollment based on Contractor's persistent and pervasive poor performance on Quality Performance Measures.

In addition to sanctions and Corrective Actions, DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor's performance on specified quality and equity benchmarks, as determined by DHCS and communicated to Contractor in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

Contractor is responsible for ensuring that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also exceed the DHCS-established MPL. If its Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor fails to exceed the DHCS-established MPL, Contractor must have policies and procedures in place

to subject its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors to appropriate enforcement actions, which may include, but are not limited to, financial sanctions, Corrective Action plans, and a requirement to change its executive personnel.

B. PIPs

1) Contractor must conduct or participate in PIPs, including any PIP required by CMS, in accordance with 42 CFR section 438.330. Contractor must conduct or participate in, at a minimum, two PIPs per year, as directed by DHCS. At its sole discretion, DHCS may require Contractor to conduct or participate in additional PIPs, including statewide PIPs. DHCS may also require Contractor to participate in statewide collaborative PIP workgroups.

2) Contractor must have policies and procedures in place to ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors also conduct and participate in PIPs and any collaborative PIP workgroups as directed by CMS or DHCS.

3) Contractor must comply with the PIP requirements outlined in a forthcoming APL and must use the PIP reporting format as designated therein to request DHCS' approval of proposed PIPs.

4) Each PIP must include the following:

a) Measurement of performance using objective quality indicators;

b) Implementation of equity-focused interventions to achieve improvement in access to Quality of Care;

c) Evaluation of the effectiveness of the interventions based on the performance measures; and

d) Planning and initiation of activities for increasing or sustaining improvement.

5) Contractor must report the status of each PIP at least annually to DHCS.

C. Consumer Satisfaction Survey

1) On an annual basis until January 1, 2026, Contractor must timely provide all data requested by the EQRO in a format designated by the EQRO in conducting a consumer satisfaction survey.

2) Beginning January 1, 2026, concurrent with the requirement for HPA by the NCQA, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's, CAHPS survey on Contractor's website, including results of any supplemental questions as directed by DHCS.

3) If Contractor has HPA prior to January 1, 2026 and reports its CAHPS data to the NCQA, Contractor must publicly post the annual results of its, and its Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's, CAHPS survey on Contractor's website, including results of any supplemental questions as directed by DHCS.

4) Contractor must incorporate results from the CAHPS survey in the design of QI and Health Equity activities.

D. Network Adequacy Validation

Contractor must participate in the EQRO's validation of Contractor's Network adequacy representations from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.14(b), 438.68, and 438.358.

E. Encounter Data Validation

As directed by DHCS, Contractor must participate in the EQRO's validation of Encounter Data from the preceding 12 months to comply with requirements set forth in 42 CFR sections 438.242(d) and 438.818.

F. Focused Studies

As directed by DHCS, Contractor must participate in an external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of quality outcomes and timeliness of, and access to, services provided by Contractor.

G. Technical Assistance

In accordance with 42 CFR section 438.358(d) and at the direction of DHCS, Contractor must implement EQRO's technical guidance provided to Contractor in conducting mandatory and optional activities described in 42 CFR section 438.358 and this Contract.

2.2.10 Quality Care for Children

Contractor must maintain a robust program to ensure the provision of all physical, behavioral, and oral health services to Members less than 21 years of age. Contractor must also maintain mechanisms to identify and improve on gaps in the quality of and access to care in each of the following areas:

A. Scope of Services

1) Contractor must ensure the provision of all screening, preventive, and Medically Necessary diagnostic and treatment services for Members less than 21 years of age in accordance with Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*);

2) Contractor must actively promote Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screenings and Bright Futures/American Academy of Pediatrics (AAP) preventive services to Members and their families. Additionally, Contractor must ensure Network Providers receive standardized training on EPSDT utilizing the developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit;

3) Contractor must identify Members who have not utilized EPSDT screening services or Bright Futures/AAP preventive services, and ensure outreach to these Members in a culturally and linguistically appropriate manner;

4) Contractor must maintain Memorandums of Understanding (MOUs) with Local Health Departments (LHDs) and Local Government Agencies (LGAs), in Contractor's Service Area, including but not limited to the California Children's Services program, the Women, Infants and Children Supplemental Nutrition Program (WIC), maternal and Child health, social services, Regional Centers, and Child welfare departments, as outlined in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) in order to facilitate the provision of EPSDT services to Members less than 21 years of age;

5) Contractor must comply with APL 23-005 requirements to include conducting ongoing training, at least once every two years, for Network Providers on required preventive healthcare services, including EPSDT services for Members less than 21 years of age as outlined in Exhibit A, Attachment III, Subsection 3.2.5.B (*Network Provider Training*), to ensure Providers are able to support Members and families in fully utilizing EPSDT services.

B. Utilization Management

Contractor must ensure that all requirements outlined in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) apply to the review and provision of Medically Necessary services for Members less than 21 years of age.

C. PHM and Coordination of Care

1) Contractor must ensure that all requirements outlined in Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), including the development of the annual PNA, apply to Members less than 21 years of age;

2) Contractor's Population Health Management Strategy (PHMS), as described in Exhibit A, Attachment III, Subsection 4.3.1 (*Population Health Management Program Requirements*), must contain a specific section focused on how Contractor will provide PHM services to Members less than 21 years of age, including but not limited to, Basic Population Health Management, EPSDT services, Care Coordination services, Early Intervention Services, and a Wellness and Prevention Program;

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must provide a comprehensive wellness and prevention program to all Members less than 21 years of age, which includes but is not limited to initiatives, programs, and evidence-based approaches to improving access to preventive health visits, developmental screenings, and services for Members less than 21 years of age, as described in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*). See full requirements in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management)*.

D. Network and Access to Care

1) Contractor must ensure that each Member less than 21 years of age has an assigned PCP as well as access to Specialists for Covered Services and Medically Necessary services, in accordance with Exhibit A, Attachment III, Subsection 5.2.1 (*Access to Network Providers and Covered Services*);

2) Contractor must provide information to all Network Providers regarding the Vaccines for Children (VFC) Program and is expected to promote and support the enrollment of applicable Network Providers in the VFC program in order to improve access to immunizations; and

3) Contractor must maintain and continually monitor, improve, and evaluate Cultural and Linguistic services that support the delivery of Covered Services to Members less than 21 years of age, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

E. Quality and Health Equity

1) Contractor must identify and address the underutilization of Children's preventive services, including but not limited to, EPSDT services such as well Child visits, developmental screenings and immunizations;

2) Contractor must report on DHCS-identified Quality Performance Measures and Health Equity performance measures related to health care services for Members less than 21 years of age, and must exceed any DHCS-specified MPL, in accordance with Exhibit A, Attachment III, Subsection 2.2.9.A (*Quality Performance Measures*);

3) Contractor must engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to health care services for Members less than 21 years of age;

4) Contractor must meet any Health Disparity reduction targets for specific populations and measures for Members less than 21 years of age, as identified by DHCS and in accordance with Exhibit A, Attachment III, Subsection 2.2.9.A.2 (*Quality Performance Measures*);

5) Contractor must participate in any value-based payment programs for services provided to Members less than 21 years of age, as directed by DHCS;

6) Contractor must engage in planned Health Equity-focused interventions to address identified gaps in the quality of and access to care for Members less than 21 years of age, including preventive and screening services; and

7) Contractor must engage in a Member and family-oriented engagement strategy with QI and Health Equity, including Children and caregiver representation on the Community Advisory Committee (CAC), and using CAC findings and recommendations, and the results of Member listening sessions, focus groups and surveys, to inform QI and Health Equity interventions, as outlined in Exhibit A, Attachment III, Subsection 5.2.11.D. (*Cultural and Linguistic Programs and Committees*).

F. Mental Health and Substance Use Disorder Services

Contractor must adhere to all requirements of Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*) for the provision of mental health and Substance Use Disorder (SUD) services to Members less than 21 years of age, as appropriate, including collaborating with county Behavioral Health plans and complying with APL 23-010 and all mental health parity requirements in 42 CFR section 438.900 *et seq*.

Contractor must collaborate with the Department in its effort to implement the California Children and Youth Behavioral Health Initiative.

G. School-Based Services

To facilitate the provision of Medically Necessary services to Children, Contractor must collaborate with, and, by January 1, 2025 execute, an MOU with Local Education Agencies (LEAs) in each county within Contractor's Service Area for school-based services, including but not limited to EPSDT and Behavioral Health Services for Members less than 21 years of age. Contractor must also ensure that a Members' PCP cooperates and collaborates with LEAs in the development of the Individualized Education Plans (IEPs) or Individualized Family Service Plans (IFSPs), and ultimately ensure that care is coordinated regardless of financial responsibility, as outlined in Exhibit A, Attachment III, Subsections 4.3.16 (*School-Based Services*) and 5.6.1 (*MOU Purpose*).

2.2.11 Quality Monitoring for Skilled Nursing Facilities—Long-Term Care

Contractor must implement and maintain policies and procedures for providing applicable Long-Term Care (LTC) services for Members as detailed in Exhibit A Attachment III, Subsection 5.3.7.G *(Services for All Members).* Contractors must maintain a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided. Contractor must have a system in place to collect quality assurance and improvement findings from the California Department of Public Health to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings. Contractor's comprehensive QAPI program must incorporate all requirements in APL 23-004.

2.2.12 Disease Surveillance

Contractor must implement and maintain procedures for reporting any serious diseases or conditions to both local and State public health authorities and to implement directives from the public health authorities as required by law, including but not limited to, 17 CCR section 2500 *et seq*.

2.2.13 Credentialing and Recredentialing

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must implement and maintain written policies and procedures regarding the initial Credentialing, recredentialing, recertification, and reappointment of Network Providers in accordance with 42 CFR section 438.214 and APL 22-013. Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure its policies and procedures are reviewed and approved by its Governing Board. Contractor must ensure that the responsibility for recommendations regarding Credentialing decisions rests with a Credentialing committee or other peer review body.

A. Standards

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all their Network Providers who deliver Covered Services and have executed Network Provider Agreements with Contractor are qualified in accordance with current applicable legal, professional, and technical standards, and are appropriately licensed, certified, or registered.

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all their Network Providers have good standing in the Medicare and Medicaid/Medi-Cal programs and

have a valid National Provider Identifier (NPI) number. Contractor must ensure that Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's Network.

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must ensure that all contracted Laboratory Testing Sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

B. Subcontractor and Downstream Subcontractor Credentialing

Contractor may delegate Credentialing and recredentialing activities, but Contractor remains ultimately responsible for the completeness and accuracy of these activities, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*).

C. Credentialing Provider Organization Certification

Contractor may obtain Credentialing provider organization certification from the NCQA. Contractor may accept evidence of NCQA provider organization certification in lieu of a monitoring visit at Network Provider's facilities.

D. Disciplinary Actions

Contractor must implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner, including dentists, to the appropriate authorities. Contractor must implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating the privileges of practitioners, including dentists. Contractor must implement and maintain a Provider appeal process.

E. Medi-Cal and Medicare Provider Status

Contractor must verify that its Subcontractors, Downstream Subcontractors, and Network Providers have not been terminated as Medi-Cal or Medicare Providers or have not been placed under a restriction (payment or temporary suspension) resulting in placement on the Suspended and Ineligible Provider List, List of Excluded Entities, or Restricted Provider Database (RPD). Contractor cannot maintain contracts with Network Providers, Subcontractors, or Downstream

Subcontractors who have been terminated by either Medicare or Medi-Cal or placed on the Suspended and Ineligible Provider List.

F. Contractor's NCQA Health Plan Accreditation

If Contractor has received an accredited status from NCQA, Contractor will be deemed to meet the DHCS requirements for Credentialing and may be exempt from the DHCS medical review audit for Credentialing.

G. Credentialing of Other Non-Physician Providers

Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors must develop and maintain policies and procedures that ensure that the credentials of Nurse Practitioners (NPs), Certified Nurse Midwives, clinical nurse Specialists, Physician Assistants, mental health Providers, and substance use treatment Providers have been verified in accordance with State requirements applicable to the Provider category.

Exhibit A, ATTACHMENT III

2.3 Utilization Management Program

2.3.1 Prior Authorizations and Review Procedures
2.3.2 Timeframes for Medical Authorization
2.3.3 Review of Utilization Data
2.3.4 Delegating Utilization Management Activities

2.3 Utilization Management Program

Contractor must develop, implement, update as needed (but at least annually), and improve its Utilization Management (UM) program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services for its Members. Contractor must ensure that its UM program:

A. Includes a designated medical director or clinical director responsible for the UM process in accordance with Health and Safety Code (H&S) section 1367.01, and qualified staff responsible for the UM program.

B. Prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities must not be structured to provide incentives to deny, limit, or discontinue Medically Necessary Covered Services.

C. Allows for a second opinion from a qualified health professional within the Network, if available. If a qualified health professional within the Network is not available, Contractor must authorize an out-of-Network Provider to provide the second opinion at no cost to the Member, in accordance with 42 CFR section 438.206.

D. Makes available to Network Providers all relevant UM policies and procedures upon request.

E. Makes available to Members all relevant UM policies and procedures upon request. Makes available to Members clinical criteria used by Contractor, Subcontractors, and Downstream Subcontractors, as applicable for assessing Medical Necessity for Covered Services.

F. Provides training to Network Providers on the procedures and services that require Prior Authorization for Medically Necessary Covered Services, and ensures that all Network Providers are aware of the procedures and timeframes necessary to obtain Prior Authorization for Medically Necessary Covered Services, within 30 calendar days of executing this Contract and within 30 calendar days of contracting with a Network Provider.

G. Has a Standing Referral process providing a determination within three Working Days from the date the request is made by the Member or the Member's Primary Care Provider (PCP) and all appropriate Medical Records and other items of information necessary to make the determination are provided. Once a determination is made, the referral

must be made within four Working Days of the date that the proposed treatment plan, if any, is submitted to Contractor's medical director or the medical director's designee, in accordance with H&S section 1374.16.

H. Has a specialty referral system to track and monitor referrals requiring Prior Authorization by Contractor. When Prior Authorization is delegated to Subcontractors and Downstream Subcontractors, Contractor must ensure that Subcontractors and Downstream Subcontractors have systems in place to track and monitor referrals requiring Prior Authorization and must furnish documentation of Subcontractor's and Downstream Subcontractor's referrals to DHCS upon request. Contractor's specialty referral systems must include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor's specialty referral systems must include information on requested out-of-Network services. Contractor must ensure that all Network Providers are aware of the specialty referral processes and tracking procedures.

I. Integrates UM activities into the Quality Improvement System (QIS) specified in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program*), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or their designee.

J. Has timelines and processes that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and Substance Use Disorder (SUD) services than are imposed on medical/surgical services, in accordance with the parity in mental health and SUD requirements in 42 CFR section 438.900, et seq.

K. Makes Contractor's UM policies and procedures available to Members and Providers on Contractor's website and upon request. These policies and procedures must set out how Contractor authorizes, modifies, delays, or denies health care services via Prior Authorization, concurrent authorization, or Retrospective Review, under the services provided by Contractor, in accordance with 42 CFR section 438.915.

1) Contractor must ensure that policies and procedures for authorization decisions are based on the Medical Necessity of a requested Covered Service and are consistent with criteria or guidelines supported by sound clinical principles and evidence-based practice.

2) Contractor must ensure that policies, processes, strategies, evidentiary standards, and other factors used for UM are consistently applied to medical/surgical, mental health, and SUD services and benefits.

3) Contractor must notify Network Providers, as well as Members and Potential Members upon request, of all services that require Prior Authorization, concurrent authorization, or Retrospective Review, and ensure that all Network Providers are aware of the procedures and timeframes necessary to obtain authorization for these services.

All UM activities must be performed in accordance with H&S sections 1363.5 and 1367.01 and 28 CCR section 1300.70(a)(3), (b)(2)(H), and (c).

2.3.1 Prior Authorizations and Review Procedures

Contractor must ensure that its Prior Authorization, concurrent review, and Retrospective Review authorization procedures meet the following minimum requirements, in accordance with H&S section 1367.01:

A. Contractor must consult with Providers as needed for Prior Authorization requests for the purposes of determining Medical Necessity for Covered Services unless doing so would lead to undue delay in care;

B. Decisions to deny or to authorize an amount, duration, or scope that is less than requested must be made by a qualified health care professional with appropriate clinical expertise in treating the medical or Behavioral Health condition and disease or Long-Term Services and Supports (LTSS) needs. Appropriate clinical expertise may be demonstrated by relevant specialty training, experience, or certification. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions;

C. Qualified health care professionals must supervise the review of medical decisions, including service reductions, and must review all denials that are made, in whole or in part, based on Medical Necessity. Contractor is not responsible for the review of Prior Authorizations for physician administered drugs, medical supplies, enteral nutritional products, and covered outpatient Prescription Drugs provided by an outpatient pharmacy. Contractor must review Prior Authorizations for physician administered drugs which include Prescription Drugs administered by a health care professional in a clinic, physician's office, or outpatient setting; medical supplies; and enteral nutritional products. These Prescription

Drugs and supplies are covered under the medical benefit and would be included in the medical claim or Encounter;

D. Contractor must establish written criteria or guidelines for UM that are developed with practicing health care Providers. The written criteria or guidelines must be based on sound clinical practices and processes which are evaluated and updated when necessary, and at least annually, in accordance with H&S section 1363.5;

E. Contractor must provide a clear and concise written explanation of the reasons for denying, deferring, or modifying a service; a description of the criteria or guidelines used; and the clinical reasons for the decision based on Medical Necessity. Any written communication to a Provider of a denial, delay, or modification of a request must include the name and telephone number of Contractor's health care professional responsible for the denial, delay, or modification;

F. Contractor must notify Members regarding denied, deferred or modified referrals as specified in Exhibit A, Attachment III, Subsection 5.1.5, (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*). Contractor must publish on its website an Appeals procedure for both Providers and Members;

G. Decisions and Appeals must be made in a timely manner and not be unduly delayed when Member's medical condition requires time sensitive services;

H. Prior Authorization requirements must not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, Sexually Transmitted Disease (STD) services, Human Immunodeficiency Virus (HIV) testing, or initial mental health and SUD assessments;

I. Records relating to Prior Authorization requests, including any Notices of Action (NOA), must meet the retention requirements described in Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*);

J. Contractor must notify the requesting Provider of any decision to deny, approve, modify, or delay a service authorization request, a request by a Member or a Member's Provider for the provision of a Covered Service, or when authorizing a service in an amount, duration, or scope that is less than requested. The notice to the Provider may be oral or in writing; and

K. All of Contractor's authorization requirements must comply with the requirements for parity in mental health and SUD benefits in 42 CFR section 438.900, et seq.

2.3.2 Timeframes for Medical Authorization

A. Emergency Services: Contractor must not require Prior Authorization for Emergency Services for complaints or conditions that a prudent layperson would determine could seriously jeopardize their physical or mental health.

B. Post-Stabilization Care Services: Contractor must respond to a Network Provider's or out-of-Network Provider's request for authorization for Post-Stabilization Care Services within 30 minutes or the service is deemed approved, in accordance with All Plan Letter (APL) 23-009.

C. Non-Urgent Care Following an Exam in the Emergency Room: Contractor must respond to a Provider's request for Post-Stabilization Care Services within 30 minutes or the service is deemed approved.

D. Retrospective Review Authorization Request for Treatment Received: Contractor must accept requests for Retrospective Review authorization within a reasonably established time limit, not to exceed 365 calendar days from the date of service. Contractor must communicate decisions to the Provider and to the Member who received the services or to the Member's Authorized Representative within 30 calendar days of the receipt of information that is reasonably necessary to make this determination, in accordance with 42 CFR section 438.404(a) and H&S section 1367.01(h)(1).

E. Routine Authorizations: Contractor must respond to routine requests and concurrent requests as expeditiously as the Member's condition requires, but no longer than five Working Days from receipt of the information reasonably necessary and requested by Contractor to render a decision, and no longer than 14 calendar days from Contractor's receipt of the request, in accordance with 42 CFR section 438.210 and H&S section 1367.01.

F. Expedited Authorizations: Contractor must make expedited authorization decisions for service requests where a Member's Provider indicates, or Contractor, Subcontractor, Downstream Subcontractor, or Network Provider determines that, following the standard timeframe for Prior Authorizations and concurrent requests could seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, in accordance with 42 CFR section 438.210 and H&S section

1367.01. Contractor must provide its authorization decision as expeditiously as the Member's health condition requires, but no longer than 72 hours after Contractor's receipt of the request for services. Contractor must also expedite Prior Authorization requests for Members who are transitioning from an acute care hospital to all settings, including Contractor's chosen Community Supports, and make an authorization decision in a timeframe that is appropriate for the nature of the Member's condition but is no longer than 72 hours after Contractor's receipt of all information needed to make an authorization decision.

G. Hospice Services: Contractor may only require Prior Authorization for inpatient hospice care. Contractor must respond to inpatient hospice care authorization requests in accordance with 22 CCR section 51003 and APLs.

H. Therapeutic Enteral Formula: Contractor must comply with all timeframes for medical authorization of Medically Necessary therapeutic enteral formula billed on a medical or institutional claim, and the equipment and supplies necessary for delivery of enteral formula billed on a medical or institutional claim, as set forth in W&I section 14103.6, H&S section 1367.01, and all applicable APLs.

I. Physician Administered Drugs: For medical authorization of Medically Necessary physician administered drugs billed on a medical or institutional claim, Contractor must comply with the same timeframes as other medical services, at set out in this subsection.

2.3.3 Review of Utilization Data

A. Contractor must include within the UM program mechanisms to detect both under- and over-utilization of health care services including Behavioral Health Services. Contractor's internal reporting mechanisms used to detect Member utilization and Provider prescribing patterns must be reported to DHCS no later than 30 calendar days after the beginning of each calendar year and upon request.

B. Contractor must monitor utilization data to appropriately identify Members eligible for Enhanced Care Management (ECM) and applicable Community Supports as specified in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management)* and Subsection 4.5.6 (*Identifying Members for Community Supports)*.

C. Contractor must monitor and track Non-Specialty Mental Health Services (NSMHS) utilization data for both Members. Upon request, Contractor must submit data to DHCS.

2.3.4 Delegating Utilization Management Activities

Contractor may delegate UM activities. If Contractor delegates any UM activities, Contractor must comply with Exhibit A, Attachment III, Subsection 2.2.5 (*Subcontractor and Downstream Subcontractor Quality Improvement Activities*).

Exhibit A, ATTACHMENT III

3.0 Providers, Network Providers, Subcontractors, and Downstream Subcontractors

DHCS is committed to ensuring that all Contractors are aware of their obligations under this Contract and are committed to being accountable not only for their own obligations, but for those of their Subcontractors and Downstream Subcontractors for delegated functions. In this Article, DHCS includes provisions requiring Contractors to disclose what entities provide delegated functions through Subcontractor Agreements and Downstream Subcontractor Agreements as applicable.

In addition, Contractors are to demonstrate that they have robust compliance, monitoring, and oversight programs, including for all Subcontractors and Downstream Subcontractors to ensure Members receive quality care and have access to services. This Article requires Contractors to not only disclose delegation arrangements but include justification for the use of Subcontractors and Downstream Subcontractors to ensure that the Member's experience and outcomes are front and center. DHCS is particularly focused on those entities that take risk; thus, this Article includes provisions requiring reporting of Subcontractors and Downstream Subcontractors that assume responsibility for taking that risk and managing the health care of a portion of assigned lives.

This Article articulates DHCS' commitment in moving the delivery system towards value-based payment. Contractors are to report on the proportion of spend that is tied to value. In addition, Contractors are to implement Financial Arrangements that link payments to value in the form of higher quality of care, better health care outcomes, and lower cost of care. Such arrangements include, but are not limited to, incentive payment arrangements that reward Providers for high or improved performance on selected measures or benchmarks. Finally, Contractors are to report on the proportion of spend on Primary Care specifically in an effort to encourage investment in Primary Care as appropriate.

3.1 Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties

3.1.1 Overview of Contractor's Duties and Obligations
3.1.2 DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements
3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan
3.1.4 Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance
3.1.5 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements
3.1.6 Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers
3.1.7 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics
3.1.8 Network Provider Agreements with Safety-Net Providers
3.1.9 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments
3.1.10 Nondiscrimination in Provider Contracts
3.1.11 Public Records
3.1.12 Requirement to Post

3.1 Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties

3.1.1 Overview of Contractor's Duties and Obligations

A. Contractor is fully responsible for all duties and obligations set forth in this Contract. However, Contractor may enter into agreements with other individuals, groups, or entities to fulfill its obligations and duties under the Contract, including Network Provider Agreements and Subcontractor Agreements. Some individuals, groups, or entities may be a combination of Network Provider, Subcontractor, and/or Downstream Subcontractor, in which case they would need to comply with the requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as applicable. Subcontractors and Downstream Subcontractors may enter into agreements to fulfill their obligations and duties under the Contract, in which case they would need to comply with the requirements of Downstream Subcontractor Agreements or Network Provider Agreements, as applicable.

B. Contractor must ensure that all Subcontractors and Downstream Subcontractors comply with all Contract requirements related to the delegated functions undertaken by each Subcontractor or Downstream Subcontractor. Contractor remains fully responsible for the performance of all duties and obligations it delegates to Subcontractors and Downstream Subcontractors. To ensure Subcontractor's and Downstream Subcontractor's compliance, Contractor must, at a minimum, do the following:

1) Include all Contract duties and obligations relating to the delegated duties in the Subcontractor Agreement;

2) Ensure Subcontractor includes all Contract obligations relating to the delegated duties in all Downstream Subcontractor Agreements;

3) Provide policies and procedures to Subcontractors applicable to the delegated functions and ensure Subcontractor provides the relevant policies and procedures as applicable to delegated functions;

4) Monitor and oversee all delegated functions, including those that may flow down to Downstream Subcontractors; and

5) Provide to DHCS a delegation reporting and compliance plan, as set forth in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's*

Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan).

C. Contractor must ensure that Network Providers comply with all applicable Contract requirements and all requirements set forth in their Network Provider Agreements (See Exhibit A, Attachment III, Subsection 3.1.5.A (*Network Provider Agreement Requirements).*

3.1.2 DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements

A. Submission and Approval of Network Provider Agreements Templates

1) Contractor must submit to DHCS all Network Provider Agreement templates, and any proposed amendments thereto, for review and approval before use. The contents of the Network Provider Agreement templates are set forth in All Plan Letter (APL) 19-001.

2) Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing the use of all Network Provider Agreement templates. DHCS will provide Contractor with a written explanation indicating whether the template is approved, disapproved, or an estimated date for completion of DHCS' review. If DHCS does not complete its review of Network Provider Agreement templates within 60 calendar days of receipt, or within DHCS' estimated date of completion, whichever is later, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHCS.

B. Submission and Approval of Subcontractor Agreements and Downstream Subcontractor Agreements Templates

1) Contractor must submit to DHCS all Subcontractor and Downstream Subcontractor Agreement templates, and any amendments thereto, as follows:

a) For Fully Delegated Subcontractors and Downstream Subcontractors Fully Delegated, Contractor must submit all Subcontractor and Downstream Subcontractor Agreements templates and any amendments thereto, to DHCS for review and approval before use. Contractor must also file with DHCS all executed Subcontractor Agreements with Fully Delegated Subcontractors and Downstream Subcontractors.

b) For Partially Delegated Subcontractors and Administrative Subcontractors, and Downstream Partially Delegated Subcontractors and Downstream Administrative Subcontractors, Contractor must submit all Subcontractor Agreements and Downstream Subcontractor Agreements templates, and any amendments thereto, to DHCS for review and approval prior to execution of the Subcontractor Agreement or Downstream Subcontractor Agreement.

2) Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing the use of Subcontractor Agreement and Downstream Subcontractor Agreement templates and/or actual proposed Subcontractor Agreements and Downstream Subcontractor Agreements submitted by Contractor. DHCS will provide Contractor with a written explanation indicating whether the template and/or actual proposed Subcontractor Agreement or Downstream Subcontractor Agreement is approved, disapproved, or an estimated date for completion of DHCS review. If DHCS does not complete its review of the submitted material within 60 calendar days of receipt, or by DHCS estimated date of completion, whichever is later, Contractor may elect to implement or use the template and/or actual proposed Subcontractor Agreement or Downstream Subcontractor Agreement at Contractor's sole risk and subject to possible subsequent disapproval by DHCS.

3.1.3 Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan

A. Content of Delegation Reporting and Compliance Plan

Contractor must report its delegation and compliance plan using the templates provided in Exhibit J *(Delegation Reporting and Compliance Plan),* which includes, but is not limited to, the following:

1) All Contractor's contractual relationships with Subcontractors and Downstream Subcontractors;

2) Contractor's oversight responsibilities for all delegated obligations; and

3) How Contractor intends to oversee all delegated activities, including, but not limited to, details regarding key personnel who will be overseeing each delegated function.

B. Timing of Submission

Contractor must submit its delegation reporting and compliance plan to DHCS as follows:

1) During the operational readiness period;

2) Annually, whether or not changes have been made to its delegation structure; and

3) Anytime there is a change in the delegation reporting and compliance plan, including but not limited to a change in a Subcontractor and/or a change in the scope of the delegation.

The report must be submitted within 30 calendar days from either the beginning of the annual reporting period or any change, as identified above.

3.1.4 Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance

Contractor must maintain policies and procedures approved by DHCS to ensure that Network Providers, Subcontractors, and Downstream Subcontractors fully comply with all applicable terms and conditions of this Contract and all duties delegated to Subcontractors and Downstream Subcontractors as set forth above. Contractor must evaluate each prospective Network Provider's, Subcontractor's, and Downstream Subcontractor's ability to perform the contracted services or functions, must oversee and remain responsible and accountable for any services or functions undertaken by a Network Provider, Subcontractor, or Downstream Subcontractor, and must meet all applicable requirements set forth in State and federal law, regulation, any APLs or DHCS guidance, and this Contract.

3.1.5 Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements

A. Network Provider Agreement Requirements

Network Provider Agreements must contain the following provisions:

1) Specification of the Covered Services to be ordered, referred, or rendered;

2) The term of the agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination, if any;

3) Full disclosure of the method and amount of compensation or other consideration to be received by Network Provider;

4) Specification that the agreement will be governed by and construed in accordance with all applicable laws and regulations governing the Contract, including but not limited to, Knox-Keene Health Care Service Plan Act of 1975 (KKA), Health and Safety Code (H&S) section 1340 *et seq*. (unless excluded under this Contract); W&I sections 14000 and 14200 *et seq*.; 28 CCR section 1300.43 *et seq*.; and 22 CCR sections 53800 *et seq.*, 22 CCR sections 53900 *et seq*;

5) Network Provider will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and provisions of this Contract;

6) Network Provider will submit to Contractor, either directly or through a Subcontractor or Downstream Subcontractor as applicable, complete, accurate, reasonable, and timely Encounter Data and Provider Data, and any other reports or data as requested by Contractor, in order for Contractor to meet its data reporting requirements to DHCS;

7) Network Provider will maintain and make available to DHCS, upon request, copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Network Provider Agreement, and will ensure that all such contracts are in writing;

8) Network Provider will make all of its premises, facilities, equipment, books, records, contracts, and computer and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*), as follows:

a) In accordance with inspections and audits, as directed by DHCS, The Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), the Department of Managed Health Care (DMHC), or their designees; and

b) At all reasonable times at Network Provider's place of business or at such other mutually agreeable location in California.

9) Network Provider will maintain all of its books and records, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term annual of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

10) Network Provider will timely gather, preserve and provide to DHCS, CMS, the Division of Medi-Cal Fraud and Elder Abuse (DMFEA), and any authorized State or federal regulatory agencies, any records in Network Provider's possession, in accordance with Exhibit E, Subsection 1.1.27 (*Litigation Support*);

11) Network Provider will assist Contractor, or if applicable a Subcontractor or Downstream Subcontractor, in the transfer of Member's care in accordance with Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*) in the event of Contract termination, or in the event of termination of the Network Provider Agreement for any reason;

12) Network Providers will be terminated, or subject to other actions, fines, and/or penalties, if DHCS or Contractor determine that the Network Provider has not performed satisfactorily;

13) Network Provider will hold harmless both the State and Members in the event Contractor or, if applicable a Subcontractor or Downstream Subcontractor, cannot or will not pay for Covered Services ordered, referred, or rendered by Network Provider pursuant to the Network Provider Agreement;

14) Network Provider will not bill a Member for Medi-Cal Covered Services;

15) Contractor must inform Network Provider of prospective requirements added by State or federal law or DHCS related to this Contract that impact obligations undertaken through the Network Provider Agreement before the requirement would be effective, and agreement by Network Provider to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

16) Network Provider must ensure that cultural competency/humility, sensitivity, Health Equity, and diversity training is provided for employees and staff at key points of contact with Members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*);

17) Network Provider must provide interpreter services for Members and comply with language assistance standards developed pursuant to H&S section 1367.04;

18) Network Provider must notify Contractor, and Contractor's Subcontractor or Downstream Subcontractor, within ten Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with Exhibit A, Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*) and Subsection 1.3.2.D.6 (*Confidentiality*);

19) Network Provider must report to Contractor, or Contractor's Subcontractor or Downstream Subcontractor, when it has received an overpayment; return the overpayment to Contractor, or Contractor's Subcontractor or Downstream Subcontractor, within 60 calendar days of the date the overpayment was identified; and notify Contractor, or Contractor's Subcontractor or Downstream Subcontractor, in writing of the reason for the overpayment in accordance with Exhibit A, Attachment III, Subsection 1.3.6 (*Treatment of Overpayment Recoveries*) and 42 CFR section 438.608(d)(2);

20) Confirmation of Network Provider's right to all protections afforded them under the Health Care Providers' Bill of Rights, including, but not limited to Network Provider's right to access Contractor's dispute resolution mechanism and submit a Grievance pursuant to H&S section 1367(h)(1).

B. Subcontractor and Downstream Subcontractor Agreement Requirements

Subcontractor Agreements and Downstream Subcontractor Agreements must contain the following provisions, as applicable to the specific obligations and functions that Contractor delegates in the Subcontractor Agreement or that the Subcontractor or Downstream Subcontractor delegates in the Downstream Subcontractor Agreement:

1) Specification of Contractor's obligations and functions undertaken by the Subcontractor or Downstream Subcontractor;

2) The term of the Subcontractor Agreement or Downstream Subcontractor Agreement, including the beginning and ending dates as well as methods of extension, renegotiation, phaseout, and termination, if any;

3) Full disclosure of the method and amount of compensation or other consideration to be received by Subcontractor or Downstream Subcontractor per unit of service;

4) Specification that the Subcontractor Agreement or Downstream Subcontractor Agreement and amendments as set forth in Exhibit A, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*);

5) Subcontractor's assignment or delegation of an obligation or responsibility under a Subcontractor Agreement to any Downstream Subcontractor is void unless prior written approval is obtained from DHCS;

6) Downstream Subcontractor's assignment or delegation of an obligation or responsibility under a Downstream Subcontractor Agreement to any Downstream Subcontractor is void unless prior written approval is obtained from DHCS;

7) Specification that the Subcontractor Agreement or Downstream Subcontractor Agreement is governed by and construed in accordance with all applicable laws and regulations governing the Contract, including but not limited to 42 CFR section 438.230; KKA, H&S section 1340 *et seq*. (unless otherwise excluded under this Contract); 28 CFR section 1300.43 *et seq.*; W&I sections 14000 and 14200 *et seq.*; and 22 CCR sections 53800 *et seq.*, 22 CCR sections 53900 *et seq*;

8) Subcontractor and Downstream Subcontractors must comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, including but not limited to, all applicable federal and State Medicaid and Medi-Cal laws, regulations, sub-regulatory guidance, APLs, and the provisions of this Contract;

9) Language comparable to Exhibit A, Attachment III, Subsection 3.3.16 (*Emergency Services and Post-Stabilization Care Services*), for those Subcontractors or Downstream Subcontractors obligated to reimburse Providers of Emergency Services;

10) Subcontractor and Downstream Subcontractors must submit to Contractor, either directly or through a Subcontractor or Downstream Subcontractor as applicable, complete, accurate, reasonable, and timely Encounter Data and Provider Data, and any other reports and data as requested by Contractor, in order for Contractor to meet its reporting requirements to DHCS;

11) Subcontractor and Downstream Subcontractors must comply with all monitoring provisions of this Contract and any monitoring requests by DHCS;

12) Subcontractor and Downstream Subcontractors must maintain and make available to DHCS, upon request, copies of all contracts it enters into related to the performance of the obligations and functions it undertakes pursuant to the Subcontractor Agreement, and to ensure that such contracts are in writing;

13) Subcontractor and Downstream Subcontractors must make all of their premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*), as follows:

    a) In accordance with inspections and audits, as directed by DHCS, CMS, U.S. DHHS Inspector General, the Comptroller General, DOJ, DMHC, or their designees; and

b) At all reasonable times at Subcontractor's or Downstream Subcontractor's place of business or at such other mutually agreeable location in California.

14) Subcontractor and Downstream Subcontractors must maintain all of its books and records, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

15) Subcontractor and Downstream Subcontractors must timely gather, preserve, and provide to DHCS, CMS, DMFEA, and any authorized State or federal regulatory agencies, any records in Subcontractor's possession, in accordance with Exhibit E, Subsection 1.1.27 (*Litigation Support*).

16) Subcontractor and Downstream Subcontractors must assist Contractor as applicable in the transfer of the Member's care as needed, and in accordance with Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*), in the event of Contract termination, or in the event of termination of the Subcontractor Agreement or Downstream Subcontractor Agreement for any reason;

17) Subcontractor and Downstream Subcontractors must notify DHCS in the event the Subcontractor Agreement or any Downstream Subcontractor Agreement is amended or terminated for any reason;

18) Subcontractor and Downstream Subcontractors must hold harmless both the State and Members in the event Contractor, or another Subcontractor or Downstream Subcontractor as applicable, cannot or will not pay for the obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement;

19) Subcontractor and Downstream Subcontractors must participate and cooperate in Contractor's Quality Improvement System as applicable;

20) If Subcontractor or Downstream Subcontractors takes on Quality Improvement activities, the Subcontractor Agreement or Downstream Subcontractor Agreement must include those provisions stipulated in Exhibit A, Attachment III, Subsection 2.2.5

(*Subcontractor and Downstream Subcontractor Quality Improvement Activities*);

21) To the extent Subcontractor or Downstream Subcontractor undertakes coordination of care obligations and functions for Members, an agreement to share with Subcontractor and Downstream Subcontractor any utilization data that DHCS has provided to Contractor, and agreement by the Subcontractor and Downstream Subcontractors to receive the utilization data provided and use it solely for the purpose of Member Care Coordination;

22) Contractor must inform Subcontractor of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Subcontractor Agreement before the requirement is effective, and Subcontractor's agreement to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

23) Subcontractor or Downstream Subcontractors must inform the Downstream Subcontractor taking on delegated functions of prospective requirements added by federal or State law or DHCS related to this Contract that impact obligations and functions undertaken pursuant to the Downstream Subcontractor Agreement before the requirement is effective, and the agreement of the Downstream Subcontractor taking on delegated functions to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

24) Subcontractor and Downstream Subcontractors must ensure that cultural competency/humility, sensitivity, Health Equity, and diversity training is provided for Subcontractor's and Downstream Subcontractor's staff at key points of contact with Members in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*);

25) Subcontractor and Downstream Subcontractors must provide interpreter services for Members and comply with language assistance standards developed pursuant to H&S section 1367.04;

26) Subcontractor and Downstream Subcontractors must notify Contractor within ten Working Days of any suspected Fraud, Waste, or Abuse and a provision that allows Contractor to share such information with DHCS in accordance with Exhibit A,

Attachment III, Subsection 1.3.2.D (*Contractor's Reporting Obligations*) and Subsection 1.3.2.D.6) (*Confidentiality*);

27) Subcontractor and Downstream Subcontractors must report directly to Contractor, or through the Subcontractor or Downstream Subcontractor, as applicable, when it has received an overpayment; return the overpayment to Contractor within 60 calendar days after the date the overpayment was identified; and notify Contractor in writing of the reason for the overpayment in accordance with Exhibit A, Attachment III, Subsection 1.3.6 *(Treatment of Overpayment Recoveries) and* 42 CFR section 438.608(d)(2);

28) Subcontractor and Downstream Subcontractors must perform the obligations and functions of Contractor undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, including but not limited to reporting responsibilities, in compliance with Contractor's obligations under this Contract in accordance with 42 CFR section 438.230(c)(1)(ii); and

29) Express agreement and acknowledgement by Subcontractor and Downstream Subcontractors that DHCS is a direct beneficiary of the Subcontractor Agreement or Downstream Subcontractor Agreement with respect to all obligations and functions undertaken pursuant to the Subcontractor Agreement or Downstream Subcontractor Agreement, and that DHCS may directly enforce any and all provisions of the Subcontractor Agreement or Downstream Subcontractor Agreement.

3.1.6 Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers

Contractor must maintain a system to evaluate and monitor the financial viability of all Network Providers, Subcontractors, and Downstream Subcontractors that accept financial risk for the provision of Covered Services including, but not limited to, Medi-Cal managed care plans, independent Physician/Provider associations, medical groups, hospitals, risk-bearing organizations as defined by 28 CCR section 1300.75.4(b), Federal Qualified Health Centers (FQHC), and other clinics.

3.1.7 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics

Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with FQHCs, Rural Health Clinics (RHCs), and other clinics must meet the requirements of Exhibit A, Attachment III, Subsections 3.1.5.A and B (*Network Provider Agreement Requirements* and *Subcontractor and Downstream Subcontractor Agreement Requirements*), above, and the reimbursement requirements set forth in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider)*. Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements with FQHCs, RHCs, and other clinics also must contain a provision stating that any negotiated and agreed-upon rate with an FQHC, RHC, or other clinic constitutes complete reimbursement and payment in full for the Covered Services rendered to a Member.

3.1.8 Network Provider Agreements with Safety-Net Providers

A. Contractor must offer a Network Provider Agreement to any Safety-Net Provider that agrees to provide its scope of services in accord with the same terms and conditions that Contractor requires of other similar Providers.

B. Contractor must notify DHCS of intent to terminate a Network Provider Agreement with a Safety-Net Provider at least 60 calendar days prior to the effective date of termination unless such Provider's license has been revoked or suspended or where the health and welfare of a Member is threatened, in which event termination will be effective immediately, without DHCS prior approval, and Contractor must notify DHCS concurrently with the termination.

3.1.9 Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments

A. Contractor must negotiate in good faith and execute Network Provider Agreements and Subcontractor Agreements, as appropriate, with the Local Health Department (LHD) in each county within Contractor's Service Area for the following public health services:

1) Family Planning Services, as specified in Exhibit A, Attachment III, Subsection 3.3.9 (*Non-Contracting Family Planning Providers*);

2) Sexually Transmitted Disease (STD) services, as specified in Exhibit A, Attachment III, Subsection 3.3.10 (*Sexually Transmitted Disease*), including diagnosis and treatment of the following: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid,

trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum, and granuloma inguinal;

3) Human Immunodeficiency Virus (HIV) testing and counseling as specified in Exhibit A, Attachment III, Subsection 3.3.11 (*Human Immunodeficiency Virus Testing and Counseling*); and

4) Immunizations as specified in Exhibit A, Attachment III, Subsection 3.3.12 (*Immunizations*).

B. Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with LHDs must specify the scope and responsibilities of both parties in the provision of services to Members, billing and reimbursements, reporting responsibilities, and how services are to be coordinated between the LHD and Contractor, including exchange of medical information as necessary. Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements must also meet the requirements described in Exhibit A, Attachment III, Subsection 3.1.5 (*Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

3.1.10 Nondiscrimination in Provider Contracts

Contractor must not discriminate against Providers, in connection with the participation, reimbursement, or indemnification of any Provider, who is acting within the scope of practice of their license or certification under applicable State law, solely on the basis of that license or certification. If Contractor declines to include individual or groups of Providers in its Network, it must give the affected Providers written notice of the reason for its decision. Contractor's Provider selection policies must not discriminate against Providers that serve high-risk populations or specialize in conditions requiring costly treatment. Upon request, Contractor must provide to DHCS its selection of Providers chosen to meet the need of Contractor's Members. This section will not be construed to require Contractor to contract with Providers beyond the number necessary to meet the needs of Contractor's Members, preclude Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with Contractor's responsibilities to Members.

3.1.11 Public Records

To the extent DHCS receives Contractor's Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, these agreements and all information received in accordance with these agreements will be public records on file with DHCS, except as specifically exempted in statute. The names of the officers and owners of the Network Provider, Subcontractor or Downstream Subcontractor; stockholders owning more than 5 percent of the stock issued by the Network Provider, Subcontractor or Downstream Subcontractor; and major creditors holding more than 5 percent of the debt of the Network Provider, Subcontractor, or Downstream Subcontractor must be attached to the Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement at the time that agreement is submitted to DHCS.

3.1.12 Requirement to Post

Contractor must post on its website a summary of its delegation model that outlines how it delegates obligations and duties of this Contract to Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

Exhibit A, ATTACHMENT III

3.2 Provider Relations

3.2.1 Exclusivity
3.2.2 Provider Dispute Resolution Mechanism
3.2.3 Out-of-Network Provider Relations
3.2.4 Contractor's Provider Manual
3.2.5 Network Provider Training
3.2.6 Emergency Department Protocols
3.2.7 Prohibited Punitive Action Against the Provider
3.2.8 Submittal of Inpatient Days Information

3.2 Provider Relations

3.2.1 Exclusivity

Contractor must not, by use of any exclusivity provision, clause, agreement, nor in any other way, prohibit any Network Provider from providing services to other persons enrolled in Medi-Cal who are not Contractor's Members.

3.2.2 Provider Dispute Resolution Mechanism

In accordance with Health and Safety Code (H&S) section 1367(h)(1), Contractor must have a fast, fair, and cost-effective Provider Dispute Resolution Mechanism in place for Network Providers and out-of-Network Providers to submit disputes.

A. Contractor must have a formal procedure to accept, acknowledge, and resolve Network Provider and out-of-Network Provider disputes. The Provider Dispute Resolution Mechanism must occur in accordance with the timeframes set forth in H&S sections 1371 and 1371.35 for both Network Providers and out-of-Network Providers. Any Provider of Medi-Cal services may submit a dispute to Contractor regarding:

   1) The authorization or denial of a service;

   2) The processing of a payment or non-payment of a claim by Contractor; or

   3) The timeliness of the reimbursement on an uncontested Clean Claim and any interest Contractor is required to pay on claims reimbursement.

B. Contractor's Provider Dispute Resolution Mechanism must be set forth in all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements.

C. Contractor must inform all Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors that provide services to Contractor's Members of its Provider Dispute Resolution Mechanism, regardless of contracting status.

D. Contractor must resolve Network Provider and out-of-Network Provider disputes within the timeframes set forth in H&S section 1371.35 of receipt of the dispute, including supporting documentation. Contractor and the Network Provider or out-of-Network Provider may agree that additional time is needed. If Contractor unilaterally requests additional time, it must

show good cause for the extension and provide supporting good cause documentation to DHCS upon request.

E. Contractor must submit a Provider Dispute Resolution Mechanism report annually to DHCS which includes information on the number of Providers who utilized the Provider Dispute Resolution Mechanism and a summary of the disposition of those disputes, in accordance with H&S section 1367(h)(3). This report must be delineated by Network Providers and out-of-Network Providers, and by Contractor, Subcontractor, or Downstream Subcontractor.

F. On an annual basis, Contractor must assess the Network Providers and out-of-Network Providers that utilize the Provider Dispute Resolution Mechanism to identify trends and systemic issues. Contractor must submit the results of its annual assessment to DHCS with discussion on how it is addressing trends and systemic issues identified based on the assessment.

3.2.3 Out-of-Network Provider Relations

A. Contractor must develop and maintain protocols for payment of claims to out-of-Network Providers, and for communicating and interacting with out-of-Network Providers regarding services and claims payment.

B. Contractor must provide its clinical protocols and evidence-based practice guidelines governing Prior Authorization, Utilization Management (UM) and Retrospective Review to all out-of-Network Providers providing services to its Members. Contractor must arrange to provide these protocols and guidelines at the time that Contractor enters into an agreement with an out-of-Network Provider or anytime an out-of-Network Provider submits a claim for services provided to Contractor's Members.

3.2.4 Contractor's Provider Manual

A. Contractor must issue a Provider manual to Network Providers, Subcontractors, and Downstream Subcontractors that includes information regarding Medi-Cal Covered Services and responsibilities for the provision of services including Basic Population Health Management; Care Coordination for Excluded Services; policies and procedures; quality assurance; improvement and monitoring; clinical protocols governing Prior Authorization and UM; timeliness standards; Credentialing; prohibited claims; statutes; regulations; telephone access; special requirements; data reporting; and the Member Grievance, Appeal, and State Hearing process. Contractor must ensure the most updated Provider manual is available

through Provider portals, the internet, or upon request. When updates are made to the Provider manual, Contractor must notify Network Providers, Subcontractors, and Downstream Subcontractors.

B. Contractor must solicit feedback from Contractor committees including but not limited to the Community Advisory Committee (CAC) and Quality Improvement Committee (QIC), to inform the development of Contractor Provider manual and clarify new and revised policies and procedures contained therein.

C. Contractor must conduct an annual review of its Provider manual and document that the review has been conducted by the appropriate Contractor committees including the QIC. Contractor must update its Provider manual annually or at any time to ensure that the information reflects current requirements.

D. Contractor's Provider manual must include and inform Network Providers, Subcontractors, and Downstream Subcontractors of the following Member rights information, as set forth in Exhibit A, Attachment III, Section 5.1 (*Member Services*):

1) Member's right to file Grievances and Appeals, and the requirements and timeframes for filing, including the right to have the Member's Medical Record and to have an Authorized Representative or Provider appeal on the Member's behalf, with written consent from the Member;

2) Availability of assistance in filing a Grievance, Appeal, or State Hearing;

3) Toll-free numbers to file oral Grievances and Appeals;

4) Member's right to request continuation of benefits during an Appeal or State Hearing;

5) Member's right to a State Hearing, how to obtain a State Hearing, and representation rules at a State Hearing; and

6) Member's right to an Independent Medical Review (IMR), if applicable.

3.2.5 Network Provider Training

Contractor must ensure that all Network Providers receive training regarding the Medi-Cal Managed Care program to ensure they operate in full compliance with the Contract and all applicable federal and State statutes, regulations, All Plan Letters (APLs), and Policy Letters (PLs). Contractor must conduct training for all Network Providers. Contractor must start training within ten Working Days and complete training within 30 Working Days after Contractor places a newly contracted Network Provider on active status. Contractor may conduct Network Provider training online or in-person. Contractor must maintain records of attendance to validate that Network Providers received training on a bi-annual basis.

A. Contractor must ensure that Network Provider training includes education on Covered Services, policies and procedures for clinical protocols governing Prior Authorization and UM, and carved out services including, how to refer to and coordinate care with agencies, programs and third parties with which Contractor has a Memorandum of Understanding (MOU) as required under this Contract.

B. Contractor must conduct ongoing training, at least once every two years, for Network Providers on required preventive healthcare services, including Early Periodic Screening, Diagnosis and Testing (EPSDT) services for Members less than 21 years of age; appropriate Medical Record documentation; and coding requirements. This must include training on existing Contractor data collection and reporting requirements and Quality Improvement (QI) programs to ensure required preventive services are offered and provided. This training also must include, but is not limited to, training on Population Health Management (PHM) program requirements (i.e., care management services) including referrals, health education resources, and Provider and Member incentive programs.

C. Contractor must immediately notify Network Providers when changes to its existing policies and procedures impact Network Providers' provision of Medi-Cal Covered Services to Members and not wait until the next biennial mandatory training.

D. Contractor's training must educate Network Providers on Member access, including compliance with appointment waiting time standards and ensuring telephone, translation, and language access is available for Members during hours of operation. Training must also include education on secure methods for sharing information between Contractor, Network Providers, Subcontractors, Downstream Subcontractors, Members, and other healthcare professionals. This must include training on ensuring Providers have accurate contact information for the Member and all Network Providers involved in the Member's care. Contractor must also

provide training on how to refer and coordinate care for Members who need access to Excluded Services.

E. Contractor must ensure that Network Provider biennial mandatory training includes information on all Member rights specified in Exhibit A, Attachment III, Section 5.1 (*Member Services*), and diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency/humility training) as specified in Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*). This process must also include an educational program for Network Providers regarding health needs to include but not be limited to, the Seniors and Persons with Disabilities (SPD) population, Members with chronic conditions, Members with Specialty Mental Health Service (SMHS) needs, Members with Substance Use Disorder (SUD) needs, Members with intellectual and Developmental Disabilities (DDs), and Children with Special Health Care Needs. Trainings must include Social Drivers of Health (SDOH) and disparity impacts on Members' health care. Attendance records must be reviewed and maintained by Contractor's Health Equity officer.

F. Trainings must be reviewed by the appropriate Contractor committees, including Contractor's board of director's compliance and oversight committee and QIC, routinely, but not less than biennially, to ensure consistency and accuracy with current requirements and Contractor's policies and procedures.

G. In compliance with 42 Code of Regulations (CFR) section 438.236(b), Contractor must ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of Providers in that particular field, consider the needs of Contractor's Members, are adopted in consultation with Network Providers, and are reviewed and updated periodically as appropriate. In addition to Network Provider training, Contractor must disseminate their practice guidelines to all affected Providers.

3.2.6 Emergency Department Protocols

Contractor must develop and maintain protocols for communicating and interacting with emergency departments in and out of its Service Area. Contractor's protocols must be distributed to all emergency departments in the Service Area and must include, at a minimum, the following:

A. All information on telephone or other secure methods of communicating with Contractor's triage and advice systems;

B. Contact information for Contractor's designated contact person responsible for coordinating Emergency Services who is available 24 hours a day for the coordination of Emergency Services and Post-Stabilization Care Services;

C. Written referral procedures (including after-hours instruction) that emergency department personnel can provide to Members who present at the emergency department for non-emergency services;

D. Procedures for emergency departments to report Contractor's system and/or protocol failures and Contractor's processes for correcting deficiencies when failures occur;

E. Procedures for the authorization and payment of Medically Necessary Post-Stabilization Care Services consistent with 42 CFR section 438.114, APL 19-008,and APL 23-009;

F. Procedures for screening and referral of Members who meet Enhanced Care Management (ECM) Population of Focus eligibility criteria, especially the Individuals at risk for avoidable hospital or Emergency Department utilization Population of Focus; and

G. Procedures for screening and referral of Members who meet Medical Necessity eligibility criteria for Community Health Workers services.

3.2.7 Prohibited Punitive Action Against the Provider

Contractor is prohibited from taking punitive action against a Provider who either requests an expedited resolution or supports a Member's Appeal. Further, Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising, or advocating on behalf of, a Member about:

A. The Member's health status, medical care, treatment options, or alternative treatment options (including any alternative treatment that may be self-administered), including obtaining any information the Member needs in order to decide among all relevant treatment options;

B. The risks, benefits, and consequences of treatment or non-treatment; or

C. The Member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

3.2.8 Submittal of Inpatient Days Information

Contractor must report hospital inpatient days to DHCS as required by W&I section 14105.985(b)(2). Upon DHCS' written request, Contractor must also provide these reports for the time period and in the form and manner specified in DHCS' request, within 30 calendar days of receipt of the request. Contractor must submit additional reports to DHCS, as requested, for the administration of the Disproportionate Share Hospital program.

Exhibit A, ATTACHMENT III

3.3 Provider Compensation Arrangements

3.3.1 Compensation and Value Based Arrangements
3.3.2 Capitation Arrangements
3.3.3 Provider Financial Incentive Program Payments
3.3.4 Identification of Responsible Payor
3.3.5 Claims Processing
3.3.6 Prohibited Claims
3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider
3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers
3.3.9 Non-Contracting Family Planning Providers
3.3.10 Sexually Transmitted Disease
3.3.11 Human Immunodeficiency Virus Testing and Counseling
3.3.12 Immunizations
3.3.13 Community Based Adult Services
3.3.14 Organ and Bone Marrow Transplants
3.3.15 Long-Term Care Services
3.3.16 Emergency Services and Post-Stabilization Care Services
3.3.17 Provider-Preventable Conditions
3.3.18 Prohibition Against Payment to Excluded Providers
3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements

3.3 Provider Compensation Arrangements

3.3.1 Compensation and Value Based Arrangements

A. Except as otherwise specified in this Contract, Contractor may compensate Providers as Contractor and Provider negotiate and agree.

B. DHCS encourages Contractor to utilize value-based and alternative payment models to compensate Network Providers, especially for Primary Care Covered Services, in ways that ensure Provider accountability for both quality and total cost of care with a focus on Population Health Management (PHM). Contractor must monitor and must report, within 90 calendar days of DHCS' request, the number or amount, and percent, of Contractor's Members, Network Providers, and medical expenditures that are made under such payment models, separately for hospital services, professional services, and other services at a minimum.

C. Payment to support Networks based on value: To continue to build and strengthen Networks based on value, Contractors must support their Providers through value-based payment models that promote high-quality, affordable, and equitable care.

On an annual basis, as specified by DHCS, Contractor must report on its Network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) framework categories as outlined.

D. Effective Primary Care: Contractor must support effective Primary Care and integrated care through use of alternative payment models, such as population-based payment and shared savings. Specifically, Contractor must:

1) Ensure investment in Primary Care service delivery

a) Contractor must report on total Primary Care spend, as defined by the Integrated Healthcare Association, and the percent of spend within each HCP LAN APM Framework Category. Contractor must report the percentage of spend within each HCP LAN APM Framework Category as a percentage of its total spend.

b) Contract must stratify the reporting of Primary Care spend (and as a percentage of total spend) by age (Children and

youth ages zero to 20; adults ages 21+), by race/ethnicity, and as requested by DHCS.

c) Contractor must work with DHCS and other stakeholders to analyze the relationship between the percent of spend for Primary Care services with performance of the overall delivery system. If the evidence shows that rebalancing to increase Primary Care spend improves quality or drives lower total cost of care, DHCS may set a target or floor for Primary Care spend in future requirements, and Contractor will be required to meet these targets for minimum Primary Care spend.

2) Ensure promotion of Primary Care delivery through alternative payment models:

a) As specified by DHCS, Contractor must report on its Primary Care payment models using the HCP LAN APM Framework Categories.

b) As specified by DHCS, Contractor must report on an annual basis the number and percent of its contracted Primary Care clinicians paid using each HCP LAN APM Framework Category.

c) A description of Contractor's payment model for its five largest medical groups, as defined by the number of Providers, and how its Primary Care clinicians are paid. Contractor must adopt and progressively expand the percent of Primary Care clinicians paid through the HCP LAN APM Framework Categories of population-based payment (Category 4) and alternative payment models built on a fee-for-service structure such as shared savings (Category 3).

3.3.2 Capitation Arrangements

Payments by Contractor to a Network Provider on a capitation basis must be payable effective the date the Member's Enrollment is assigned to the Network Provider. Capitation Payments by Contractor to a Network Provider must be payable no later than 30 calendar days after the Member Assignment.

3.3.3 Provider Financial Incentive Program Payments

A. Contractor may compensate Providers through financial incentive program payments, so long as:

1) Financial incentive program payments to Providers are not designed to induce Providers to reduce or limit Medically Necessary Covered Services provided to a Member;

2) Financial incentive program payments comply with the requirements of All Plan Letter (APL) 19-005, where applicable; and

3) All financial incentive programs related to this Contract are reported in the form, manner, and frequency specified by DHCS.

B. Contractor may implement and maintain a physician incentive plan, as defined in 42 CFR section 422.208, so long as:

1) No specific payment is made directly or indirectly under the physician incentive plan as an inducement to reduce or limit Medically Necessary Covered Services provided to a Member; and

2) The physician incentive plan complies with the requirements of 42 CFR sections 438.3(i) and 438.10(f)(3).

3.3.4 Identification of Responsible Payor

Contractor must provide information to DHCS that identifies the payor(s) responsible for reimbursement of Covered Services provided to a Member. Contractor must identify the Network Provider, Subcontractor, or Downstream Subcontractor responsible for payment, if applicable, and the name and telephone number of the Provider responsible for providing care. Contractor must provide this information upon DHCS' request and in a manner prescribed by DHCS.

3.3.5 Claims Processing

Contractor must pay all Clean Claims submitted by Providers in accordance with this Section, unless the Provider and Contractor have agreed in writing to an alternate payment schedule, subject to the following:

A. Contractor must comply with 42 USC section 1396u-2(f) and Health and Safety Code (H&S) sections 1371 – 1371.36 and their implementing regulations. Contractor must be subject to any penalties and sanctions, including interest at the rate of 15 percent per annum, provided by law if Contractor fails to meet the standards specified in this section.

B. Contractor is expected to pay Clean Claims within 30 days of receipt. For the purpose of establishing compliance thresholds, Contractor must pay at least 90 percent of all Clean Claims from Providers within 30 calendar days of the date of receipt and 99 percent of all Clean Claims within 90 calendar days. For purposes of calculation, the date of receipt is considered the date Contractor receives the claim, as indicated by its date stamp on the claim, and the date of payment is considered be the date of the check or other form of payment.

C. Contractor must provide direct instruction, training, and technical assistance to its providers to support information transmission and the submission of Clean Claims, including bills or invoices submitted by ECM providers; Community Support providers; Doulas, or other community-based providers that are unable to submit claims through an electronic file format. Contractor must make claiming, billing or invoicing guides and notices readily available to its Providers, including through Provider portals and/or Provider manuals. Contractor is are required to train Network Providers to effectively use electronic systems to facilitate timely submission of Clean Claims, equivalent encounters, or bills or invoices.

D. If claims are denied, rejected, or contested in whole or in part, Contractor must specify the reason(s) for contesting or denying a claim and specify the additional information necessary to complete the claim as well as offering technical assistance to remediate deficiencies.

D. Contractor must maintain procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, Members, and the Covered Services for which payment is claimed.

E. Contractor must maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and Contract requirements, to determine the status of received claims and to provide an Incurred and Unreported Claim Estimate as specified by 28 CCR sections 1300.77.1 and 1300.77.2.

3.3.6 Prohibited Claims

A. Contractor must comply with 22 CCR sections 53866, 53220, and 53222 regarding the submission and recovery of claims for services provided under this Contract. Contractor must ensure that its Subcontractors and Downstream Subcontractors also comply with 22 CCR sections 53866, 53220, and 53222.

B. Contractor must hold harmless and indemnify Members for Contractor's debt to Providers for services rendered and billed to Members.

3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider

A. Reimbursement of Non-Contracting Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

If FQHC and RHC services are not available in Contractor's Network in a particular county of Contractor's Service Area, Contractor must reimburse non-contracting FQHCs and RHCs for Covered Services in that county provided to Members at a level and amount of payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a Provider which is not a FQHC or RHC.

B. Required Terms and Conditions for Network Provider Agreements with FQHCs and RHCs

1) Contractor must submit to DHCS, within 30 calendar days of a request and in the form and manner specified by DHCS, documentation of the services provided, the reimbursement level, and amount for each of Contractor's FQHC and RHC Network Provider Agreements.

2) Contractor must certify in writing to DHCS within 30 calendar days of DHCS' written request that, pursuant to W&I sections 14087.325(b) and (d), Contractor's Network Provider Agreement terms and conditions with FQHCs and RHCs are the same 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 services if the services were furnished by a Provider which is not a FQHC or an RHC.

3) Contractor is not required to pay FQHCs and RHCs the Medi-Cal per-visit rate for that clinic.

4) Contractor must fully cooperate with any DHCS review and audit of Contractor's operations and records related to FQHC and RHC reimbursement to ensure compliance with State and federal law.

5) Contractor must submit any FQHC and RHC Network Provider Agreements to DHCS for approval in accordance with W&I section 14087.325.

6) To the extent that an Indian Health Care Provider (IHCP) Facility qualifies as an FQHC or RHC, the above requirements in this Paragraph B must apply to a Network Provider Agreement with an IHCP. Moreover, Contractor must pay any non-contracted IHCP that qualifies as an FQHC or RHC an amount equal to what Contractor would pay a contracted FQHC or RHC, and DHCS must make any additional payment needed to comply with 42 CFR section 438.14(c).

7) Contractor or its Subcontractors and Downstream Subcontractors may enter into financial incentive payment arrangements with FQHC and RHC Network Providers provided such agreements meet all applicable conditions of federal and State law and of APL 19-005 including, but not limited to, the following:

   a) Contractor must establish and maintain clear, objective criteria for the financial incentive payments and the conditions under which payments will be made.

   b) The financial incentive payment arrangement must enumerate specific metrics and/or performance terms for the FQHC or RHC to attain the financial incentive payment.

   c) Contractor must have written agreements in place with the FQHC or RHC prior to the start of the financial incentive payment arrangement, including the methodology used to determine the total incentive payment amount.

   d) The financial incentive payments must be similar to, and not less in amount than, other financial incentive payments Contractor makes to non-FQHC or non-RHC Network Providers who are providing similar services.

   e) Financial incentive payment arrangements must not result in payments that are less than the payments made by Contractor to non-FQHC or non-RHC Network Providers who are providing similar services.

f) Contractor must evaluate the effectiveness of the financial incentive payments and adjust or discontinue them if they are determined ineffective upon evaluation.

g) Contractor must provide to DHCS, upon request, written agreements for, as well as policies and procedures for oversight and monitoring of, such financial incentive payments.

C. Indian Health Care Providers

1) Contractor must attempt to contract with each IHCP in its Service Area as set forth in 22 CCR sections 55120 - 55180. Contractor must reimburse an IHCP that qualifies as a FQHC but is not a Network Provider as set forth in 42 CFR section 438.14(c)(1).

2) For services provided to Members who are qualified to receive services from an IHCP pursuant to the California Medicaid State Plan, Supplement 6, Attachment 4.19-B, regardless of whether the IHCP is a Network Provider:

a) Contractor must reimburse IHCP at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service (IHS) in accordance with APL 17-020 and APL 21-008.

b) Contractor must ensure compliance with any retroactive changes to the outpatient per visit rates published in the Federal Register by the IHS by appropriately reimbursing IHCPs in accordance therewith.

c) Contractor must reimburse IHCPs at the Medi-Cal Fee-For-Service (FFS) Rate for services that, pursuant to the California Medicaid State Plan, Supplement 6, Attachment 4.19-B, are not eligible for the outpatient per-visit rate published in the Federal Register by the IHS.

3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers

In accordance with 22 CCR section 51345 *et seq*. and APL 18-022, if there are no non-contracting Certified Nurse Midwife (CNM), Nurse Practitioner (NP), or Licensed Midwife (LM) Providers in Contractor's Network, Contractor must reimburse non-contracting CNMs, CNPs, or LMs for services provided to

Members at no less than the applicable Medi-Cal FFS Rates. For hospitals, the requirements of Exhibit A, Attachment III, Subsection 3.3.16.A.3 (*Emergency Services and Post-Stabilization Care Services*), if applicable, apply. For Free Standing Birthing Centers, Contractor must reimburse non-contracting Free Standing Birthing Centers at no less than the applicable Medi-Cal FFS Rate. If an appropriately licensed non-contracting Free Standing Birthing Center is used, Contractor also must pay the Center's facility fee.

3.3.9 Non-Contracting Family Planning Providers

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracting family planning Providers at no less than the appropriate Medi-Cal FFS Rate, for services listed in Exhibit A, Attachment III, Subsection 5.2.8 (*Specific Requirements for Access to Programs and Covered Services*), provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

3.3.10 Sexually Transmitted Disease

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracted family planning Providers, including local health departments, at no less than the Medi-Cal FFS Rate for the diagnosis and treatment of a Sexually Transmitted Disease (STD) episode, as defined in Policy Letter (PL) 96-09. Contractor must provide reimbursement only if the STD treatment Provider provides treatment records or documentation of the Member's refusal to release Medical Records to Contractor along with billing information.

3.3.11 Human Immunodeficiency Virus Testing and Counseling

Pursuant to federal law, including but not limited to 42 USC sections 1396a(a)(23) and 1396n(b) and 42 CFR section 431.51, Contractor must reimburse non-contracting family planning Providers, including local health departments, at no less than the Medi-Cal FFS Rate for Human Immunodeficiency Virus (HIV) testing and counseling in accordance with PL 97-08. Contractor must provide reimbursement only if such non-contracting family planning Providers make reasonable efforts to report confidential test results to Contractor in accordance with applicable laws and regulations, including but not limited to H&S section 121025 *et seq*.

3.3.12 Immunizations

Contractor must reimburse local health departments for the administration fee for immunizations given to Members, in accordance with the terms set forth in APL 18-004, who are not already immunized as of the date of the immunization. The local health department must provide immunization records when immunization services are billed to Contractor. Other than local health departments, Contractor is not obligated to reimburse Providers for immunizations under this provision unless the Provider enters into an agreement with Contractor.

3.3.13 Community Based Adult Services

Contractor must reimburse Network Providers for Community Based Adult Services (CBAS) pursuant to a reimbursement structure that must include an all-inclusive per-Member, per-day of attendance rate, or otherwise be reflective of the acuity and/or level of care of the Member population served by Network Providers of CBAS. In accordance with W&I section 14184.201(d)(4), Contractor must reimburse Network Providers of CBAS the amount the Provider could collect if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d), unless Contractor and the Network Provider mutually agree to reimbursement in a different amount. Contractor may include incentive payment adjustments and performance and/or quality standards in its rate structure in paying Network Providers of CBAS.

3.3.14 Organ and Bone Marrow Transplants

In accordance with W&I section 14184.201(d), and for applicable dates of service, Contractor must reimburse a Provider furnishing organ or bone marrow transplant surgeries to a Member the amount the Provider could collect for those same services if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d).

3.3.15 Long-Term Care Services

In accordance with W&I sections 14184.201(b) and (c), and for applicable dates of service, Contractor must reimburse a Network Provider furnishing institutional Long-Term Care (LTC) services to a Member the amount the Provider could collect if the Member accessed those services in the FFS delivery system, as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, including but not limited to guidance issued pursuant to W&I section 14184.102(d). As used in this provision, “institutional LTC services” has the same meaning as set forth in the California

Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions and, subject to W&I section 141814.201(g), includes, at a minimum, all of the following services: Skilled Nursing Facility (SNF) services; subacute facility services; pediatric subacute facility services; and Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) services.

3.3.16 Emergency Services and Post-Stabilization Care Services

A. Emergency Services

1) Subject to 42 CFR section 422.113(b), Contractor is responsible for coverage and payment of Emergency Services and must cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor. Contractor 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 section 438.114(a)(i) – (iii). Further, Contractor must not deny payment for treatment obtained when a representative of Contractor instructs the Member to seek Emergency Services. Emergency Services must not be subject to Prior Authorization by Contractor.

2) Contractor must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to reimburse Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's Primary Care Providers (PCP), Contractor, 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 stabilize the Member.

3) Contractor must reimburse Providers for Emergency Services received by a Member from out-of-Network Providers. Payments to non-contracting Providers must 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 Contractor 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 Contractor. Emergency Services must not be subject to Prior Authorization by Contractor.

4) At a minimum, Contractor must reimburse the non-contracting emergency department and, if applicable, its Affiliated Providers for physician services at the lowest level of the emergency department evaluation and management physician's Current Procedural Terminology (CPT) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

5) For all non-contracted Emergency Services Providers, reimbursement by Contractor or by a Subcontractor or Downstream Subcontractor who is at risk for out-of-Network Emergency Services for properly documented claims for services rendered by out-of-Network Provider pursuant to this provision must be made in accordance with Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) above and 42 USC section 1396u-2(b)(2)(D).

B. Post-Stabilization Care Services

1) Except for the response time periods set forth in 42 CFR section 422.113(c)(2)(ii) and (iii)(A), Post-Stabilization Care Services must be covered by and paid for in accordance with 42 CFR section 422.113(c) and APL 23-009. Applicable response time periods involving Post-Stabilization Care Services is governed by Exhibit A, Attachment III, Subsection 2.3.2(B) (*Timeframes for Medical Authorization*) of this Contract and APL 23-009. Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Network that are authorized by Contractor, Subcontractor, or Downstream Subcontractor.

2) In accordance with 28 CCR section 1300.71.4, Contractor must approve or disapprove a request for Post-Stabilization Care Services made by a Provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization is deemed approved.

3) Contractor is also financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Network that are not authorized by Contractor, Subcontractor, or Downstream Subcontractor, but administered to maintain, improve, or resolve the Member's stabilized condition if Contractor, Subcontractor, or

Downstream Subcontractor does not respond to a request for authorization within 30 minutes; Contractor, Subcontractor, or Downstream Subcontractor cannot be contacted; or Contractor, 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 Contractor, Subcontractor, or Downstream Subcontractor is reached and assumes responsibility for the Member's care or one of the criteria of 42 CFR section 422.113(c)(3) is satisfied.

4) Contractor's financial responsibility for Post-Stabilization Care Services it has not authorized ends when a Network Provider with privileges at the treating hospital assumes responsibility for the Member's care; a Network Provider assumes responsibility for the Member's care through transfer; Contractor's Representative and the treating Provider reach an agreement concerning the Member's care; or the Member is discharged.

5) Consistent with 42 CFR sections 422.214, 422.113(c)(2), and 438.114(e), Contractor is financially responsible for payment of Post-Stabilization Care Services, following an emergency admission, at the hospital's Medi-Cal FFS Rate 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.

   a) For the purposes of this Subsection 3.3.16 (*Emergency Services and Post-Stabilization Care Services*), the FFS payment amounts for dates of service when the Post-Stabilization Care Services were rendered must be the FFS payment method known as diagnosis-related groups, which for the purposes of this Paragraph 5 must apply to all acute care hospitals, including public hospitals that are reimbursed under the certified public expenditure basis methodology (W&I section 14166 *et seq.*), less any associated direct or indirect medical education payments to the extent applicable.

   b) Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this Paragraph 5 must constitute payment in full and must not be subject to subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid law and regulations. A

hospital's tentative and final cost settlement processes required by 22 CCR section 51536 must not have any effect on payments made by Contractor pursuant to this Paragraph 5.

C. Disputed claims involving Emergency Services and/or Post-Stabilization Care Services may be submitted for resolution under provisions of W&I section 14454 and 22 CCR section 53620 *et seq.* (except section 53698) to:

Department of Health Care Services
Office of Administrative Hearings and Appeals
3831 North Freeway Blvd, Suite 200
Sacramento, CA 95834

Contractor agrees to implement DHCS' determination and reimburse the out-of-Network Provider within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim and must provide proof of reimbursement in such form as DHCS directs. Failure to reimburse the out-of-Network Provider within 30 calendar days must result in capitation offsets in accordance with W&I sections 14115.5 and 14454(c) and 22 CCR section 53702 and may subject Contractor to sanctions pursuant to W&I section 14197.7.

3.3.17 Provider-Preventable Conditions

Contractor, Subcontractor, or Downstream Subcontractor, or Network Provider must not pay any Provider claims nor reimburse a Provider for a Provider-Preventable Condition (PPC) in accordance with 42 CFR section 438.3(g). Contractor must report and require any and all of its Network Providers, Subcontractors, and Downstream Subcontractors to report PPCs in the form and frequency required by APL 17-009.

3.3.18 Prohibition Against Payment to Excluded Providers

In accordance with 42 USC section 1396b(i)(2), Contractor must not pay any amount for any services or items, other than Emergency Services, to an Excluded Provider as defined in Exhibit A, Attachment III, Subsection 1.3.4.A, (*Tracking Suspended, Excluded, and Ineligible Providers*) of this Contract. This prohibition applies to non-emergent services furnished by a Provider at the medical direction or prescribed by an Excluded Provider when the Provider knew or had a reason to know of the exclusion or prescribed by an Excluded Provider to whom DHCS has failed to suspend payment while pending an investigation of a credible allegation of Fraud.

3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements

Contractor must reimburse eligible Providers in accordance with the terms of applicable Pass-Through Payments and Directed Payment Incentives as specified in Exhibit B, Subsection 1.1.14 (*Special Contract Provisions Related to Payment*). Contractor must provide Provider-level data to DHCS and Providers eligible for Directed Payment Initiatives in a form and manner specified by DHCS through APLs or other technical guidance.

Exhibit A, ATTACHMENT III

4.0 Member

DHCS is committed to ensuring the Medi-Cal Member's experience is at the center of health care delivery – from the point of Enrollment into a managed care plan throughout their time as a Member.

This Article makes explicit DHCS' commitment to a comprehensive population health managed approach that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination, Complex Care Management, Transitional Care Services, and Enhanced Care Management (ECM). From assessing the needs of Members on a population basis, to identifying and stratifying Members' risk on an individual basis, Contractors are required to have the systems (including data analytic capabilities), processes, and people (including ECM Providers in network with direct experience working with specific Populations of Focus) to support appropriate Population Health Management (PHM) functions.

This Article also makes explicit DHCS' commitment to ensure that Members are appropriately accessing Covered Services, including when they are referred to community-based Providers. For example, Contractor must ensure referrals to services provided by Community Health Workers, peer counselors, and local community organizations providing Community Support services.

This Article includes provisions that directly address Social Drivers of Health (SDOH) – from capturing and tracking SDOH data to providing Community Support services. Community Support services, such as medically tailored meals and short-term post-hospitalization services, are intended to address SDOH and can be provided by Contractors to the extent they are medically appropriate, cost-effective substitutes for Covered Services.

Finally, this Article outlines provisions related to Grievances and Appeals which includes processes by which Contractors must inform Members of their rights and ensure seamless processes by which Members can exercise their rights. DHCS also includes reporting requirements to enable DHCS to effectively monitor, oversee, and enforce Contract provisions when needed.

4.1 Marketing

4.1.1 Training and Certification of Marketing Representatives
4.1.2 Marketing Plan

4.1 Marketing

4.1.1 Training and Certification of Marketing Representatives

Before conducting any Marketing, Contractor must develop a training and certification program for Contractor's Marketing Representatives, and ensure that all staff performing any Marketing activities or distributing Marketing Materials are appropriately certified.

A. Contractor is responsible for all Marketing activities conducted on its behalf. Contractor is liable for all violations committed by any of its Marketing Representatives. Marketing staff must not provide Marketing services for more than one Contractor, and Marketing strategies must align with Contractor's efforts in improving Health Equity. Marketing Representatives must not engage in Marketing practices that illegally discriminate against a Member or Potential Member on the basis of any characteristic protected by federal or State law. Such protected characteristics include, without limitation, sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56. Contractor must ensure all Marketing activities and Marketing Materials are culturally and linguistically competent in compliance with Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*) and Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

B. Training Program

Contractor must develop a training program that will train staff and prepare Marketing Representatives for certification. Prior to implementation, Contractor must obtain written approval from DHCS for Contractor's training and certification program, and any changes in the program. Contractor must develop and provide to Marketing Representatives a staff orientation and Marketing Representative training/certification manual. At a minimum, the manual must explain:

1) The Medi-Cal program, including Medi-Cal Fee-For-Service (FFS), Medi-Cal managed care, Network Providers, Subcontractors, Downstream Subcontractors, and program eligibility;

2) The Medi-Cal scope of services;

3) Contractor's administrative operations and health delivery system program, including the Service Area covered, Excluded Services, additional services, conditions of Member Enrollment, and aid categories;

4) Contractor's Utilization Management (UM) policy, including, but not limited to, how Members are obligated to obtain all non-emergency medical care through Contractor's Network and a description of all prerequisites to medical care and other health care services, such as referrals and Prior Authorizations;

5) Contractor's Grievance and Appeals procedures; the State Hearing process; and, as applicable to Contractor's plan model, the Independent Medical Review (IMR) process;

6) When Members can disenroll from Contractor, including qualifying conditions for both voluntary and mandatory disenrollment;

7) Contractor's obligation to keep confidential any information obtained from Members and Potential Members, including information regarding eligibility under any public welfare or social services program;

8) How Contractor will supervise and monitor its Marketing Representatives and staff to ensure compliance with applicable statutes and regulations;

9) The types of acceptable and prohibited communication methods and sales techniques Marketing Representatives may or may not use;

10) Contractor's anti-discrimination policy and the prohibition against the Enrollment or failure to enroll a Member or Potential Member due to a pre-existing medical condition (except for conditions requiring Excluded Services); and

11) The consequences of Marketing misrepresentation and Abuse, including, but not limited to, discipline, suspension of Marketing activities, termination, and civil and criminal prosecution. The Marketing Representative and Contractor must understand that any Abuse of Marketing requirements can result in termination of this Contract.

4.1.2 Marketing Plan

Before conducting any Marketing, or implementing any Marketing plan, Contractor must develop and obtain DHCS written approval for its Marketing plan or changes to a Marketing plan as specified below. The Marketing plan must be specific to the Medi-Cal program only and Marketing Materials must be distributed within Contractor's entire Service Area. Contractor must ensure that the Marketing plan and all related materials are accurate and do not mislead, confuse, or defraud Members, Potential Members, or the Medi-Cal program.

A. Contractor must submit a Marketing plan to DHCS for review and approval on an annual basis and any time Contractor desires to change its Marketing plan. The Marketing plan, whether new or revised, must describe all of Contractor's current and proposed Marketing, including, but not limited to, all procedures, activities, events, and methods.

B. Contractor's Marketing plan must contain the following:

1) A table of contents section that divides the Marketing plan into chapters, sections, or pages. Each page must be dated and numbered so that chapters, sections, or pages can be easily identified and replaced when revised.

2) A mission statement or statement of purpose for the Marketing plan.

3) An organizational chart including key staff positions and the Marketing director's name, address, telephone, and facsimile number.

4) A narrative description explaining how Contractor's internal Marketing department operates by identifying key staff positions, roles, and responsibilities. The narrative must also report relationships including, if applicable, how Contractor's commercial Marketing staff and functions interface with Contractor's Medi-Cal Marketing staff and functions.

5) Copies of all Member incentives Contractor will distribute during any Marketing event or through any other Marketing activities, in accordance with All Plan Letter (APL) 16-005.

6) An explicit description of all of Contractor's expected Marketing methods and activities.

7) Documentation of all agreements between Contractor and the organizations with which it is undertaking Marketing activities.

8) All Marketing Materials Contractor will use, including those for English-speaking populations, non-English speaking populations, and alternative formats for people with disabilities (including Braille, large-size print font no smaller than 20-point, accessible electronic format, and audio format).

9) A description of the methods Contractor will use to distribute Marketing Materials in compliance with APLs, this Contract, and State and federal law, including, but not limited to, the Telephone Consumer Protection Act of 1991 (47 USC section 227).

10) Copies of a sample Marketing identification badge and business card clearly identifying Marketing Representatives as Contractor's employees. Marketing identification badges and business cards must not resemble those of a government agency.

11) Written formal procedures for monitoring the performance of Contractor's Marketing Representatives to ensure Marketing integrity, pursuant to W&I section 14408(c).

12) All sites for proposed Marketing activities, such as annual health fairs and community events in which Contractor proposes to participate.

13) All other information requested by DHCS to assess Contractor's Marketing program.

C. If Contractor wishes to conduct a Marketing activity not included in the approved Marketing plan, Contractor must submit a written request and obtain prior written approval for that Marketing activity from DHCS. Contractor must submit the written request, a copy of the proposed Marketing Materials, and all other required documentation at least 30 calendar days prior to the Marketing activity, unless DHCS agrees to a shorter review period.

D. At least 30 calendar days before Contractor's participation in any proposed Marketing events, Contractor must notify its designated DHCS Contract Manager in writing and provide required documentation for DHCS review and approval. In cases where Contractor learns of a Marketing event less than 30 calendar days before the event, Contractor must immediately provide written notification and required documentation

to DHCS for review and approval. In no instance may notification be less than two Working Days before the Marketing event.

E. At least 30 calendar days before Contractor's participation in any proposed Marketing events, Contractor must submit a community event Marketing agreement for DHCS review and approval. Along with the community event Marketing agreement, there must be an attestation from the event organization stating that:

1) Contractor will not distribute Marketing Materials or conduct Marketing presentations at a Network Provider, Subcontractor, Downstream Subcontractor, or out-of-Network Provider site, including hospitals and their property; and

2) There are trained Marketing staff at the Marketing event and, if the Marketing event is educational, there are trained health educators at the Marketing event.

F. Contractor must obtain prior DHCS approval before performing in-home Marketing presentations and must provide strict accountability, including documentation from the Potential Member requesting an in-home Marketing presentation or a telephone log entry documenting the Potential Member's request.

G. Contractor must submit any advertisement intended for Marketing purposes to DHCS for prior approval. Such advertisements include, but are not limited to, mass media, magazines, newspapers, radio, telephonic Marketing, TV, billboards, bus sides, and any mobile advertisements.

H. Contractor must not position any mobile advertisements at any Network Provider, Subcontractor, Downstream Subcontractor, or non-contracted Provider sites, including hospitals and their property.

I. When conducting Marketing, Contractor must comply with W&I sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411 and 22 CCR sections 53880 and 53881.

J. Contractor must not engage in door-to-door, telephone, e-mail, texting, or other Cold-Call Marketing for the purpose of enrolling Potential Members, or for any other purpose.

K. Contractor must not distribute Marketing Materials or conduct Marketing presentations at any Network Provider, Subcontractor, Downstream

Subcontractor, or out-of-Network Provider sites, including hospitals and their property.

L. Contractor must not seek to influence Enrollment in conjunction with the sale or offering of any private insurance.

M. Contractor's Marketing Materials must not contain any statements that suggest Enrollment is necessary to obtain or to avoid losing Medi-Cal benefits, or that Contractor is endorsed by DHCS, Centers for Medicare & Medicaid Services, or any other State or federal government entity.

N. All of Contractor's Marketing must be accurate and not mislead, confuse, or defraud Members, Potential Members, or the Medi-Cal program, pursuant to 42 CFR section 438.104.

Exhibit A, ATTACHMENT III

4.2 Enrollments and Disenrollments

4.2.1 Enrollment
4.2.2 Disenrollment

4.2 Enrollments and Disenrollments

4.2.1 Enrollment

Contractor must cooperate with the DHCS Enrollment processes and the DHCS Enrollment contractor in enrolling all Potential Members into Medi-Cal managed care health plans. DHCS and its Enrollment contractor will verify eligibility status and notify the Potential Member of the available Medi-Cal managed care health plans in their County. Contractor must ensure mandatory and voluntary Potential Members residing in its Service Area, are properly enrolled pursuant to the requirements of this provision.

A. Non-Discrimination in Enrollment

Contractor must accept as Members all Potential Members who select or are assigned to Contractor without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, pre-existing medical condition(s), genetic information, health status, marital status, gender, gender identity, sexual orientation, existing or prior involvement in the justice system, or identification with any other persons or groups defined in California Penal Code section 422.56.

B. Enrollment Processing Criteria

1) Contractor must accept as Members all Potential Members who meet the Enrollment criteria in 22 CCR section 53845, as follows:

a) Potential Members with a Mandatory aid Code unless they qualify for an exemption from Enrollment pursuant to 22 CCR section 53887 or meet the criteria in 22 CCR section 53891(c).

b) Potential Members with a Mandatory aid code who are default enrolled because they did not select a Medi-Cal managed care plan during the choice timeframe.

c) Potential Members with a Voluntary aid code who select Contractor as their Medi-Cal managed care plan.

C. Enrollment Process

1) Contractor will receive an effective Enrollment date from DHCS that is no later than 90 calendar days from the date that Medi-Cal

Eligibility Data System (MEDS) lists the individual as meeting the required Enrollment criteria contained in 22 CCR section 53845(a).

2) DHCS or its Enrollment contractor will assign Potential Members meeting the Enrollment criteria contained in 22 CCR section 53845(a) to Medi-Cal managed care health plans in accordance with 22 CCR section 53884, if the Potential Member fails to select a plan after receiving notice that they are required to enroll in Medi-Cal Managed Care.

3) Notwithstanding any other provision in this Contract, Paragraphs 1) and 2) above do not apply to Potential Members without a current valid deliverable address or with an address designated as a county post office box for homeless Members.

D. Enrollment Disputes

1) Contractor must notify DHCS of Enrollment disputes, pursuant to the requirements and procedures contained in Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*).

2) DHCS has 120 calendar days from the date of DHCS' receipt of Contractor's Enrollment dispute notice (the "cure period") to make necessary Enrollment corrections or adjustments, identified in Contractor's dispute notice, without incurring any financial liability to Contractor. For purposes of this Provision, DHCS will be deemed to have corrected or adjusted any issues identified in Contractor's notice if, within the cure period, any of the following occurs:

   a) Mandatory plan Members receive an effective Member Assignment date that is within the cure period; or

   b) DHCS corrects or adjusts an Enrollment issue by redirecting Enrollment from Contractor to another Contractor within the cure period; or

   c) Within the cure period, DHCS changes the distribution of Member Assignment, subject to the requirements of 22 CCR section 53845, to the maximum extent new Members are available to be assigned, to adjust for the number of incorrectly assigned Members.

3) If it is necessary to redirect Enrollment or change the distribution of Member Assignment and such change varies from the

requirements of 22 CCR section 53884(b)(5) or (b)(6), Contractor agrees it will neither seek legal nor equitable relief for such variance or the results of such variance if DHCS resumes assignment consistent with 22 CCR sections 53884(b)(5) or (b)(6) after any necessary Enrollment correction or adjustment.

4) DHCS will not be financially liable to Contractor for any Enrollment dispute, in an affected county (on a county-by-county basis) if Contractor's loss of mandatory plan Members, in a month in which a dispute occurs, is less than 5 percent of Contractor's total Members in that affected county. The parties acknowledge that the above referenced 5 percent threshold will apply on a county-by-county basis, not in the aggregate. DHCS' financial liability must not exceed 15 percent of Contractor's monthly Capitation Payment.

E. Coverage

1) Member coverage begins at 12:01 a.m. on the first day of the calendar month for which the Potential Member's name is included on the list of new Members assigned to Contractor. The term of Enrollment continues indefinitely until this Contract expires, is terminated, or the Member is disenrolled pursuant to the conditions described in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) below.

2) Contractor must authorize and provide coverage for Medically Necessary Covered Services to a Child born to a Member for the month of birth and the following month. No additional Capitation Payment is owed Contractor for the services provided to the newborn Child for month of birth and the month following birth.

F. Temporary Exemption from Mandatory Enrollment

A Member in a mandatory aid code category who currently has a DHCS approved medical exemption request pursuant to 22 CCR section 53887 will not be assigned to Contractor until the medical exemption expires or the medical exemption is subsequently denied by DHCS.

G. Mandatory Assignment Restrictions

Assignment will continue on a monthly basis unless restricted by DHCS. DHCS will impose assignment restrictions and provide written notice to Contractor at least ten calendar days prior to the start of the restriction

period. DHCS will notify Contractor at least ten calendar days before the end of the restriction period.

4.2.2 Disenrollment

DHCS or its agent will process a Member's disenrollment from Contractor under the following conditions, in accordance with the provisions of 22 CCR section 53891:

A. Disenrollment from Contractor is mandatory when:

1) The Member requests disenrollment with a request for Enrollment in the competing Medi-Cal managed care plan pursuant to 22 CCR section 53891(c), subject to any lock in restrictions on disenrollment under the federal lock in option, if applicable, or when the Member enrolls in a Medicare Advantage plan that is affiliated with a competing Medi-Cal managed care plan.

2) The Member is no longer eligible for Enrollment with Contractor because they lost Medi-Cal eligibility, including the death of a Member.

3) Contractor's contract is terminated or Contractor no longer participates in the Medi-Cal Program.

4) Enrollment was in violation of 22 CCR section 53891(a)(2), or requirements of this Contract regarding Marketing.

5) The Member requests disenrollment in accordance with W&I section 14303.1, following a merger with other organizations, or W&I section 14303.2, following a reorganization or merger, with a parent or subsidiary corporation. In these circumstances, Contractor must give Members the option to disenroll for any cause, and request Enrollment in another Medi-Cal managed care plan within 60 calendar days following the date of the reorganization or merger. Contractor must not disenroll the Member to Fee-For-Service(FFS).

6) A Member's change of residence is outside of Contractor's Service Area.

Mandatory disenrollment from Contractor will be effective on the first day of the next month after DHCS receives all documentation it determines are

necessary to process the disenrollment, provided disenrollment was requested at least 30 calendar days prior to that date.

B. Except as provided in above Paragraph A.6) of this Subsection, Enrollment terminates no later than midnight on the last day of the first calendar month after DHCS receives the Member's disenrollment request and all required supporting documentation for Enrollment in a competing plan. On the first day after Enrollment ceases, Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor agrees in turn to return to DHCS any Capitation Payment forwarded to Contractor for Members no longer enrolled with Contractor under this Contract.

C. Contractor must implement and maintain procedures to ensure that all Members requesting disenrollment are provided an explanation of the Member's right to disenroll at any time, with the requirement that the Member enroll in the competing Medi-Cal managed care plan in the county, subject to the requirements in 22 CCR section 53891(c), and any restricted disenrollment period. Additionally, Contractor must immediately refer Members requesting disenrollment from Contractor to the DHCS Enrollment contractor so the Member may be enrolled in another Medi-Cal managed care plan or disenrolled because they require a carved-out service.

Exhibit A, ATTACHMENT III

4.3 Population Health Management and Coordination of Care

4.3.1 Population Health Management Program Requirements
4.3.2 Population Needs Assessment
4.3.3 Data Integration and Exchange
4.3.4 Population Health Management Service
4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering
4.3.6 Screening and Assessments
4.3.7 Care Management Programs
4.3.8 Basic Population Health Management
4.3.9 Other Population Health Requirements for Children
4.3.10 Transitional Care Services
4.3.11 Targeted Case Management Services
4.3.12 Mental Health Services
4.3.13 Alcohol and Substance Use Disorder Treatment Services
4.3.14 California Children's Services
4.3.15 Services for Persons with Developmental Disabilities
4.3.16 School-Based Services
4.3.17 Dental
4.3.18 Direct Observed Therapy for Treatment of Tuberculosis
4.3.19 Women, Infants, and Children Supplemental Nutrition Program
4.3.20 Home and Community-Based Services Programs
4.3.21 In-Home Supportive Services
4.3.22 Indian Health Care Providers
4.3.23 Managed Care Liaisons

4.3 Population Health Management and Coordination of Care

4.3.1 Population Health Management Program Requirements

A. Contractor must develop and maintain a Population Health Management (PHM) program that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination and care management. Contractor must assess each Member's needs across the continuum of care based on Member preferences, data-driven risk stratification, identified gaps in care and standardized assessment processes. Contractor must maintain a PHM program that seeks to improve the health outcomes of all Members consistent with the requirements set forth in this Section and DHCS guidance. Contractor must report on PHM program operations, effectiveness, and outcomes based on DHCS guidance specified in the PHM Policy Guide, as noted in All Plan Letter (APL) 22-024.

B. Contractor must ensure its PHM program meets all National Committee for Quality Assurance (NCQA) PHM standards as well as applicable federal and State requirements as set forth in APL 22-024. Contractor must conduct a Population Needs Assessment (PNA) as described in Subsection 4.3.2 (*Population Needs Assessment*) and submit a Population Health Management Strategy (PHMS) to DHCS for approval that details all components of its PHM program activities in accordance with the requirements of this Section and the DHCS Comprehensive Quality Strategy. Contractor must engage Local Health Departments (LHDs), Local Education Agencies (LEAs), Local Government Agencies (LGAs) and other stakeholders identified in Subsection 4.3.2 (*Population Needs Assessment*) to develop its PNA and PHMS and when developing new initiatives.

4.3.2 Population Needs Assessment

In accordance with 42 CFR sections 438.206(c)(2), 438.330(b)(4), and 438.242(b)(2), 22 CCR sections 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), 53904(a)(3), and 53910.5(a)(2), and applicable DHCS guidance, Contractor must conduct a PNA at least every three years in partnership with the local health jurisdictions and county behavioral health agencies, in addition to other key stakeholders including but not limited to local delivery systems, hospital associations/organizations, Medi-Cal members, Community Advisory Committee, and in alignment with requirements held by NCQA population health standards.Contractor must use the PNA to identify population-level health and social needs, including Health Disparities, and to provide and maintain culturally competent and linguistically appropriate services and translations. Contractor

must implement Health Equity, health education, and Continuous Quality Improvement (QI) programs and services, and determine relevant subpopulations for targeted, person-centered interventions. Contractor must develop the PNA in accordance with the following requirements:

A. Contractor's PNA must evaluate, at a minimum, the following factors for its entire Member population:

1) General characteristics and health needs;

2) Health status, behaviors and utilization trends, including use of Emergency Services;

3) Health education and Cultural and Linguistic (C&L) needs;

4) Health Disparities;

5) Social Drivers of Health (SDOH); and

6) Any gaps in services and resources even if they are not Covered Services under this contract.

B. Contractor's PNA must consider all relevant data for its entire Member population, including, but not limited to:

1) Data from Subcontractors and Downstream Subcontractors; and

2) Needs assessments conducted by other entities and community-based organizations within Contractor's Service Area.

C. Contractor must use reliable data sources, including Subcontractor and Downstream Subcontractor level data, to conduct and update the PNA at least every three years. Reliable data sources must include the most recent results from the Member satisfaction survey and DHCS Health Disparities data.

D. In order to assess Member needs in Contractor's Service Area, Contractor must engage representatives of LHDs, LEAs, LGAs, Safety Net Providers, community based organizations, county Mental Health Plans (MHPs), Drug Medi-Cal and Drug Medi-Cal Organized Delivery System (DMC-ODS) plans, community mental health programs, Primary Care Provider (PCPs), social service Providers, Regional Centers (RC), California Department of Corrections and Rehabilitation, county jails and juvenile facilities, Child welfare agencies as well as stakeholders from special

needs groups, including Seniors and Persons with Disabilities (SPD), Children with Special Health Care Needs (CSHCN), Members with Limited English Proficiency (LEP), and other Member subgroups from diverse cultural and ethnic backgrounds.

E. Contractor must provide a report on the PNA to its Community Advisory Committee (CAC). Contractor must have a process to obtain input, advice, and recommendations on the PNA from its CAC.

F. Based on the PNA, Contractor must annually review and update the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:

1) Targeted health education materials for Members;

2) Member-facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-Specialty Mental Health Services (NSMHS);

3) C&L and QI strategies to address identified population-level health and social needs; and

4) Wellness and prevention programs.

G. Contractor must produce its PNA in writing, make it available to the public, and post it on its website.

4.3.3 Data Integration and Exchange

In accordance with the Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access final rule (CMS-9115-F) and applicable federal and State data exchange requirements, Contractor must integrate its PHM data by expanding its Management Information System (MIS) capabilities outlined in Exhibit A, Attachment III, Section 2.1 (*Management Information System*), as follows:

A. Integrate additional data sources in accordance with all NCQA PHM standards to ensure the ability to assess the needs and characteristics of all Members;

B. Enhance interoperability of its MIS to allow for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks as specified by the DHCS;

C. Enhance interoperability of the PHM Service, in support of population health principles, integrated care, and Care Coordination across delivery systems;

D. Provide DHCS with administrative, clinical, and other data requirements as specified by the DHCS; and

E. Comply with all data sharing agreements, including data exchange policies and procedures, as defined by the California Health and Human Services Data Exchange Framework in accordance with Health & Safety Code (H&S) section 130290.

F. Comply with the CMS Interoperability and Patient Access Final Rule set forth at CMS-9115-F

4.3.4 Population Health Management Service

Contractor must use the PHM Service in accordance with all applicable federal and State laws and regulations, and in a manner specified by DHCS. Contractor must use the PHM Service, at a minimum, to:

A. Perform Risk Stratification and Segmentation (RSS) activities and Risk Tiering functions as described in this Subsection;

B. Identify and assess Member-level risks and needs through use of the PHM Service's Risk Tiering functionality, which places Members into high, medium-rising, or low Risk Tiers, and use the RSS and Risk Tiering functionality to identify and assess Member-level risks and needs as specified in the PHM Policy Guide;

C. Inform and enable Member screening and assessment activities, including pre-populating screening and assessment tools; and

D. Support Member engagement and education activities.

4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering

A. Contractor must use RSS and Risk Tiering to identify and assess Member-level risks and needs and, as needed, connect Members to services in a manner specified in the PHM Policy Guide and detailed below:

1) Consider findings from the PNA and all Members' behavioral, developmental, physical, oral health, and Long-Term Services and

Supports (LTSS) needs, as well as health risks, rising-risks, and health-related social needs due to SDOH;

2) Comply with NCQA PHM standards;

3) Risk stratify and/or segment all Members at least annually and during each of the following timeframes:

   a) Upon each Member's Enrollment;

   b) Annually after each Member's Enrollment;

   c) Upon a Significant Change in the health status or level of care of the Member; and

   d) Upon the occurrence of events or new information that Contractor determines as potentially changing a Member's needs, including but not limited to, referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), and Transitional Care Services.

4) Submit its processes to DHCS upon request regarding how it identifies Significant Changes in Members' health status or level of care and how it is monitoring appropriate re-stratification;

5) Incorporate a minimum list of data sources, as specified in the PHM Policy Guide;

6) Avoid and reduce biases in its RSS approach, such as only using utilization data, by using evidence-based methods to prevent further exacerbation of Health Disparities; and

7) Continuously reassess the effectiveness of the RSS methodologies and tools.

B. Once the PHM Service RSS and Risk Tiering functionality is available for use by Contractor, Contractor must use RSS and PHM Service Risk Tiers to:

1) Connect all Members, including those with rising risk, to an appropriate and available Contractor-identified level of service, including but not limited to, care management programs, Basic Population Health Management (Basic PHM), and Transitional Care Services; and

2) Contractor may supplement the PHM Service outputs with local data sources and methodologies

C. Upon request, Contractor must ensure that its RSS and Risk Tiering approach is submitted to DHCS for review and approval in a form and method prescribed by DHCS.

4.3.6 Screening and Assessments

A. In accordance with 42 CFR section 438.208, Contractor must conduct an initial screening or assessment of each Member's needs within 90 days of Enrollment and share that information with DHCS, and other managed care health plans or Providers serving the Member, to prevent duplication of those activities. Contractor must make at least three attempts to contact a Member to conduct the initial screening or assessment using available modalities.

B. Contractor must conduct necessary screening and assessments to gain timely information on the health and social needs of all Members, in accordance with applicable State and federal laws and regulations, and NCQA PHM standards.

C. Contractor must abide by DHCS guidance for Member screening and assessment, including guidance for how to use the PHM Service for the screening and assessment process.

D. Contractor must monitor what percentage of required assessments are completed per the specifications above.

4.3.7 Care Management Programs

Contractor must maintain a PHM delivery infrastructure to ensure that the needs of its entire Member population are met across the continuum of care. The infrastructure must provide Members with the appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions described in this Subsection are intended for specific segments of the population that require more intensive engagement than the Basic PHM described in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*). Members receiving care management must have an assigned CCM Care Manager and a Care Management Plan (CMP).

Enhanced Care Management

Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and consistently apply comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. This benefit is intended for the highest risk Medi-Cal managed care health plan Members who meet the Populations of Focus criteria. ECM is described in Exhibit A, Attachment III, Section 4.4 (*Enhanced Care Management*).

Complex Care Management

The overall goal of CCM is to help Members regain optimum health or improved functional capability, in the right setting, and in a cost-effective manner. Contractor must consider CCM to be an opt-out program, i.e. all eligible Members have the right to participate or to decline to participate.

Both ECM and CCM are inclusive of Basic PHM, which Contractor must provide to all Members. Care Managers conducting ECM or CCM must integrate all elements of Basic PHM into their ECM or CCM approach.

A. Care Management Programs

Contractor must operate and administer the following care management programs:

1) ECM as described in Exhibit A, Attachment III, Section 4.4 (*Enhanced Care Management*).

2) CCM

a) Contractor must operate and administer CCM in accordance with all NCQA CCM standards and requirements, and coordinate services for high and medium/rising-risk Members through Contractor's CCM approach. To the extent NCQA's standards are updated, Contractor must comply with most recent standards. Contractor must maintain and provide DHCS with policies and procedures that, at a minimum, include the following details regarding its CCM program:

i) Contractor's CCM program must be designed and implemented to help Members gain or regain optimum

health or improved functional capability in the right setting;

ii) Contractor's CCM program must include comprehensive assessment of the Member's condition; determination of available benefits and resources; and development and implementation of a CMP with performance goals, monitoring and follow-up;

iii) Contractor's CCM program must have an opt-out method under which Members meeting criteria for CCM have the right to decline to participate;

iv) Contractor's CCM program must include a variety of interventions for Members that meet the differing needs of high and medium/rising-risk populations, including longer-term chronic Care Coordination and interventions for episodic, temporary needs;

v) Contractor's CCM program must incorporate disease-specific management programs (including, but not limited to, asthma and diabetes) that include self-management support and health education.

vi) Contractor's CCM program must include Early Periodic Screening, Diagnosis and Testing (EPSDT); all Medically Necessary services, including those that are not necessarily covered for adult Members, must be provided as long as they could be Medi-Cal-services.

b) Contractor must assess Members for the need for Community Supports as part of its CCM program and provide Community Supports, if medically appropriate and cost effective.

c) A description of the CCM program must be included, in a manner to be prescribed by DHCS, in Contractor's annual PHMS for DHCS review and approval, outlining all the components of its CCM program, including all those listed in this Subsection.

B. CCM Care Manager Role

1) Assignment of CCM Care Manager

   a) Contractor must identify and assign a CCM Care Manager for every Member receiving CCM. PCPs may be assigned as CCM Care Managers when they are able to meet all the requirements specified in this Subsection.

   b) When a CCM Care Manager other than the Member's PCP is assigned, Contractor must provide to the Member's PCP the identity of the Member's assigned CCM Care Manager, and a copy of the Member's CMP.

   c) When multiple Providers perform separate aspects of Care Coordination for a Member, Contractor must:

      i) Identify a lead CCM Care Manager and communicate the identity of the Care Manager to all treating Providers and the Member; and

      ii) Maintain policies and procedures to ensure compliance and non-duplication of Medically Necessary services and delegation of responsibilities between Contractor and the Member's Providers in meeting all care management requirements.

2) CCM Care Manager Responsibilities

   a) Contractor is responsible for ensuring CCM Care Managers comply with all of the Basic PHM requirements in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*) and all NCQA CCM standards.

   b) Contractor must ensure that the CCM Care Manager performs the following duties:

      i) Conduct Member assessments as needed to identify and close any gaps in care and address the Member's physical, mental health, Substance Use Disorder (SUD), developmental, oral health, dementia, palliative care, chronic disease, and LTSS needs as well as needs due to SDOH;

ii) Complete a CMP for all Members receiving CCM, consistent with the Member's goals in consultation with the Member. The CMP must:

a. Address a Member's health and social needs, including needs due to SDOH;

b. Be reviewed and updated at least annually, upon a change in Member's condition or level of care, or upon request of the Member;

c. Be in an electronic format and a part of the Member's Medical Record, and document all of the Member's services and treating Providers;

d. Be developed using a person-centered planning process that includes identifying, educating, and training the Member's parents, family members, legal guardians, Authorized Representatives (ARs), caregivers, or authorized support persons, as needed; and

e. Include referrals to community-based social services and other resources even if they are not Covered Services under this Contract.

iii) Ensure continuous information sharing and communication with the Member and their treating Providers; and

iv) Specify the responsibility of each Provider that provides services to the Member.

c) Ensure Members receive all Medically Necessary services, including Community Supports, to close any gaps in care and address the Member's mental health, SUD, developmental, physical, oral health, dementia, palliative care needs as well as needs due to SDOH;

d) Support and assist the Member in accessing all needed services and resources, including across the physical and Behavioral Health delivery systems;

e) Communicate to Member'sparents, family members, legal guardians, ARs, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

f) Provide referrals to Community Health Workers, peer counselors, and other community-based social services including, but not limited to, personal care services, LTSS, Community Supports and local community organizations and other programs or services offered by other agencies and third-party entities with which Contractor has or will have a Memorandum of Understanding (MOU);

g) Assess the Member's understanding of the referral instructions and follow-up to determine whether the referral instructions were completed or whether the Member needs further assistance to access the services, and if so, provide such assistance;

h) Review and/or modification of Member's CMP, when applicable, to address unmet service needs;

i) Facilitate and encourage the Member's adherence to recommended interventions and treatment; and

j) Ensure timely authorization of services to meet the Member's needs in accordance with the Member's CMP.

4.3.8 Basic Population Health Management

A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that meet the following Basic PHM requirements, at a minimum:

1) Ensure that each Member has an ongoing source of care that is appropriate, ongoing and timely to meet the Member's needs;

2) Ensure Members have access to needed services including Care Coordination, navigation and referrals to services that address Members' developmental, physical, mental health, SUD, dementia, LTSS, palliative care, and oral health needs;

3) Ensure that each Member is engaged with their assigned PCP and that the Member's assigned PCP plays a key role in the Care

Coordination functions described in this Subsection, in partnership with Contractor;

4) Ensure each Member receives all needed preventive services in partnership with the Member's assigned PCP;

5) Ensure efficient Care Coordination and continuity of care for Members who may need or are receiving services and/or programs from out-of-Network Providers;

6) Ensure Members are provided with resources and education about how to access the various programs and services offered by agencies and third-party entities with whom Contractor has or will have an executed MOU;

7) Review Member utilization reports to identify Members not using Primary Care; stratify such reports, at minimum, by race and ethnicity to identify Health Disparities that result from differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization;

8) Facilitate access to care for Members by, at a minimum, helping to make appointments, arranging transportation, ensuring Member health education on the importance of Primary Care for Members who have not had any contact with their assigned Medical Home/PCP or have not been seen within the last 12 months, particularly Members less than 21 years of age;

9) Ensure all services are delivered in a culturally and linguistically competent manner that promotes Health Equity for all Members;

10) Coordinate health and social services between settings of care, across other Medi-Cal managed care health plans, delivery systems, and programs (e.g., Targeted Case Management (TCM), Specialty Mental Health Services(SMHS)), with external entities outside of Contractor's Network, and with Community Supports and other community-based resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH;

11) Coordinate referrals to ensure Care Coordination with public benefits programs, including without limitation, as required by this Contract under the requirements set forth for MOUs in Exhibit A,

Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*);

12) Assist Members, Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons with navigating health delivery systems, including Contractor's Subcontractor and Downstream Subcontractor Networks, to access Covered Services as well as services not covered under this Contract;

13) Provide Members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;

14) Communicate to Members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

15) Ensure that Providers furnishing services to Members maintain and share, as appropriate, Members' Medical Records in accordance with professional standards and State and federal law;

16) Facilitate exchange of necessary Member Information in accordance with any and all State and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable; and

17) Maintain processes to ensure no duplication of services occurs.

B. Wellness and Prevention Programs

1) Contractor must provide wellness and prevention programs that meet NCQA PHM standards, including for the provision of evidence-based self-management tools;

2) Contractor must ensure that the wellness and prevention programs align with the DHCS Comprehensive Quality Strategy;

3) Contractor must provide wellness and prevention programs in a manner specified by DHCS, and in collaboration with LGAs as appropriate, that include the following, at a minimum:

a) Identification of specific, proactive wellness initiatives and programs that address Member needs as identified in the PNA;

b) Evidence-based disease management programs including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education interventions, target Members for engagement, and seek to close care gaps for Members participating in these programs;

c) Initiatives, programs, and evidence-based approaches to improving access to preventative health visits, developmental screenings and services for Members less than 21 years of age, as described in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*);

d) Initiatives, programs, and evidence-based approaches on improving pregnancy outcomes for women, including through 12 months post-partum;

e) Initiatives, programs, and evidence-based approaches on ensuring adults have access to Preventive Care, as described in Exhibit A, Attachment III, Subsection 5.3.5 (*Services for Adults*) and in compliance with all applicable State and federal laws;

f) A process for monitoring the provision of wellness and preventive services by PCPs as part of Contractor's Site Review process, as described in Exhibit A, Attachment III, Subsection 5.2.14 (*Site Review*);

g) Health education materials, in a manner that meets Members' health education and C&L needs, in accordance with Exhibit A, Attachment III, Subsection 5.3.7 (*Services for All Members*); and

h) Initiatives and programs that implement evidence-based best practices that are aimed at helping Members set and achieve wellness goals.

4) Contractor must ensure that its wellness and prevention programs are submitted to DHCS for review and approval in a form and method prescribed by DHCS.

5) Contract must report annually through the PHMS on how community-specific information and stakeholder input from the PNA is used to design and implement evidence-based wellness and prevention strategies.

4.3.9 Other Population Health Requirements for Children

For Members less than 21 years of age, Contractor must provide as part of care management and Basic PHM the following services for Children:

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Case Management Responsibilities

Contractor must provide case management to assist Members less than 21 years of age in gaining access to all Medical Necessary medical, Behavioral Health, dental, social, educational, and other services, as defined in 42 USC sections 1396d(a), 1396d(r), and 1396n(g)(2), and W&I section 14059.5(b). Case management services for Members less than 21 years of age also include the data exchange necessary for the provision of services as well as the coordination of non-covered services such as social support services. Additionally, Contractor must provide EPSDT case management services as Medically Necessary services for Members less than 21 years of age, as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*), and must ensure that all Medically Necessary services for Members less than 21 years of age are initiated within timely access standards whether or not the services are Covered Services under this Contract.

B. Children with Special Health Care Needs

Contractor must develop and implement policies and procedures to provide services for CSHCN. Contractor must ensure that the policies and procedures include the following information, at a minimum, to encourage CSHCN Member participation:

1) Methods for ensuring and monitoring timely access to pediatric Specialists, sub-Specialists, ancillary therapists, transportation, and Durable Medical Equipment (DME) and supplies. These may include assignment to a Specialist as PCP, Standing Referrals, or other methods.

2) Methods for monitoring and improving the quality, Health Equity and appropriateness of care for CSHCN.

3) Methods for ensuring Care Coordination with Department of Developmental Services (DDS), local health departments and local California Children's Services (CCS) Programs, as appropriate and as required under any applicable MOUs between Contractor and local health departments and DDS for the CCS Program.

C. Early Intervention Services

Contractor must develop and implement systems to identify Members who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These Members include those with a condition known to lead to developmental delay, those in whom a developmental delay is suspected, or whose early health history places them at risk for delay. Contractor must collaborate with the local RC or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members. Contractor must provide case management and Care Coordination to the Member to ensure the provision of all Medically Necessary Covered Services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

4.3.10 Transitional Care Services

Contractor must provide Transitional Care Services (TCS) to all Members transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and State laws and regulations, and DHCS guidance. Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports, post-acute care facilities, or Long-Term Care (LTC) settings.

If the Member is receiving CCM or ECM, Contractor must ensure that the Member's assigned Care Manager provides all Transitional Care Services. If the Member is not receiving CCM or ECM, Contractor's Basic PHM staff are required to provide all Transitional Care Services, including making referrals and ensuring no gaps in care.

Additional guidance is forthcoming on the specific TCS requirements for different

populations.

A. Transitional Care

Contractor must implement transitional care processes that meet the following requirements, at minimum:

1) Implement a standardized discharge risk assessment that is to be completed prior to discharge to be approved by DHCS, to assess a Member's risk of re-institutionalization, re-hospitalization, and risk of mental health and/or SUD relapse;

2) Obtain permission from Members, Members' parents, legal guardians, or ARs, as appropriate to share information with Providers to facilitate transitions, in accordance with federal and State privacy laws and regulations;

3) Ensure that medication reconciliation is conducted pre- and post-transition;

4) Ensure referrals to Community Supports and coordination with county social service agencies and waiver agencies for In-Home Supportive Services (IHSS) and other Home and Community-Based Services (HCBS);

5) Ensure all Prior Authorizations required for the Member's discharge are processed within timeframes consistent with the urgency of the Member's condition, not to exceed five Working Days for routine authorizations, or 72 hours for expedited authorizations, in accordance with Exhibit A, Attachment III, Subsection 2.3.2 (*Timeframes for Medical Authorization*). This includes Prior Authorizations for therapy, home care, medical supplies, prescription medications for which Contractor is responsible, and DME that are processed in accordance with 42 CFR section 438.210, H&S section 1367.01, and Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) of this Contract;

6) Ensure all Network Provider hospitals, institutions, and facilities educate their Discharge Planning staff on the services, supplies, medications, and DME needing Prior Authorization;

7) Ensure that mutually agreed-upon policies and procedures for Discharge Planning and Transitional Care Services exist between Contractor and each of its Network Provider and out-of-Network

Provider hospitals within its Service Area;

8) Prevent delayed discharges of a Member from a hospital, institution, or facility due to circumstances such as, but not limited to, Contractor authorization procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur;

9) Ensure each Member is evaluated for all care settings appropriate to the Member's condition, needs, preferences and circumstances. Members must not be discharged to a setting that does not meet their medical and/or LTSS needs; and

10) Ensure Members with SUD and mental health needs receive treatment for those conditions upon discharge.

B. Discharge Planning and Care Coordination

Contractor must provide a Discharge Planning document to Members, Member's parents, legal guardians, or ARs, as appropriate, when being discharged from a hospital, institution or facility. Contractor's Discharge Planning document must include the following information, at a minimum:

1) Pre-admission status, including living arrangements, physical and mental function, SUD needs, social support, DME uses, and other services received prior to admission;

2) Pre-discharge factors, including the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge;

3) The hospital, institution or facility to which the Member was admitted;

4) Specific agency or home recommended by the hospital, institution or facility after the Member's discharge based upon Member needs and preferences; specific services needed after the Member's discharge; specific description of the type of placement preferred by the Member, specific description of type of placement agreed to by the Member, specific description of agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling;

5) Summary of the nature and outcome of participation of Member,

Member's parents, legal guardians, or ARs in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital, institution or facility to be included in the Member's Medical Record; and

6) Information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.

C. Nursing Facility Transitions

When transitioning Members to and from SNFs, Contractor must comply with APL 23-004. Contractor must ensure timely Member transitions that do not delay or interrupt any Medically Necessary services or care by meeting the following requirements, at a minimum:

1) Coordinate with facility discharge planners, care or Case Managers, or social workers to provide case management and Transitional Care Services during all transitions;

2) Assist Members being discharged or Members' parents, legal guardians, or ARs by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other HCBS programs;

3) Maintain contractual requirements for SNFs to share Minimum Data Set (MDS) Section Q, have appropriate systems to import and store MDS Section Q data and incorporate MDS Section Q data into transition assessments;

4) Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge;

5) Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

6) Follow-up with Members, Members' parents, legal guardians, or ARs, as appropriate, regarding the new care setting to ensure compliance with Transitional Care Services requirements.

4.3.11 Targeted Case Management Services

A. Contractor must identify the target populations for TCM programs within their Service Area, and maintain procedures to refer Members to TCM services. If upon notification from DHCS that Members are receiving TCM services Contractor is not already aware of, Contractor must reach out to LGAs to coordinate care, as appropriate.

B. Contractor must coordinate with LGAs to provide Care Coordination for all Medically Necessary Covered Services identified by TCM Providers in their Member care plans, including referrals and Prior Authorization for out-of-Network medical services. Coordination with LGAs must continue for Members receiving TCM services until the LGA notifies Contractor that TCM services are no longer needed for the Member.

C. Because TCM can be a direct duplication of services such as, but not limited to, Basic PHM, CCM, ECM, and Community Supports, Contractor must have processes to ensure Members receiving TCM are not receiving duplicative services.

D. Contractor must designate a representative responsible for coordinating TCM services with LGAs for the Member. Contractor representative's responsibilities include, but are not limited to, sharing the appropriate Member Provider(s) information and PCP and/or Care Manager assignment with LGAs and resolving all related operational issues.

E. Contractor must also notify Members' PCPs and/or Care Managers when Members are receiving TCM services and provide them with the appropriate LGA contact information.

F. For Members less than 21 years of age, Contractor must ensure that all Medically Necessary services are provided timely as required in Exhibit A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age)*. Notwithstanding medical services recommended in TCM care plans or arranged by LGAs or TCM Providers for Members less than 21 years of age, Contractor remains responsible for the provision of the EPSDT benefit, as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*).

4.3.12 Mental Health Services

Contractor must use DHCS-approved standardized screening tools as identified in APL 22-028 to ensure Members seeking mental health services who are not currently receiving NSMHS or SMHS receive referrals to the appropriate delivery

system for mental health services, either in Contractor's Network or the MHP network, in accordance with the No Wrong Door policies set forth in W&I section 14184.402(f) and specified in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*).

A. Non-Specialty Mental Health Services

Contractor must provide timely NSMHS for Members consistent with the No Wrong Door policies even when:

1) NSMHS were provided:

a) During the assessment process;

b) Prior to determination of a diagnosis; or

c) Prior to determination of whether NSMHS criteria set forth in W&I section 14184.402(b)(2) are met;

2) NSMHS were not included in a Member's individual treatment plan;

3) Member has a co-occurring mental health condition and SUD; or

4) NSMHS are provided to a Member concurrently with SMHS, if those services are not duplicative and coordinated between Contractor and the MHP.

B. Specialty Mental Health Services

1) Contractor must maintain policies and procedures to refer Members who meet the criteria for SMHS to the MHP in accordance with the No Wrong Door policies.

2) Contractor must also enter into a MOU with the MHP in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) to ensure services for its Members are properly coordinated and provided in a timely and non-duplicative manner.

3) If a Member receiving NSMHS is determined to meet the criteria for SMHS due to a change in the Member's condition, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2 (*Non-Specialty Mental Health Services and Substance Use Disorder Services*), and continue to provide NSMHS to the Member concurrently

receiving SMHS when those services are not duplicative and coordinated between Contractor and the MHP.

C. Mental Health Services Disputes

1) Disputes between Contractor and MHP must not delay the provision of Medically Necessary services by Contractor or MHP.

2) If Contractor and MHP cannot agree on the appropriate place of care, disputes must be resolved pursuant to APL 21-013, and as specified in Exhibit A, Attachment III, Subsection 5.5.5 (*Mental Health and Substance Use Disorder Services Disputes*). Specifically, as set forth in APL 21-013, Contractor and MHPs must complete the plan level dispute resolution process within 15 Working Days of identifying the dispute.

3) Contractor and MHP may seek to enter into an expedited dispute resolution process if a Member has not received a disputed service(s) and Contractor and/or MHP determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, Contractor and MHP will have one Working Day after identification of a dispute to attempt to resolve the dispute at the plan level. All terms and requirements established in APL 21-013 apply to disputes between Contractor and MHP.

4.3.13 Alcohol and Substance Use Disorder Treatment Services

A. Contractor must identify and refer Members requiring alcohol and/or SUD treatment services to the County Department responsible for alcohol and SUD treatment, other community resources when services are not available through the County Department, or to outpatient heroin and other opioid detoxification Providers available through the Medi-Cal Fee-For-Service (FFS), as appropriate. Contractor must assist Members in locating available treatment service sites. To the extent that alcohol and/or SUD treatment services are not available within Contractor's Service Area, Contractor must coordinate with the County Department responsible for SUD treatment to refer Members to available treatment outside of Contractor's Service Area.

B. Contractor must have MOUs with each County Department responsible for alcohol and SUD treatment services within Contractor's Service Area in accordance with the MOU requirements in Exhibit A, Attachment III,

Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*). The MOU must delineate the roles and responsibilities between Contractor and County Departments for coordinating care, and ensuring non-duplication of services and timeliness of care for the Members.

C. For Members receiving alcohol and SUD treatment services through County Departments, Contractor must continue to provide all Medically Necessary Covered Services and coordination and referral of services between its Network Providers and other treatment programs for the Member.

D. Prescribing and medication management of buprenorphine and other prescribed medications for SUD treatment (also known as medication-assisted treatment or MAT) are the responsibility of Contractor when they are provided in Primary Care offices, departments, hospitals, or other contracted medical facilities.

E. Contractor must enter into a data sharing agreement with the County Department responsible for alcohol and SUD treatment, other community resources when services are not available through the County Department, or to outpatient opioid disorder treatment. Contractor's data sharing agreement with such County Departments must also require such County Departments, and all Part 2 programs contracting with such County Departments that provide services to Members, to use authorization forms for the disclosure of information that provide the following:

1) Comply with 42 CFR part 2;

2) Name both Contractor and DHCS as potential recipients of the data being disclosed;

3) Indicate that Contractor and DHCS are permitted to use such data for payment and health care operations purposes, as defined by Health Insurance Portability and Accountability Act of 1996 (HIPAA); and

4) If 42 CFR Part 2 is modified to permit such a practice, include a statement indicating that any information disclosed to a covered entity or business associate may be redisclosed to the extent permitted by the HIPAA privacy rule, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against the patient.

4.3.14 California Children's Services

A. Notwithstanding any other provisions in W&I section 14094.4 *et seq*. for Contractors operating in County Organized Health Systems (COHS) counties, Contractor must maintain policies and procedures to identify and refer Members with CCS-Eligible Conditions to the local CCS Program for determination of CCS eligibility. These policies and procedures must include the following, at a minimum:

1) The requirement that Network Providers complete the appropriate baseline health assessments and diagnostic evaluations, which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-Eligible Condition;

2) The requirement that Contractor supports CCS program referral pathways in the non-Whole Child Model counties including but not limited to identifying children who may be eligible for the CCS program through internal reports, Provider directed referrals, or direct referrals from Contractor.

3) Instruct Network Providers that CCS reimburses only CCS-paneled Providers and CCS-approved hospitals within Contractor's Network, and that reimbursement is only from the date of referral;

4) The requirement that Network Providers complete the initial referrals of Members with suspected CCS-Eligible Conditions same day using modalities accepted by the local CCS Program. The initial referral must be followed by submission of supporting medical documentation sufficient to allow for CCS eligibility determination by the local CCS Program;

5) Instruct Network Providers of their requirement to continue to provide all Covered Services to the Member until CCS Program eligibility is confirmed;

6) The requirement that once eligibility for the CCS Program is established for a Member, Contractor must continue to provide all Covered Services that are not authorized by CCS Program and must ensure the coordination of services and joint case management between the Member's PCP, CCS Providers, and the local CCS Program. Contractor must continue to provide case management services to ensure all Covered Services authorized through the CCS Program are provided timely as required in Exhibit

A, Attachment III, Subsection 5.3.4 (*Services for Members Less Than 21 Years of Age*). Without limitation, Contractor must, as necessary, including upon a Member's request, arrange for all in-home nursing hours authorized by the CCS Program that a Member desires to utilize, as required by APL 20-012; and

7) The requirement that Contractor ensure all Medically Necessary Covered Services are provided to the Member if the local CCS Program does not approve CCS Program eligibility. If the local CCS Program denies authorization for any service, Contractor remains responsible for providing and reimbursing for the cost of the service if it is determined to be Medically Necessary.

B. Authorization for payment must be retroactive to the date the CCS Program was informed about the Member through an initial referral by Contractor or a Network Provider. In an emergency admission, Contractor or a Network Provider must be allowed until the next Working Day to inform the CCS Program about the Member.

C. Contractor must maintain policies and procedures for identifying CCS-Eligible Members that are aging out of the CCS Program. Within 12 months of a CCS Member aging out of the program, Contractor must develop a Care Coordination plan to assist the Member in transitioning out of the CCS Program. The policies and procedures must include, the following, at a minimum:

1) Identifying the Member’s CCS-Eligible Condition;

2) Planning for the needs of the Member to transition from the CCS Program;

3) A communication plan with the Member in advance of the transition,

4) Identification and coordination of Primary Care and specialty care Providers appropriate to the Member’s CCS-Eligible Condition(s); and

5) Continued assessment of the Member through first 12 months of the transition.

D. Contractor must have MOUs with each CCS Program within its Service Area that are in accordance with the MOU requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies,*

County Programs, and Third Parties). The MOU must delineate the roles and responsibilities of Contractor and the CCS Program for coordinating care and ensuring the non-duplication of services.

4.3.15 Services for Persons with Developmental Disabilities

A. Contractor must maintain policies and procedures for identifying and tracking Members with Developmental Disabilities (DD), including all services they receive.

B. Contractor must designate its own liaison to coordinate with each RC operating within Contractor's Service Area to assist Members with DD in understanding and accessing services, and to act as a central point of contact for questions, access and care concerns, and problem resolution, as required by W&I section 14182(c)(10).

C. Contractor must refer Members with DD to a RC for evaluation and for access to non-medical services provided by the RC, including, but not limited to, respite, out-of-home placement, and supportive living. Contractor must have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to coordinate services for the Member with RC staff to ensure the non-duplication services and to create the individual developmental services plan required for all Members with DD, which includes identification of the Member's medical needs and the provision of Medically Necessary services such as medical care, NSMHS, and Behavioral Health Treatment.

D. Contractor must maintain policies and procedures to identify and refer eligible Members to the HCBS program administered by the Department of Developmental Services (DDS).

E. Contractor must refer to Exhibit A, Attachment III, Subsection 4.3.20 (*Home and Community-Based Services Programs*) for further coordination of care requirements related to providing HCBS programs through the HCBS-DD Waiver.

4.3.16 School-Based Services

A. Contractor must have an MOU in place with all LEAs in its Service Area in accordance with Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*) to ensure there are processes that account for facilitating cooperation and collaboration between the Member's PCP and the LEA in the development of the Member's Individualized Education Plan (IEP) or

the IFSP. Contractor must provide case management and Care Coordination to the Member, or the parent, legal guardian, or AR, to ensure the provision of all Medically Necessary Covered Services identified in the IEP developed by the LEA, with PCP participation.

B. Contractor must cover Medically Necessary mental health and SUD services as specified by DHCS when delivered by school-linked behavioral health providers to a Member who is 25 years of age or younger. Contractor must cover these services in accordance with DHCS guidance related to the Children and Youth Behavioral Initiative (CYBHI) and at the DHCS established fee schedule Contractor must execute agreements in accordance with DHCS guidance and in accordance with H&S section 1374.722 and W&I section 5963.4(c).

C. By 2025, Contractor is required to provide Covered Services, including preventive services and adolescent health services provided in schools or by school-affiliated health providers.

D. Contractor must implement interventions that increase access to preventive, early intervention, and Behavioral Health Services by school-affiliated Behavioral Health Providers for Children in publicly funded childcare and preschool, and TK-12 Children in public schools, in accordance with the interventions, goals, and metrics set forth in W&I section 5961.3(b).

4.3.17 Dental

A. Contractor must cover and ensure that dental screenings and oral health assessments are included for all Members. Contractor must ensure that all Members are given referrals to appropriate Medi-Cal dental Providers. Contractor must provide Medically Necessary Federally Required Adult Dental Services (FRADS), fluoride varnish, and dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental Providers are not covered under this Contract.

B. For Members less than 21 years of age, Contractor must ensure that a dental screening and an oral health assessment are performed as part of every periodic assessment, with annual dental referrals beginning with the eruption of the Member’s first tooth or at 12 months of age, whichever occurs first.

C. Contractor must ensure the provision of Medically Necessary dental-related Covered Services that are not exclusively provided by dentists or

dental anesthetists. Contractor must also have an identified Contractor liaison available to Medi-Cal dental Providers to assist with referring the Member to other Covered Services. Other Covered Services include, but are not limited to, laboratory services, and pre-admission physical examinations required for admission to an outpatient surgical service center, or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for Medically Necessary Covered Services needed in support of dental procedures.

If Contractor requires Prior Authorization in support of dental procedures, Contractor must develop and publish the policies and procedures for obtaining Prior Authorization for dental services to ensure that services are provided to the Member in a timely manner. Contractor must coordinate with DHCS Medi-Cal Dental Services Division in the development of their policies and procedures pertaining to Prior Authorization for dental services and must submit such policies and procedures to DHCS for review and approval.

4.3.18 Direct Observed Therapy for Treatment of Tuberculosis

Contractor must assess the risk of treatment resistance or noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy.

A. The following groups are at risk for treatment resistance or noncompliance for the treatment of Tuberculosis (TB):

1) Members with demonstrated resistance to Isoniazid and Rifampin;

2) Members whose treatment has failed or who have relapsed after completing a prior regimen;

3) Substance users;

4) Members with mental health conditions or SUD;

5) Elderly, Children and adolescent Members;

6) Members with unmet housing needs;

7) Members with language and/or cultural barriers; and

8) Members who have demonstrated noncompliance by failing to keep office appointments.

B. Contractor must refer Members with active TB and Members who have treatment resistance or non-compliance issue risks to the TB control officer of the LHD for Direct Observed Therapy (DOT). If a Provider finds that a Member is at risk for treatment resistance or noncompliance with treatment, Contractor must refer the Member to the LHD for DOT.

C. Contractor must have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure joint case management and Care Coordination with the LHD TB Control Officer. Contractor must provide all Medically Necessary Covered Services to Members with TB on DOT.

4.3.19 Women, Infants, and Children Supplemental Nutrition Program

A. Women, Infants, and Children Supplemental Nutrition Program (WIC) services are not covered under this Contract. However, Contractor must maintain procedures to identify and refer eligible Members for WIC services. Contractor must also have an MOU in place as required in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure referrals. As part of the referral process, Contractor must provide the WIC program with the Member's current hemoglobin or hematocrit laboratory value. Contractor must also document the laboratory values and the referral in the Member's Medical Record.

B. Contractor must refer, and document the referral of, Members who are pregnant, breastfeeding, or postpartum, or a legal guardian or AR for a Member under the age of five, to the WIC program either as part of the initial evaluation of newly pregnant women pursuant to 42 CFR section 431.635(c) and Policy Letter (PL) 98-010.

4.3.20 Home and Community-Based Services Programs

A. DHCS administers, either directly or through another State entity, a number of Medi-Cal Home and Community-Based Services (HCBS) programs authorized under the Medi-Cal program. HCBS programs provide long-term community-based services and supports to eligible Members in the community setting of their choice instead of in an institution.

B. Contractor must continue to provide all Covered Services to a Member when that Member is enrolled in, or applying to enroll in, receiving, or applying to receive an HCBS program other than this Contract. Contractor must continuously collaborate and exchange Member health care and medical information with all third-party entities providing the Member with Medi-Cal HCBS or administering a Medi-Cal-funded HCBS program pursuant to the third-party entity's contractual or legal authority to administer Medi-Cal-funded HCBS programs and/or provide HCBS to the Member. Such third-party entities include, but are not limited to:

1) DHCS;

2) State departments that operate or administer Medi-Cal programs offering HCBS pursuant to legal authority and/or Inter-Agency Agreements with DHCS, including but not limited to, the California Department of Social Services; the California Department of Developmental Services, the California Department of Public Health, and the California Department of Aging;

3) Home and Community Based Alternatives Waiver agencies;

4) Assisted Living Waiver Care Coordination agencies;

5) RCs;

6) Multipurpose Senior Service Program (MSSP) sites;

7) Medi-Cal Waiver Program agencies; and

8) California Community Transitions lead organizations.

C. Contractor must maintain procedures to identify Members who may benefit from Medi-Cal HCBS programs and refer Members to the third-party entity administrating the HCBS program. The HCBS programs include, but are not limited to HCBS programs authorized under the Social Security Act (SSA) at 42 USC section 1396n(c), the California Medicaid State Plan option authorized under 42 USC section 1396n(k), California Medicaid State Plan HCBS benefits authorized under 42 USC section 1396n(k), and other State and federally-funded Medi-Cal HCBS programs. If the Member is then authorized to receive Medi-Cal-funded HCBS program services, the Member must remain enrolled with Contractor and Contractor must continue to provide all services and benefits covered under this Contract to the Member.

D. Contractor's collaboration with third-party entities providing the Member with HCBS program services or administering a HCBS program pursuant to the third-party entity's contractual or legal authority to administer HCBS programs and/or provide HCBS program services to the Member, must include, but is not limited to:

1) Maintaining staff assigned to coordinate with such third-party entities that is sufficient to assist Members in understanding and accessing HCBS program services, and to act as a central point of contact for questions, access, and Care Coordination concerns.

2) Working in collaboration with such third-party entities' care managers and Providers to coordinate Covered Services, all HCBS program services, and any other relevant medical or supportive services. Such coordination must include, but is not limited to, the timely exchange of information regarding the Member and their health care needs, services, and efforts to obtain and arrange for the provision of both Medi-Cal and non-Medi-Cal programs pursuant to DHCS guidance to Contractor and HCBS Providers.

3) As contracted delegates of the State, Contractor and such third-party entities administering HCBS programs and/or providing HCBS program services are authorized to share Member information with one another, including Protected Health Information (PHI)/Personal Identifiable Information (PII) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Exhibit G of this Contract, because both are under a contract with DHCS, are legally authorized to receive such information, and/or are responsible for administration of the Medi-Cal program, complying with the provisions within their respective Business Associate Agreements with the State, and sharing this information with each other as part of their contractual responsibilities pursuant to and in compliance with 45 CFR sections 164.502(a)(1)(ii), 164.502(a)(3), and 164.506(c).

4.3.21 In-Home Supportive Services

Contractor must maintain policies and procedures for identifying and referring eligible Members to the county IHSS program. Contractor's procedures must address the following requirements, at a minimum:

A. Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services;

B. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies Contractor that IHSS is no longer needed for the Member;

C. Designate a person to serve as the day-to-day IHSS liaison with county IHSS agency.

1) Contractor, in collaboration with county IHSS agency, must ensure Contractor's IHSS liaison is sufficiently trained on IHSS assessment and referral processes and providers, and how Contractor and PCPs can support IHSS eligibility applications and coordinate care across IHSS, medical services, and long-term services and supports. This includes training on IHSS referrals for Members in inpatient and SNF settings as a part of Transitional Care Service requirements, to support safe and stable transitions to home and community-based settings.

2) The IHSS liaison functions may be assigned to the LTSS liaison as long as they meet the training requirements and have the expertise to work with the county IHSS liaison.

D. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;

E. Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per the population RSS and Risk Tiering requirements in this Section; and

F. Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.

4.3.22 Indian Health Care Providers

Contractor must have an identified tribal liaison dedicated to working with each Indian Health Care Provider (IHCP) in its Service Area and responsible for coordinating referrals and payment for services provided to Indian Members who are qualified to receive services from an IHCP, in accordance with the requirements in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider*).

4.3.23 Managed Care Liaisons

Contractor must designate an individual or set of individuals to serve as the day-to-day liaisons for specific services and programs as set forth in the list below to ensure services are closely coordinated with Member's other services and to ensure effective oversight and delivery of services.

Liaisons must receive training on the full spectrum of rules and regulations pertaining to the service they are coordinating, including referral requirements and processes, care management, and authorization processes.

Contractor must notify the other party, for which they are serving as a liaison, of any changes to the liaison as soon as reasonably practical but no later than the date of change and must notify DHCS within five (5) days of the change.

Pursuant to the obligations set forth in this section, Contractor must designate the following liaisons:

A. Tribal liaison as required in Exhibit A, Attachment III, Subsection 4.3.22 (*Indian Health Care Providers*)

B. Long-Term Services and Supports (LTSS) Liaison

LTSS Liaisons must receive training on the rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies; prompt claims payment requirements; Provider resolutions, policies and procedures; and care management, coordination and transition policies.

C. Transportation Liaison

Contractor must have a direct line for Providers and Members to receive real-time assistance directly from Contractor with unresolved transportation issues that can result in missed appointments. The liaison role may not be delegated to a transportation broker. Contractor must also have a process to triage urgent transportation calls when the Member or Provider communicates that they have attempted to work with the broker but the issue remains unresolved and is time sensitive.

D. California Children's Services Liaison

1) Contractor must designate at least one individual to serve as the CCS liaison who will serve as the primary point of contact responsible for the CCS members' care coordination.

2) CCS liaisons must receive training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with counties, care management and authorization processes for CCS Children.

E. Foster Care Liaison

1) Contractor must designate at least one individual to serve as the foster care liaison. Additional foster care liaisons must be designated as needed to ensure the needs of members involved with foster care are met.

2) Contractor's foster care liaison(s) will follow DHCS-issued standards and expectations as set forth in APLs or other similar instructions. Contractor's foster care liaison must:

a) Have expertise in Child welfare services, County Behavioral Health Services.

b) Ensure appropriate ECM staff, including the ECM Lead Care Manager whenever possible, attend meetings of the Child and family teams, in accordance W&I section 16501(a)(4), and ensure Covered services are closely coordinated with other services, including social services and Specialty Mental Health Care Services.

c) Act as a resource to the ECM Porviders providing services to Child welfare-involved Children and youth, provide technical assistance to Contractor and ECM Provider staff as needed, and serve as a point of escalation for care managers if they face operational obstacles when working with County and community partners.

d) Be sufficiently trained on County Care Coordination and assessment processes.

e) Coordinate with foster care liaisons for other Medi-Cal managed care plans to notify them when Members cross county lines and/or change managed care plans.

f) Must also serve as a family advocate.

F. RC Liaison as required in Exhibit A, Attachment III, Subsection 4.3.15 (Services for Persons with Developmental Disabilities)

G. Dental Liaison as required in Exhibit A, Attachment III, Subsection 4.3.17 (Dental)

H. IHSS Liaison as required in Exhibit A, Attachment III, Subsection 4.3.21 (In-Home Support Services)

Exhibit A, ATTACHMENT III

4.4 Enhanced Care Management

4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management
4.4.2 Populations of Focus for Enhanced Care Management
4.4.3 Enhanced Care Management Providers
4.4.4 Enhanced Care Management Provider Capacity
4.4.5 Enhanced Care Management Model of Care
4.4.6 Member Identification for Enhanced Care Management
4.4.7 Authorizing Members for Enhanced Care Management
4.4.8 Assignment to an Enhanced Care Management Provider
4.4.9 Initiating Delivery of Enhanced Care Management
4.4.10 Discontinuation of Enhanced Care Management
4.4.11 Core Service Components of Enhanced Care Management
4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management
4.4.13 Oversight of Enhanced Care Management Providers
4.4.14 Payment of Enhanced Care Management Providers
4.4.15 Enhanced Care Management Reporting Requirements
4.4.16 Enhanced Care Management Quality and Performance Incentive Program

4.4 Enhanced Care Management

4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management

A. Contractor must follow all provisions in the Enhanced Care Management (ECM) Policy Guide, in addition to provisions outlined in this Contract.

B. Contractor must take a whole-person approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-need and high-cost Members in distinct Populations of Focus, Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*), through systematic coordination of services and comprehensive care management.

C. Contractor must ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.

D. Contractor must ensure ECM is available throughout its Service Area.

E. Contractor must ensure ECM is offered primarily through in-person interaction where Members and their family members, legal guardians, Authorized Representatives (ARs), caregivers, and authorized support persons live, seek care, or prefer to access services in their local community. Contractor must ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and Telehealth, when appropriate and with the Member's consent.

F. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor must follow the same requirements as an ECM Provider that is a Network Provider or Subcontractor, especially that all such services are community-based, interdisciplinary, high-touch and person-centered. All such situations require DHCS approval through the exemption process and plans must be also making demonstrable progress to moving these ECM functions to community-based providers.

G. Contractor must follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract.

H. Contractor must ensure ECM provided to each Member encompasses the ECM core service components described in Exhibit A, Attachment III, Subsection 4.4.11 (*Core Service Components of Enhanced Care Management*).

I. Contractor must ensure a Member receiving ECM is not receiving duplicative case management services from other sources, including but not limited to county-specific Targeted Case Management (TCM) services administered by Local Governmental Agencies (LGAs).

J. For Members who are dually eligible for Medicare and Medi-Cal and enrolled in a Medicare Advantage Plan, Contractor must coordinate with the Medicare Advantage Plan for the provision of ECM for those Members.

K. Contractor must develop Member-facing written material about ECM for use across its network of ECM Providers. The written material must be submitted for DHCS review and approval prior to use. This material must include the following, at a minimum:

1) Explain ECM and how a Member may to request it;

2) Explain that ECM participation is voluntary and can be discontinued at any time;

3) Explain that the Member must authorize ECM-related data sharing;

4) Describe the process by which the Member may choose a different ECM Lead Care Manager or ECM Provider; and

5) Meet standards for culturally and linguistically appropriate communication Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*) and in Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*).

4.4.2 Populations of Focus for Enhanced Care Management

A. Subject to the phase-in and Member transition requirements described in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*).

B. Contractor must provide ECM to Members that meet the eligibility criteria for at least one of the following Populations of Focus, as described in the ECM Policy Guide

1) Members experiencing homelessness:

a) Members without dependent Children/youth living with them experiencing homelessness; and

b) Homeless families or unaccompanied Children/youth experiencing homelessness.

2) Members at risk for avoidable hospital or emergency department utilization;

3) Members with serious mental health and/or Substance Use Disorder (SUD) needs;

4) Members transitioning from incarceration;

5) Adult Members living in the community and at risk for Long-Term Care (LTC) institutionalization;

6) A Member residing in an adult nursing facility transitioning to the community;

7) Children enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS condition;

8) Children involved in Child welfare; and

9) Pregnant and postpartum Members; birth equity population of focus.

C. Contractor may offer ECM to Members who do not meet Population of Focus criteria in full but may benefit from ECM.

D. Contractor must follow all applicable DHCS policies and guidance, including All Plan Letters (APLs) and the ECM Policy Guide, that further define the approach to ECM for each Population of Focus, including the eligibility criteria for each Population of Focus and the phase-in timeline for Populations of Focus.

E. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs:

1) 1915(c) waiver programs including:

a) Multipurpose Senior Service Program (MSSP);

b) Assisted Living Waiver (ALW);

c) Home and Community-Based Alternatives (HCBA) Waiver;

d) Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver;

e) Home and Community-Based Services (HCBS) programs for Individuals with Developmental Disabilities (DD); and

f) Self-Determination Program for Individuals with intellectual and DD.

2) Fully integrated programs for Members dually eligible for Medicare and Medicaid including:

a) Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs);

b) Program for All-Inclusive Care for the Elderly (PACE);

c) Exclusively Aligned Enrollment (EAE) Dual Special Needs Plans (D-SNPs); and

d) Non EAE D-SNPs.

3) California Community Transitions Money Follows the Person (MFTP).

4) Complex Care Management.

4.4.3 Enhanced Care Management Providers

A. Contractor must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member, such as where the Member lives, seeks care, or prefers to access services in their local community.

B. ECM Providers may include, but are not limited to, the following entities:

1) Counties;

2) County Behavioral Health Providers;

3) Primary Care Provider (PCP) or Specialist or Physician groups;

4) Federally Qualified Health Centers (FQHCs);

5) Community health centers;

6) Community-based organizations;

7) Hospitals or hospital-based Physician groups or clinics (including public hospitals or district or municipal public hospitals);

8) Rural Health Clinics (RHCs) or Indian Health Care Providers (IHCP);

9) Local Health Departments (LHDs);

10) Behavioral Health entities;

11) Community mental health centers;

12) SUD treatment Providers;

13) Community Health Workers;

14) Organizations serving individuals experiencing homelessness;

15) Organizations serving justice-involved individuals;

16) CCS Providers; and

17) Other qualified Providers or entities that are not listed above, as approved by DHCS.

C. For the Population of Focus for eligible individuals with Serious Mental Illness (SMI) or SUD and the Population of Focus for eligible individuals with Serious Emotional Disturbance (SED), Contractor must prioritize county Behavioral Health staff or Behavioral Health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus, not just their Behavioral Health Services.

D. Contractor must attempt to contract with each IHCP as set forth in 22 CCR sections 55110 through 55180 to provide ECM, when applicable, as described in Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider*).

E. Contractor must ensure ECM Providers meet the requirements set forth in APLs including but not limited to the requirements regarding the use of a care management documentation system.

F. Care management documentation systems may include certified electronic health record technology, or other documentation tools that can:

1) Document Member goals and goal attainment status;

2) Develop and assign care team tasks;

3) Define and support Member Care Coordination and Care Management needs; and

4) 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, LTC facility, housing status).

G. Contractor must also comply with requirements on data exchange pursuant to Exhibit A, Attachment III, Subsection 4.4.12 (*Data System Requirements and Data Sharing to Support Enhanced Care Management*).

H. Contractor must ensure all ECM Providers for whom a State-level Enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 22-013. If APL 22-013 does not apply to an ECM Provider, Contractor must have a process for verifying qualifications and experience of ECM Providers, which must extend to individuals employed by or delivering services on behalf of the ECM Provider. Contractor must ensure that all ECM Providers meet the capabilities and standards required to be an ECM Provider.

I. Contractor must not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of entering into a Subcontractor Agreement or Network Provider Agreement, as appropriate.

4.4.4 Enhanced Care Management Provider Capacity

A. Contractor must develop and manage a network of ECM Providers.

B. Contractor must ensure sufficient ECM Provider capacity to meet the unique needs of all ECM Populations of Focus, including by contracting with providers with specific skills and experience serving specific Populations of Focus.

C. Contractor must meet DHCS' requirements regarding ECM Provider capacity separately from general Network adequacy; ECM Provider capacity does not alter the general Network adequacy provisions in Exhibit A, Attachment III, Section 5.2 (*Network and Access to Care*).

D. Contractor must report on its ECM Provider capacity to DHCS initially in its ECM Model of Care (MOC) Template as referenced in Exhibit A, Attachment III, Subsection 4.4.*5 (Enhanced Care Management Model of Care)* and on an ongoing basis pursuant to DHCS reporting requirements in a form and manner specified by DHCS.

E. Contractor must report to DHCS any Significant Changes in its ECM Provider capacity as soon as possible but no later than 60 days from the occurrence of the change, in accordance with DHCS reporting requirements in a form and manner specified by DHCS.

F. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus through Subcontractor or Network Provider Agreements, as appropriate, with community-based ECM Providers, Contractor may submit a written request to DHCS for an exception that authorizes Contractor to use its own personnel for ECM. Any such request must be submitted in accordance with DHCS guidelines and must meet at least one of the following criteria:

1) There are insufficient ECM Providers, or a lack of ECM Providers with qualifications and experience, to provide ECM for one or more of the Populations of Focus in one or more counties;

2) There is a justified Quality of Care concern with one or more of the otherwise qualified ECM Providers;

3) Contractor and the ECM Providers are unable to agree on rates;

4) ECM Providers are unwilling to contract;

5) ECM Providers are unresponsive to multiple attempts to contract;

6) ECM Providers who have a State-level pathway to Medi-Cal Enrollment but are unable to comply with the Medi-Cal Enrollment process or Contractor's verification requirements for ECM Providers; or

7) ECM Providers without a State-level pathway to Medi-Cal Enrollment that are unable to comply with Contractor's verification requirements for ECM Providers.

G. During an exception period approved by DHCS, Contractor must take steps to continually develop and increase its ECM Network capacity. After the expiration of an exception period, Contractor must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis.

H. Contractor's failure to provide network capacity that meets the needs of all ECM Populations of Focus in a community-based manner may result in imposition of Corrective Action proceedings, and may result in sanctions pursuant to Exhibit E, Subsection 1.1.19 (*Sanctions*).

4.4.5 Enhanced Care Management Model of Care

A. Contractor must develop an ECM MOC template in accordance with the DHCS-approved MOC Template. The MOC must specify Contractor's framework for providing ECM, including a listing of its ECM Providers and policies and procedures for partnering with ECM Providers for the provision of ECM.

B. In developing and executing Subcontractor Agreements or Network Provider Agreements, as appropriate, with ECM Providers, Contractor must incorporate all requirements and policies and procedures described in its MOC, in addition to APLs.

C. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on the development of its MOC as applicable for Contractor's plan model.

D. Contractor must submit its ECM MOC for DHCS review and approval. Contractor must also submit to DHCS any Significant Changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies

and guidance, including APLs. Significant Changes may include, but are not limited to, changes to Contractor's approach to administering or delivering ECM services, approved policies and procedures, and Subcontractor Agreement and Downstream Subcontractor Agreement boilerplates.

4.4.6 Member Identification for Enhanced Care Management

A. Contractor must proactively identify Members who may benefit from ECM and who meet the eligibility criteria for the ECM Populations of Focus, as described in Exhibit A, Attachment III, Subsection 4.4.2 (*Populations of Focus for Enhanced Care Management*).

B. To identify such Members, Contractor must consider the following:

1) Members' health care utilization;

2) Needs across physical, behavioral, developmental, and oral health;

3) Health risks and needs due to Social Drivers of Health (SDOH); and,

4) Long-Term Services and Supports needs.

C. Contractor must identify Members for ECM through the following pathways:

1) Analysis of Contractor's own enrollment, claims, and other relevant data and available information. Contractor must use data analytics to identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus. Contractor must consider data sources, including but not limited to:

a) Enrollment data;

b) Encounter Data;

c) Utilization/claims data;

d) Pharmacy data;

e) Laboratory data;

f) Screening or assessment data;

g) Clinical information on physical and Behavioral Health;

h) SMI/SED/SUD data, if available;

i) Risk stratification information for Children in County Organized Health Systems (COHS) counties with WCM programs;

j) Information about SDOH, including standardized assessment tools including Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) and International Classification of Diseases, Tenth Revision (ICD-10) codes;

k) Results from any available Adverse Childhood Experience screening; and

l) Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM Populations of Focus (e.g., Homeless Management Information System (HMIS), available data from the education system).

2) Receipt of requests from ECM Providers and other Providers or community-based entities.

a) Contractor must accept requests for ECM on behalf of Members from:

i) ECM Providers;

ii) Social service or other Providers; and

iii) Community-based entities, including those contracted to provide Community Supports, as described in Exhibit A, Attachment III, Subsection 4.5.3 (*Community Supports Providers)*.

b) Contractor must designate an email and dedicated phone number that is widely available by which referrals can be made.

c) Contractor must directly engage with and provide training to Network Providers, Subcontractors, Downstream Subcontractors, and county agencies to inform these entities of ECM, the ECM Populations of Focus, and how to request ECM for Members, with the goal of having the majority of ECM eligible Member referrals coming from Providers and community sources, rather than Contractor identification.

d) Contractor must encourage ECM Providers to identify Members who meet the criteria for the ECM Populations of Focus, and must develop a process for receiving and responding to requests from ECM Providers.

3) Requests from Members

a) Contractor must have a process for allowing Members to request ECM and for Members' parents, family members, legal guardians, ARs, caregivers, and authorized support persons to request ECM on a Member's behalf.

b) Contractor must provide information to Members regarding the Member initiated ECM request and approval process.

4.4.7 Authorizing Members for Enhanced Care Management

A. Contractor must authorize ECM for each eligible Member identified through any of the pathways described in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*). If a Member meets ECM Population of Focus eligibility requirements, Contractor must authorize ECM without additional requirements.

B. Contractor must develop policies and procedures that explain how it will authorize ECM for eligible Members in an equitable and non-discriminatory manner.

C. For requests from Providers and other external entities, Members, Member's parent, family member, legal guardian, AR, caregiver, or authorized support person:

1) Contractor must ensure that authorization or a decision not to authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment III, Subsection 2.3.2 (*Timeframes for Medical Authorization*) and APL 21-011;

2) If Contractor does not authorize ECM, Contractor must ensure the Member and the requesting individual or entity who requested ECM on a Member's behalf, as applicable, are informed of the Member's right to Appeal and the Appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*), and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011; and

3) Contractor must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

D. Contractor may collaborate with its ECM Providers to develop a process and identify possible circumstances under which presumptive authorization or preauthorization of ECM may occur, where select ECM Providers may directly authorize ECM for a limited period of time until Contractor authorizes or denies ECM.

E. To inform Members that ECM has been authorized , Contractor must follow its standard notice process outlined in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*) and APL 21-011.

4.4.8 Assignment to an Enhanced Care Management Provider

A. Contractor must assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS-approved exception to the ECM Provider contracting requirement as described in Exhibit A, Attachment III, Subsection 4.4.4 (*Enhanced Care Management Provider Capacity*).

B. Contractor must develop a process to disseminate information of assigned Members to ECM Providers on a regular basis.

C. Contractor must ensure communication of Member Assignment to the designated ECM Provider occurs within ten Working Days of authorization or on an agreed upon schedule.

D. If a Member prefers a specific ECM Provider, Contractor must assign the Member to that Provider, to the extent practicable.

E. If a Member's assigned PCP is a contracted ECM Provider, Contractor must assign the Member to the PCP as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

F. If a Member receives services from a MHP for SED, SUD, or SMI and the Member's Behavioral Health Provider is a contracted ECM Provider, Contractor must assign that Member to that Behavioral Health Provider as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

G. If a Member is enrolled in CCS and the Member's CCS Case Manager is Affiliated with a contracted ECM Provider, Contractor must assign that Member to that CCS Case Manager as the ECM Provider, unless the Member or parent, legal guardian, or AR has indicated otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

H. Contractor must notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten Working Days of the date of assignment.

I. Contractor must document the Member's ECM Lead Care Manager in its system of record.

J. Contractor must permit Members to change ECM Providers at any time. Contractor must implement any Member's request to change their ECM Provider within 30 calendar days to the extent practicable.

4.4.9 Initiating Delivery of Enhanced Care Management

A. Contractor must not require Member authorization for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM, unless such authorization is required by federal law.

B. Contractor must develop policies and procedures for its network of ECM Providers that meet the following requirements, including but not limited to:

1) Where required by law, ECM Providers must obtain Member's authorization to share information with Contractor and all others involved in the Member's care to maximize the benefits of ECM; and

2) ECM Providers must provide Contractor with Member-level records of any obtained authorizations for ECM-related data sharing as required by federal law and to facilitate ongoing data sharing with Contractor.

C. Contractor must ensure that upon the initiation of ECM, each Member receiving ECM has an ECM Lead Care Manager with responsibility for interacting directly with the Member and the Member's family, legal guardians, ARs, caregivers, and other authorized support persons, as appropriate.

The assigned ECM Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify any gaps in the Member's care and, at a minimum, ensure effective coordination of all physical health care, behavioral, developmental, oral health, LTSS, Community Supports, and other services to address SDOH, regardless of setting.

D. Contractor must ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

4.4.10 Discontinuation of Enhanced Care Management

A. Contractor must ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.

B. Contractor must require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met:

1) The Member has met all care plan goals;

2) The Member is ready to transition to a lower level of care;

3) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or

4) The ECM Provider has not been able to connect with the Member after multiple attempts.

C. Contractor must develop processes to determine if the Member is no longer authorized to receive ECM and, if so, to notify the ECM Provider to initiate discontinuation of services in accordance with the NOA process

described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*); Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*); and APL 21-011.

D. Contractor must develop processes for transitioning Members from ECM to other levels of care management to provide coordination of ongoing Member needs.

E. Contractor must notify the ECM Provider when ECM has been discontinued by Contractor.

F. Contractor must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to Appeal and the Appeals process by way of the NOA process as described in Exhibit A, Attachment III, Subsection 5.1.5 (*Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests*), and Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

4.4.11 Core Service Components of Enhanced Care Management

Contractor must ensure all Members receive all of the following seven ECM core service components, as further defined in APLs:

A. Outreach and engagement;

B. Comprehensive assessment and Care Management Plan;

C. Enhanced coordination of care;

D. Health promotion;

E. Comprehensive transitional care;

F. Member and family supports; and

G. Coordination of and referral to community and social support services

4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management

A. Contractor must have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:

1) Consume and use claims and Encounter Data, as well as other data types listed in Exhibit A, Attachment III, Subsection 4.4.6 (*Member Identification for Enhanced Care Management*);

2) Assign Members to ECM Providers;

3) Keep records of Members receiving ECM and authorizations necessary for sharing Protected Health Information (PHI) and PI between Contractor and ECM and other Providers, among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by Contractor;

4) Securely share data with ECM Providers and other Providers in support of ECM;

5) Receive, process, and send Encounter Data from ECM Providers to DHCS;

6) Receive and process supplemental reports from ECM Providers;

7) Send ECM supplemental reports to DHCS; and

8) Open, track, and manage referrals to Community Supports Providers.

B. To support ECM, Contractor must follow DHCS guidance on data sharing and provide the following information to all ECM Providers.

1) Member Assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

2) Encounter Data and claims data;

3) Physical, behavioral, administrative, and SDOH data (e.g., HMIS data) for all Members assigned to the ECM Provider; and

4) Reports of performance on quality measures and metrics, as requested.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS.

4.4.13 Oversight of Enhanced Care Management Providers

A. Contractor must perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract, DHCS policies and guidance, APLs, and Contractor's MOC.

1) Contractor must evaluate the prospective Subcontractor's and Downstream Subcontractor's ability to perform services as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

2) Contractor must ensure the Subcontractor's and Downstream Subcontractor's capacity is sufficient to serve all Populations of Focus;

3) Contractor must report to DHCS the names of all Subcontractors, Network Providers, and Downstream Subcontractors by Subcontractor and Downstream Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*); and

4) Contractor must make all Subcontractor Agreements or Network Provider Agreements, as appropriate, available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment III, Subsection 3.1.5.B (*Subcontractor and Downstream Subcontractor Agreement Requirements*).

B. Contractor must not impose mandatory reporting requirements that differ from or are additional to those required for Encounter and supplemental reporting; and Contractor may collaborate with other Medi-Cal managed care health plans within the same county on oversight of ECM Providers.

C. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.

D. Contractor must provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, or calls, as necessary, in addition to Network Provider training requirements, as applicable,

described in Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training).*

E. Contractor must ensure the Subcontractor Agreement and Downstream Subcontractor Agreement mirrors the requirements set forth in this Contract and in accordance with APLs, as applicable to Subcontractor.

Contractor may collaborate with its Subcontractors and Downstream Subcontractors on the approach to administration of ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractors and Downstream Subcontractors, and to ensure a streamlined, seamless experience for ECM Providers and Members.

4.4.14 Payment of Enhanced Care Management Providers

A. Contractor must pay ECM Providers for the provision of ECM in accordance with Subcontractor Agreements or Network Provider Agreements established between Contractor and each ECM Provider.

B. Contractor must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as described in Exhibit A, Attachment III, Subsection 4.4.9 (*Initiating Delivery of Enhanced Care Management*).

C. Contractor may tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.

D. Contractor must utilize the claims timeline as described in Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*).

4.4.15 Enhanced Care Management Reporting Requirements

A. Contractor must submit the following data and reports to DHCS to support DHCS' oversight of ECM:

1) Encounter Data:

a) Contractor must submit all ECM Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS.

b) Contractor must submit to DHCS all Encounter Data for ECM services to its Members, regardless of the number of

levels of delegation and/or sub-delegation between Contractor and the ECM Provider.

c) In the event the ECM Provider is unable to submit ECM Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor is responsible for converting the ECM Provider's Encounter Data information into the national standard specifications and code sets, for submission to DHCS.

2) ECM supplemental reports, on a schedule and in a format to be defined by DHCS.

B. Contractor must track and report to DHCS, on a schedule and in a format specified by DHCS, information about outreach efforts related to Potential Members to be enrolled in ECM.

C. In the event of underperformance by Contractor in relation to its administration of ECM, DHCS may impose sanctions as described in Exhibit E, Subsection 1.1.19 (*Sanctions*).

4.4.16 Enhanced Care Management Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement (QI) requirements in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program*) and any additional quality requirements set forth in associated guidance from DHCS for ECM.

B. Contractor may participate in a performance incentive program related to building Provider capacity for ECM, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance.

Exhibit A, ATTACHMENT III

4.5 Community Supports

4.5.1 Contractor's Responsibility for Administration of Community Supports
4.5.2 DHCS Pre-Approved Community Supports
4.5.3 Community Supports Providers
4.5.4 Community Supports Provider Capacity
4.5.5 Community Supports Model of Care
4.5.6 Identifying Members for Community Supports
4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status
4.5.8 Referring Members to Community Supports Providers for Community Supports
4.5.9 Data System Requirements and Data Sharing to Support Community Supports
4.5.10 Contractor's Oversight of Community Supports Providers
4.5.11 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors
4.5.12 Payment of Community Supports Providers
4.5.13 Community Supports Reporting Requirements
4.5.14 Community Supports Quality and Performance Incentive Program

4.5 Community Supports

4.5.1 Contractor's Responsibility for Administration of Community Supports

A. Contractor may provide DHCS pre-approved Community Supports as described in Exhibit A, Attachment III, Subsection 4.5.2 (*DHCS Pre-Approved Community Supports*).

This Section (Section 4.5) refers only to Community Supports that Contractor may choose to offer, unless otherwise specified.

B. In accordance with 42 CFR section 438.3(e)(2), all applicable All Plan Letters (APLs), and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the California Medicaid State Plan. See Exhibit A, Attachment III, Subsection 4.5.2 (*DHCS Pre-Approved Community Supports*) below for the list.

1) Contractor must ensure medically appropriate California Medicaid State Plan services are available to the Member regardless of whether the Member has been offered Community Supports, is currently receiving Community Supports, or has received Community Supports in the past.

2) Contractor must not require a Member to utilize Community Supports. Members always retain their right to receive the California Medicaid State Plan services on the same terms as would apply if Community Supports was not an option in accordance with regulatory requirements.

3) Contractor must not use Community Supports to reduce, discourage, or jeopardize Members' access to California Medicaid State Plan services.

4) Contractor may submit a request to DHCS to offer Community Supports in addition to the pre-approved Community Supports.

C. With respect to pre-approved Community Supports, Contractor must adhere to DHCS guidance on service definitions, eligible populations, code sets, potential Community Supports Providers, and parameters for each Community Support that Contractor chooses to provide, as referenced in APL 21-017 and the Community Supports Policy Guide.

1) Contractor is not permitted to extend Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate, as indicated in the DHCS guidance on eligible populations incorporated in the Community Supports Policy Guide.

2) Contractor may not adopt a more narrowly defined eligible population for Community Supports than outlined in the Community Supports Policy Guide.

D. If Contractor elects to offer one or more pre-approved Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 4.5.4 (*Community Supports Provider Capacity*).

E. Contractor must identify Members who may benefit from Community Supports and for whom Community Supports will be a medically appropriate and cost-effective substitute for Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described in Exhibit A, Attachment III, Subsection 4.5.6 (*Identifying Members for Community Supports*).

F. Contractor must authorize Community Supports for Members deemed eligible in accordance with Exhibit A, Attachment III, Subsection 4.5.7 (*Authorizing Members for Community Supports and Communication of Authorization Status*).

G. Contractor may elect to offer value-added services in addition to offering one or more Community Supports. Offering or not offering Community Supports does not preclude Contractor from offering value-added services.

H. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment III, Subsection 5.2.9 (*Network and Access Changes to Covered Services*).

I. When Members are dually eligible for Medicare and Medi-Cal, and enrolled in a Medicare Advantage Plan, including a Dual Special Needs

Plan (D-SNP), Contractor must coordinate with the Medicare Advantage Plan in the provision of Community Supports.

J. Contractor must not require Members to use Community Supports.

4.5.2 DHCS Pre-Approved Community Supports

A. Contractor may choose to offer Members one or more of the following pre-approved Community Supports, and any subsequent Community Supports additions pre-approved by DHCS, in each county:

1) Housing transition navigation services;

2) Housing deposits;

3) Housing tenancy and sustaining services;

4) Short-term post-hospitalization housing;

5) Recuperative care (medical respite);

6) Respite services;

7) Day habilitation programs;

8) Nursing facility transition/diversion to assisted living facilities;

9) Community transition services/nursing facility transition to a home;

10) Personal care and homemaker services;

11) Environmental accessibility adaptations;

12) Medically tailored meals/medically supportive food;

13) Sobering centers; and

14) Asthma remediation.

B. Contractor must list all Community Supports it offers in its Community Supports Model of Care (MOC) template and Community Supports MOC amendments.

C. Contractor must ensure Community Supports are provided in accordance with APLs and DHCS' Community Supports Policy Guide.

D. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports.

E. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date.

Contractor must ensure Community Supports that were authorized for a Member prior to the discontinuation of those specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet the Member's needs.

F. At least 30 calendar days before discontinuing one or more Community Supports, Contractor must notify impacted Members of the following:

1) The change and timing of discontinuation, and

2) The procedures that will be used to ensure completion of the authorized Community Supports or a transition into other comparable Medically Necessary services.

G. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of this Section 4.5 and are subject to the limitations of 42 CFR section 438.3(e)(1).

4.5.3 Community Supports Providers

A. Community Supports Providers are entities that Contractor has determined can provide Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

B. Contractor must enter into Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate,

with Community Supports Providers for the delivery of Community Supports elected by Contractor.

C. Contractor must ensure all Community Supports Providers for whom a State-level Enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 22-013. If APL 22-013 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.

D. In accordance with Exhibit A, Attachment III, Subsection 4.5.9 (*Data System Requirements and Data Sharing to Support Community Supports*), Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum:

1) Obtain and document Member Information including eligibility, Community Supports authorization status, Member authorization for data sharing (to the extent required by law), and other relevant demographic and administrative information; and

2) Support Community Supports Provider notification to Contractor, ECM Providers, and Member's Primary Care Provider (PCP), as applicable, when a referral has been fulfilled, as described in Exhibit A, Attachment III, Subsection 4.5.9 (*Data System Requirements and Data Sharing to Support Community Supports*).

E. To the extent Contractor elects to offer Community Supports, Contractor may coordinate its approach with other Medi-Cal managed care health plans offering Community Supports in the same county.

F. Contractor must prioritize contracting with locally available community-based organizations that have experience working with eligible populations and delivering the outlined Community Supports services (e.g., Supportive housing providers, Skilled Nursing Facilities (SNFs), medically tailored meals providers).

4.5.4 Community Supports Provider Capacity

A. Contractor must develop a robust network of Community Supports Providers to deliver all elected Community Supports.

B. If Contractor is unable to offer its elected Community Supports to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, Contractor must submit ongoing progress reports to DHCS in a format and manner specified by DHCS.

C. Contractor must ensure all of its Community Supports Providers have sufficient capacity to receive referrals for Community Supports and provide the agreed-upon volume of Community Supports to Members who are authorized for such services on an ongoing basis.

4.5.5 Community Supports Model of Care

A. Contractor must develop a Community Supports MOC in accordance with the DHCS-approved Community Supports MOC template. The Community Supports MOC must specify Contractor's framework for providing Community Supports, including a listing of its Community Supports Providers and policies and procedures for partnering with Community Supports Providers for the provision of Community Supports.

B. In developing and executing Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers, Contractor must incorporate all requirements and policies and procedures described in its Community Supports MOC, in addition to APLs.

C. Contractor may collaborate with other Medi-Cal managed care health plans within the same county on the development of its Community Supports MOC.

D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must also submit to DHCS any significant changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any such occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs. Significant changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services; approved policies and procedures; and Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement boilerplates, as appropriate.

4.5.6 Identifying Members for Community Supports

A. Contractor must utilize a variety of methods to identify Members who may benefit from Community Supports, in accordance with all applicable DCHS APLs.

B. Contractor must develop policies and procedures for Community Supports, and submit its policies and procedures to DHCS for review and approval prior to implementation. Contractor's policies and procedures must address the following, at a minimum:

1) How Contractor will identify Members eligible for Community Supports;

2) How Contractor will notify Members; and

3) How Contractor will receive requests to evaluate Members for Community Supports from Providers; community-based entities; and Member or Member's family, legal guardians, Authorized Representatives (ARs), and caregivers.

C. Contractor must submit all Member notices to DHCS for review and approval prior to implementation.

D. Contractor must ensure that Member identification methods for Community Supports are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.

4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status

A. Contractor must develop and maintain policies and procedures that explain how Contractor will authorize Community Supports for eligible Members in an equitable and non-discriminatory manner. Contractor must submit its policies and procedures to DHCS for review and approval prior to implementation.

1) Contractor's policies and procedures must include a framework for considering medical appropriateness in relation to Contractor's proposed approach for providing Community Supports.

2) Each Community Support authorization request must be considered separately for a Member. MCPs must evaluate each authorization request for medical appropriateness. Receiving one Community Support does not preclude a member from being

authorized for additional Community Supports unless a conflict is specified by DHCS.

B. Contractor must monitor and evaluate Community Supports authorizations to ensure they are equitable and non-discriminatory. Contractor must have policies and procedures in place for immediate actions that it will undertake if monitoring/evaluation processes reveal that service authorizations have had an inequitable effect.

C. For Members with an assessed risk of incurring other California Medicaid State Plan services, such as inpatient hospitalizations, SNF stays, or emergency department visits, Contractor must develop policies and procedures to ensure appropriate clinical support authorization of Community Supports for Members. Contractor's policies and procedures must include detailed documentation that a Network Provider using their professional judgement has determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in a form and manner specified by DHCS through APLs or other guidance.

D. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports. If Medically Necessary, Contractor must make available the California Medicaid State Plan services that the Community Supports replace, pending authorization of the requested Community Supports.

E. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with APLs.

F. When a Member has requested Community Supports, directly or through a Provider, community-based organization, or other entity, Contractor must notify the requestor and the Member of Contractor's decision regarding Community Supports authorization, in accordance with APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.

G. Members always retain the right to file Appeals and/or Grievances if they request one or more Community Supports offered by Contractor but were not authorized to receive the requested Community Supports because of a determination that it was not medically appropriate or cost-effective.

H. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) and APL 21-011.

4.5.8 Referring Members to Community Supports Providers for Community Supports

A. Contractor must develop and maintain policies and procedures to define how Community Supports Provider referrals will occur. Contractor must submit to DHCS policies and procedures for review and approval prior to implementation.

1) For Members enrolled in ECM, Contractor's policies and procedures must address how Contractor will work with the ECM Provider to coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider.

2) Contractor's policies and procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.

B. If the Member prefers a particular Community Supports Provider and Contractor is aware of this preference, Contractor must follow those preferences, to the extent practicable.

C. Contractor must track referrals to Community Supports Providers to verify if the authorized service has been delivered to the Member.

If the Member receiving Community Supports is also receiving ECM, Contractor must monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the Community Supports Provider.

D. Contractor must not require Member authorization for Community Supports-related data sharing as a condition of initiating delivery of Community Supports, unless such authorization is required by State or federal law.

E. Contractor must develop and maintain policies and procedures for its network of Community Supports Providers to:

1) Ensure the Member agrees to receive Community Supports;

2) Where required by applicable law, ensure that Members authorize information sharing with Contractor and all others involved in the Member's care as needed to support the Member and maximize the benefits of Community Supports, in accordance with APLs, laws, and regulations;

3) Provide Contractor with Member-level records of any obtained authorization for Community Supports-related data sharing which are required by law, and to facilitate ongoing data sharing with Contractor; and

4) Obtain Member authorization to communicate electronically with the Member, Member's family, legal guardians, ARs, caregivers, and other authorized support persons, if Contractor intends to do so.

4.5.9 Data System Requirements and Data Sharing to Support Community Supports

A. Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals.

Contractor must support Community Supports Provider access to systems and processes allowing them to track and manage referrals for Community Supports and Member Information.

B. Consistent with federal, State and, if applicable, local privacy and confidentiality laws, Contractor must ensure Community Supports Providers have access to the below as part of the referral process to Community Supports Providers:

1) Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;

2) Appropriate administrative, clinical, and social service information that Community Supports Providers might need to effectively provide the requested service; and

3) Billing information necessary to support the Community Supports Providers' ability to submit claims or invoices to Contractor.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

4.5.10 Contractor's Oversight of Community Supports Providers

A. Contractor must comply with all State and federal reporting requirements.

B. Contractor must perform oversight of Community Supports Providers, holding them accountable for all Community Supports requirements contained in this Contract, and APLs.

C. Contractor must use APLs to develop its Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements, as appropriate, with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS.

D. To streamline Community Supports implementation:

1) Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS;

2) Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter Data and supplemental reporting as described in Subsection 4.5.13 (*Community Supports Reporting Requirements*); and

3) Contractor may collaborate with other Medi-Cal managed care health plans within the same county on reporting requirements and oversight.

E. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of Community Supports Providers, unless by mutual consent with the Community Supports Provider.

F. Contractor must provide Community Supports training and technical assistance to Community Supports Providers, including in-person

sessions, webinars, and calls, as necessary, in addition to Network Provider training requirements, as applicable, as described in Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*).

G. Contractor must not require Community Supports Providers to use a contractor-specific portal for day-to-day documentation of services. However, this prohibition does not preclude providers and Contractor from mutually agreeing to use of portals to facilitate reporting and other administrative transactions.

4.5.11 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors

A. Contractor may enter into Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements, as appropriate, with other entities to administer Community Supports in accordance with the following:

1) Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, as described in Exhibit A, Attachment III, Section 3.1 (*Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties*);

2) Contractor must develop and maintain DHCS-approved policies and procedures to ensure Network Providers, Subcontractors, and Downstream Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

3) Contractor must evaluate the prospective Network Provider's, Subcontractor's, or Downstream Subcontractor's ability to perform services as described in Exhibit A, Attachment III, Subsection 3.1.4 (*Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance*);

4) Contractor must ensure the Network Provider's, Subcontractor's, or Downstream Subcontractor's Community Supports Provider capacity is sufficient to serve all Populations of Focus;

5) Contractor must, as applicable, report to DHCS the names of all Subcontractors and Downstream Subcontractors by Subcontractor and Downstream Subcontractor type and service(s) provided, and

identify the county or counties in which Members are served as described in Exhibit A, Attachment III, Subsection 3.1.3 (*Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan*); and

6) Contractor must make all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment III, Subsection 3.1.5. (*Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

B. Contractor must ensure all Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements mirror the requirements set forth in this Contract and APLs, as applicable to the Network Provider, Subcontractor, or Downstream Subcontractor.

C. Contractor may collaborate with its Network Providers, Subcontractors, and Downstream Subcontractors on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Network Providers, Subcontractors and Downstream Subcontractors, and to ensure a streamlined, seamless experience for Community Supports Providers and Members.

4.5.12 Payment of Community Supports Providers

A. Contractor must pay contracted Community Supports Providers for the provision of authorized Community Supports to Members in accordance with established Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements between Contractor and each Community Supports Provider.

B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment III, Subsection 3.3.5 (*Claims Processing*) to ensure timely payment of claim, bills, or invoices.

C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for a Member who is homeless and being discharged from the hospital.

For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the Community Supports Provider is expedited. Contractor must submit these policies and procedures to DHCS for review and approval prior to implementation.

D. Contractor must ensure Community Supports Providers submit a claim for rendered Community Supports, to the greatest extent possible.

1) If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider apply the DHCS approved billing and guidance to submit invoices.

2) Upon receipt of such an invoice, Contractor must document the Encounter for the Community Supports rendered.

4.5.13 Community Supports Reporting Requirements

A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers, in accordance with APLs.

B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:

1) Encounter Data

a) Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor comply with DHCS guidance on billing and invoicing standards for Contractor to use with Community Supports Providers.

b) Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under Network Provider Agreements, Subcontractor Agreements, or Downstream Subcontractor Agreements.

c) In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to

be defined by DHCS, Contractor must convert Community Supports Providers' invoicing or billing data into the national standard specifications and code sets, for submission to DHCS.

d) Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform Health Equity initiatives and efforts to mitigate Health Disparities undertaken by DHCS.

2) Supplemental reporting on a schedule and in a form to be defined by DHCS.

C. Contractor must timely submit any related data requested by DHCS, Centers for Medicare & Medicaid Services, or an independent entity conducting an evaluation of Community Supports including, but not limited to:

1) Data to evaluate the utilization and effectiveness of Community Supports.

2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.

3) Data necessary to monitor Member Appeals and Grievances associated with Community Supports.

D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions in accordance with Exhibit E, Subsection 1.1.19 (*Sanctions*).

4.5.14 Community Supports Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement (QI) requirements described in Exhibit A, Attachment III, Section 2.2 (*Quality Improvement and Health Equity Transformation Program*), and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.

B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and outcomes, and other performance milestones and measures, in accordance with APL 23-003 or other technical guidance.

Exhibit A, ATTACHMENT III

4.6 Member Grievance and Appeal System

4.6.1 Grievance and Appeal Program Requirements
4.6.2 Grievance Process
4.6.3 Discrimination Grievances
4.6.4 Notice of Action
4.6.5 Appeal Process
4.6.6 Responsibilities in Expedited Appeals
4.6.7 State Hearings and Independent Medical Reviews
4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted
4.6.9 Grievance and Appeal Reporting and Data

4.6 Member Grievance and Appeal System

4.6.1 Grievance and Appeal Program Requirements

Contractor must have in place a Member Grievance and Appeal system that complies with 42 CFR sections 438.228 and 438.400 – 424, 28 CCR sections 1300.68 and 1300.68.01, and 22 CCR section 53858 for Covered Services including Contractor's selected Community Supports under 42 CFR section 438.3(e)(2). Contractor must follow Grievance and Appeal requirements set forth in, and use all notice templates included in, All Plan Letter (APL) 21-011. Contractor must ensure that its Grievance and Appeal system meets the following requirements:

A. Allows the Member, or a Provider or Authorized Representative (AR) with the Member's written consent, to file a Grievance, or request an Appeal with Contractor either orally or in writing.

B. Ensures timely written acknowledgement of each Grievance or Appeal, and provides a notice of resolution to the Member as quickly as the Member's health condition requires, not to exceed 30 calendar days from the date the Member makes an oral or written request to Contractor for a standard Grievance or Appeal or 72 hours for an expedited Grievance or Appeal. Contractor must notify the Member, Provider, or AR with a written resolution of the Grievance or Appeal in the Member's preferred language as required by 42 CFR sections 438.10 and 438.404, W&I section 14029.91, and 22 CCR section 53876.

C. Ensures that Members are given assistance when completing Grievance and Appeal forms and all other procedural steps. Required assistance includes, but is not limited to, providing Members with all documents Contractor relied on for its decision, and providing Auxiliary Aid and services upon request, such as translation and interpreter services, use of alternative formats for all documents Contractor relied upon for its decision, and a toll-free number with Telephone Typewriters (TTY), Telecommunication Devices for the Deaf (TDD) and interpreter capability.

D. Ensures that the person making the final decision for the proposed resolution of a Grievance or Appeal has neither participated in any prior decisions related to the Grievance or Appeal, nor is a subordinate of someone who has participated in the prior decision. Contractor must ensure that all Grievance or Appeals related to medical Quality of Care issues be immediately submitted to Contractor's medical director for action. Contractor must ensure that the person making the decision on the

Grievance or Appeal has clinical expertise in treating a Member's condition or disease when deciding:

1) An Appeal of a denial based on lack of Medical Necessity or that the service is experimental or investigational;

2) A Grievance regarding denial of a request for expedited resolution of an Appeal; and

3) Any Grievance or Appeal involving clinical issues.

E. Considers all comments, documents, records, and other information submitted by the Member, Provider, or AR, regardless of whether Contractor had the Member's additional information during the initial review.

F. Ensures that Members are given a reasonable opportunity to present evidence and testimony, and make legal or factual arguments, in person, by telephone, or in writing, in support of their Grievance or Appeal. Contractor must inform Members that they must submit additional evidence for Contractor to consider within the 30-calendar-day review timeframe for an Appeal and within the 72-hour timeframe for resolving an expedited Appeal.

G. Ensures that Notices of Appeal Resolution (NAR) be in a format and a language that, at a minimum, meets the standards set forth in 42 CFR section 438.10, W&I section 14029.91, 22 CCR section 53876, and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*). Contractor must ensure that language assistance taglines and a nondiscrimination notice meeting the minimum requirements in APL 21-004 accompanies each Member notification, and that the nondiscrimination notice is made available, upon request or as otherwise required by law, in all of the Threshold Languages/Threshold or Concentration Standard Languages and Americans with Disabilities Act of 1990 (ADA)-compliant, accessible formats as needed by Members to effectively understand Contractor's notices.

H. Provides oral notice of the resolution of an expedited Appeal to the Member, Provider, or AR within 72 hours.

I. Provides Contractor's Grievance and Appeal policies and procedures to Network Providers, Subcontractors, and Downstream Subcontractors at the time that they enter into a Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement. Contractor must

ensure that Network Providers, Subcontractors, and Downstream Subcontractors are trained on and immediately notified of any changes to Contractor's Grievance and Appeal policies and procedures.

J. Maintains policies and procedures for compiling, aggregating, and reviewing Grievance and Appeal data for use in Contractor's Quality Improvement Strategy (QIS). Contractor must regularly analyze Grievance and Appeal data to identify, investigate, report, and act upon systemic patterns of improper service denials and other trends impacting health care access and delivery to Members. Contractor must impose necessary Corrective Action to remedy all identified deficiencies.

K. Maintains records of Grievances and Appeals in a manner accessible to DHCS and to the Centers for Medicare & Medicaid Services (CMS), upon request. Contractor must review Grievance and Appeal data and information as part of its ongoing monitoring procedures as well as for updates and revisions to its QIS. The record of each Grievance or Appeal must contain, at a minimum, all information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in written or electronic format, generated or obtained by Contractor in the course of responding to Adverse Benefit Determinations (ABDs), Grievances, Appeals, and Independent Medical Reviews (IMRs) are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

4.6.2 Grievance Process

Contractor's policies and procedures must include all required information set forth below for Grievances and the expedited review of Grievances as required under 42 CFR sections 438.402, 438.406, and 438.408; 28 CCR sections 1300.68 and 1300.68.01; and 22 CCR section 53858:

A. A policy and procedure for Members to file a Grievance with Contractor at any time to express dissatisfaction about any matter other than a notice of ABD.

B. A policy and procedure to allow Members to file a Grievance to contest Contractor's unilateral decision to extend the timeframe for resolution of an Appeal or expedited Appeal.

C. A policy and procedure to ensure that every Grievance involving clinical issues that is submitted is reported to qualified medical professionals with appropriate clinical expertise and is escalated to Contractor's medical director as needed, to ensure the Grievance is properly handled.

D. A policy and procedure to ensure that Contractor's staff monitor Grievances to identify issues that require Corrective Action. Grievances related to medical Quality of Care issues must be referred to qualified medical professionals with appropriate clinical expertise and be escalated to Contractor's medical director as needed.

E. A policy and procedure for Contractor to provide written acknowledgement to the Member within five calendar days of receipt of the Grievance. The acknowledgement letter must advise the Member that the Grievance has been received; provide the date of receipt; and provide the name, telephone number, and address of the representative who the Member, their Provider, or their AR may contact about the Grievance.

4.6.3 Discrimination Grievances

Contractor must process Discrimination Grievances as required by federal and State nondiscrimination law and DHCS policy, as stated in 45 CFR section 84.7, 34 CFR section 106.8, 28 CFR section 35.107, W&I section 14029.91(e)(4), and APL 21-004.

A. Contractor must designate a Discrimination Grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

B. Contractor must adopt and implement written policies and procedures to ensure the prompt and equitable resolution of Discrimination Grievances. Contractor must not require a Member or Potential Member to file a Discrimination Grievance with Contractor before filing with the DHCS Office of Civil Rights or the U.S. Department of Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a Discrimination Grievance resolution letter, Contractor must submit information regarding the Discrimination Grievance to the DHCS Office of Civil Rights, as specified in APL 21-004.

D. Contractor must inform Members on its website that Discrimination Grievances may be filed directly with the DHCS Office of Civil Rights and must include contact information for the DHCS Office of Civil Rights, as required by Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*).

4.6.4 Notice of Action

When Contractor makes an authorization decision, it must send a Notice of Action (NOA). A NOA is a notice of any action that impacts a Member's ability to obtain Covered Services or other benefits Contractor is required to provide under this Contract. A NOA includes, but is not limited to, a notice of ABD for a requested health care service under 42 CFR sections 438.210(d) and 438.404, including requested Community Supports that Contractor has elected to cover under 42 CFR section 438.3(e)(2).

Contractor's failure to render a decision and send a written NOA to the Member within the required timeframes below is considered a denial of the requested service and therefore constitutes an ABD on the date that Contractor's timeframe for approval expires, in accordance with 42 CFR section 438.404(c)(5). In cases where Contractor fails to meet the required notice timeframes, the Member may immediately request an Appeal with Contractor and Contractor must send the Member written notice of all Appeal rights.

A. Standard Authorization Requests

1) Contractor must ensure a NOA is sent when approving, denying or modifying a Provider's Prior Authorization or concurrent request for health care services (excluding pharmacy services, but including Community Supports) for a Member within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14 calendar days following Contractor's receipt of the request for service, in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3); and

2) Contractor must notify the requesting Provider of its authorization decision within 24 hours of the decision and send the written NOA to the Member within two Working Days in accordance with Health and Safety Code (H&S) section 1367.01(h)(1) and (3).

3) Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must approve, deny, or modify the request and send the written NOA within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five Working Days from Contractor's receipt of information reasonably necessary and requested by Contractor to make a determination, not to exceed 14

calendar days in accordance with 42 CFR sections 438.210(d)(1) and 438.404(c)(3); and

4) Contractor must send the written NOA to the Member with sufficient time to allow for continuation of benefits pursuant to 42 CFR section 438.420.

B. Expedited Authorization Requests

1) In instances where a Provider indicates, or Contractor determines, that the standard request timeframe may seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, Contractor must approve, modify, or deny a Prior Authorization or concurrent request for health care services, and send the written NOA, in a timeframe which is appropriate for the nature of the Member's condition, but no longer than 72 hours from receipt of the authorization request in accordance with 42 CFR section 438.210(d)(2) and (d)(2)(i).

2) Contractor must send the written NOA approving, denying, or modifying the authorization request. Contractor must send the written NOA to the Member with sufficient time to allow for continuation of benefits pursuant to 42 CFR section 438.420.

3) Contractor must approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than 72 hours from Contractor's receipt of additional information requested by Contractor to make a determination. Contractor's written notice to the Member must be sent with sufficient time to allow the Member to request Aid Paid Pending, if applicable.

C. Retrospective Review

Contractor must approve, modify, or deny a Provider's request for Retrospective Review authorization for health care services provided to a Member, and send the written NOA to the Member, within 30 calendar days from receipt of information that is reasonably necessary to make a determination.

D. Terminations, Suspensions, or Reductions

1) For terminations, suspensions, or reductions of previously authorized services, Contractor must notify Members at least ten

calendar days before the date of the action pursuant to 42 CFR section 431.211, with the exception of circumstances permitted under 42 CFR sections 431.213 and 431.214.

2) For purposes of auditing, the postmark on Contractor's notice to the Member will be used to confirm compliance with all authorization request timeframes and notice requirements set forth in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*).

E. Required Information in Contractor's NOA Informing Member of Notice of Adverse Benefit Determination (NABDs)

Contractor must ensure all NOAs informing a Member of an ABD are in writing in a format and language that, at a minimum, meets the standards set forth 42 CFR sections 438.10, 438.404, and 438.408; W&I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*), and APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services. Contractor's NOA informing of an ABD must include all of the following:

1) A clear and concise explanation of the action that Contractor or its Network Provider has taken or intends to take, including a fully translated written notice with a fully translated clinical rationale for Contractor's decision at the point of each determination.

2) The reason for the action, including notification to the Member of the right to be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and any other information Contractor relied on for the decision, including clinical criteria; Medical Necessity criteria; and any processes, strategies, or evidentiary standards relied on for the decision.

3) The Member's right to request an Appeal with Contractor no later than 60 calendar days from the date on the NOA, and information on exhausting Contractor's one-level Appeal system;

4) The Member's right to an expedited Appeal if the Member's health condition requires resolution in less than 72 hours and information on how to request an expedited Appeal;

5) The Member's rights and information on the process to request a State Hearing after having exhausted Contractor's internal Appeal process and having received notice that Contractor is upholding its action. The NOA must also advise that the Member may request a State Hearing in cases where Contractor fails to send a NAR or notice of extension in response to the Appeal within 30 calendar days of the Member's request for an Appeal. This is known as Deemed Exhaustion pursuant to 42 CFR section 438.402(c)(1)(i)(A);

6) The Member's right to continue receiving Covered Services pending the resolution of the Appeal, and Contractor's obligation to continue benefits as required by 42 CFR section 438.420 and Exhibit A, Attachment III, Subsection 4.6.8 (*Continuation of Services Until Appeal and State Hearing Rights Are Exhausted*) below; and

7) If applicable, the Member's right to request a clinical review of Contractor's action, called an IMR, from DMHC and that the Member must request an IMR before there is a final decision on their State Hearing.

F. For visually impaired Members, Contractor must provide the NOA in the Member's selected alternative format in order to be considered adequate notice. Contractor must not deny, delay, modify, limit, or terminate services or treatments without providing adequate notice within the timeframes stated in this Exhibit A, Attachment III, Subsection 4.6.4 (*Notice of Action*). In accordance with APL 22-002, Contractor must calculate the appropriate timeframe(s) for a visually impaired Member to take action from the date of receiving adequate notice in their selected alternative format, including all deadlines for Appeals.

G. Contractors are not permitted to make any changes to DHCS' NOA templates or the NOA "Your Rights" Attachment without prior review and approval from DHCS, except to insert the specific reasons for Contractor's action to the Member, as required.

4.6.5 Appeal Process

Pursuant to 42 CFR sections 438.228 and 438.400 - 424, Contractor must have an Appeal process as required below to attempt to resolve Member Appeals before the Member requests a State Hearing or an IMR. Contractor must have only one level of Appeal for Members. Upon a Member's request, Contractor must assist any Member in preparing their Appeal, which includes assisting the

Member with navigating Contractor's website, providing all documents that Contractor relied on for its decision, and providing the Appeal form to the Member.

A. Following the receipt of a NOA, a Member has 60 calendar days from the date on the NOA to file a request for an Appeal either orally or in writing. The Member, or a Provider or AR acting on behalf of the Member and with the Member's written consent, may request an Appeal. Unless the Member is requesting an expedited Appeal, the date of the Member's oral or written request for an Appeal establishes the filing date for the Appeal. Contractor must resolve the Appeal within 30 calendar days of the Member's oral or written request for an Appeal.

B. If Contractor fails to send a written NOA within 30 calendar days or fails to comply with notice and language translation requirements in 42 CFR sections 438.10, 438.404, and 438.408; W&I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*), the Member is deemed to have exhausted Contractor's internal Appeal process and may request a State Hearing pursuant to 42 CFR section 438.402(c)(1)(i)(A).

C. Contractor's NOA informing the Member of its NAR must, at a minimum, indicate whether Contractor upheld its decision on the Appeal and the date of Contractor's decision on the Appeal. For decisions not wholly in the Member's favor, Contractor's NAR must, at a minimum, include:

   1) Member's right to request a State Hearing;

   2) How to request a State Hearing;

   3) That the Member has a right to continuation of benefits during the State Hearing, and that Contractor is obligated to continue benefits as long as the requirements of 42 CFR section 438.420 are met;

   4) If applicable, the right to request an IMR or a review of Contractor's decision by DMHC, and that the IMR must be requested before there is a final State Hearing decision; and

   5) The DHCS-approved "Your Rights" Attachment.

D. If Contractor reverses its decision during the Appeal, it must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the

date it reverses the action if the disputed services were not provided during the Appeal.

E. Contractor must pay for disputed services if the Member received the disputed services while the Appeal was pending.

F. Contractor must provide the Member or AR the opportunity before and during their Appeal process to examine their case file. Contractor must provide, sufficiently in advance of the resolution timeframe and free of charge, the Member's case file, including Medical Records, clinical criteria, guidelines, and all documents and records Contractor relied on during the Appeal process for its decision. Contractor must assist any Member who requires assistance preparing their Appeal.

G. Contractor may withdraw a Grievance or Appeal upon Member request if performed in compliance with the established Grievance and Appeals processes required in this Contract and federal and State laws and regulations. Where a Grievance or Appeal was filed by a Provider or AR of a Member, written Member consent is required for a Provider or AR to withdraw the Grievance or Appeal.

4.6.6 Responsibilities in Expedited Appeals

Contractor must implement and maintain policies and procedures as described below to resolve expedited Appeals. Contractor must follow the expedited Appeal process when it determines or the requesting Provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life; physical or mental health; or ability to attain, maintain, or regain maximum function.

A. A Member, or a Provider or an AR with the Member's written consent, may file an expedited Appeal either orally or in writing. No additional follow-up from the Member is required. Contractor must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's Appeal.

B. Contractor must inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person, by phone, or in writing, sufficiently in advance of the resolution timeframe.

C. Contractor must resolve an expedited Appeal as quickly as the Member's health condition requires, but no later than 72 hours from the day Contractor receives the request for an expedited Appeal.

D. Contractor must make a reasonable effort to provide oral notice of an expedited Appeal decision.

E. If Contractor denies a request for an expedited resolution of an Appeal, it must process the request for an Appeal in accordance with the standard Appeal process timeframes for resolutions and extensions as required in Exhibit A, Attachment III, Subsection 4.6.5 (*Appeal Process*).

4.6.7 State Hearings and Independent Medical Reviews

A. State Hearings

1) The Member, or a Provider or AR with the Member's written consent, may request a State Hearing:

a) After receiving a NAR confirming that Contractor has upheld its ABD, and the request is made within 120 calendar days from the date on the NAR;

b) In cases of Deemed Exhaustion, due to Contractor's failure to comply with Appeal notice and timing requirements as required by 42 CFR sections 438.10, 438.402, 438.404, 438.406, 438.408, and 438.410; W&I sections 10951 and 10951.5; and as stated in this Contract, the Member may immediately request a State Hearing. In cases of Deemed Exhaustion, Contractor must not request a dismissal of the State Hearing based on a failure to exhaust Contractor's internal Appeal process; or

c) If Contractor fails to provide Appeal notices required in 42 CFR section 438.408 to a Member with a visual impairment, in the Member's selected alternative format and within the applicable federal or State timeframes, the Member is deemed to have exhausted Contractor's internal Appeal process and may immediately request a State Hearing. In such cases, Contractor is prohibited from requesting dismissal of a State Hearing on the basis of failure to exhaust Contractor's internal Appeal process.

2) Upon request from the Member, Contractor must assist the Member with preparing for the State Hearing by providing the Member or their AR with the Member's case file, including Medical Records, other documents and records, guidelines, clinical criteria, and any new or additional evidence that Contractor relied on for its

initial denial and anything Contractor considered during its internal Appeal process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.

3) Contractor must provide its statement of position for the State Hearing to the Member and to the California Department of Social Services at least two Working Days before the State Hearing.

4) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the State Hearing by ensuring that the employee is available and prepared to present Contractor's position and be subject to cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and *Goldberg v. Kelly* (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the State Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that a statement of position is timely filed with the California Department of Social Services and provided to the Member not less than two Working Days before the hearing as required by W&I section 10952.5.

5) In cases where the State Hearing decision overturns Contractor's decision, Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date Contractor receives notice that the State Hearing decision reversed Contractor's decision.

6) Contractor must pay for disputed services if the Member received the disputed services while the State Hearing was pending.

7) The parties to a State Hearing must include Contractor as well as the Member, their AR, or the representative of a deceased Member's estate.

8) Contractor must notify Members that the State must make a decision for a State Hearing within 90 calendar days of the date of the State Hearing request. For an expedited State Hearing, DHCS will take final administrative action as expeditiously as the individual's health condition requires, but no later than three Working Days after Contractor provides DHCS with the case file

and information supporting its Appeal of an ABD pursuant to W&I section 10951.5. Contractor must also comply with all other requirements as required by 42 CFR sections 438.410 and 438.404(a), W&I section 14029.91(e), 22 CCR sections 53876 and 53895, and APL 21-011.

B. Contractor's Obligations for Expedited State Hearings

1) Within two Working Days of being notified by DHCS or the California Department of Social Services that a Member has filed a request for State Hearing which meets the criteria for expedited resolution, Contractor must deliver directly to the designated/appropriate California Department of Social Services administrative law judge all information and documents which either support, or which Contractor considered in connection with, the action which is the subject of the expedited State Hearing. This includes, but is not limited to, copies of the relevant Treatment Authorization Request (TAR) and NOA, plus any pertinent NAR and all documents Contractor relied on for its denial, including clinical criteria and guidelines. If the NOA or NARs are not in English, Contractor must transmit fully translated copies to the California Department of Social Services along with copies of the original NOA and NARs.

2) Contractor must ensure that an employee familiar with the facts of the case and Contractor's basis for upholding its ABD is available to actively participate in the expedited State Hearing by ensuring that the employee is available and prepared to present Contractor's position during cross examination at the State Hearing as required by 42 CFR sections 431.205 and 431.242 and *Goldberg v. Kelly* (1970) 397 US 254. Contractor must ensure that it provides accurate contact information for its State Hearing representative to ensure an appearance at the Hearing via telephone or in person. Additionally, to ensure Member's right to due process during the State Hearing process, Contractor must ensure that its completed case file, including the statement of position, is timely filed with the California Department of Social Services as required by W&I section 10951.5(b)(1).

C. Independent Medical Review

1) If applicable to Contractor's plan model, Contractor must inform Members of the right to request an IMR of an action resulting in a Member request for an Appeal, or the outcome of an Appeal.

2) An IMR must be requested by the Member, or a Provider or AR with written authorization from the Member to act on the Member's behalf. Contractor must not require a Member to request an IMR before, or use one as a deterrent to, requesting a State Hearing.

3) IMRs must be conducted by the California Department of Managed Healthcare (DMHC) independently from either the Member or Contractor, and at no cost to the Member.

4) IMRs do not extend any of the time frames stated in this Contract for Appeals, and do not disrupt the continuation of Covered Services per 42 CFR section 438.420.

4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted

A. Contractor must automatically continue providing the disputed services to the Member while the Appeal and State Hearing are pending if all of the following conditions are met:

1) The Member filed their Appeal within the required timeframes set forth in 42 CFR section 438.420;

2) The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3) The disputed services were ordered by the Member's Provider; and

4) The period covered by the original authorization has not expired.

B. If Contractor, at the Member's request, continues or reinstates the provision of disputed services while an Appeal or State Hearing is pending, those services must continue until:

1) The Member withdraws their request for an Appeal or a State Hearing;

2) The Member fails to request a State Hearing and continuation of disputed services within ten calendar days of when the NOA was sent; or

3) The final State Hearing decision is adverse to the Member.

C. Contractor must pay for disputed services if the Member received the disputed services while the Appeal or State Hearing was pending. Contractor must ensure the Member is not billed for the continued services even if the State Hearing or IMR finds the disputed services were not Medically Necessary.

4.6.9 Grievance and Appeal Reporting and Data

A. Contractor must submit to DHCS a monthly Grievance and Appeal report for Medi-Cal Members only in the form that is required by and submitted to Department of Managed Health Care (DMHC), as set forth in 28 CCR section 1300.68(f), with additional information required by DHCS per 42 CFR section 438.416 and 22 CCR section 53858(e).

B. Contractor must comply with the requirements set forth in Exhibit A, Attachment III, Section 2.1 (*Management Information System*) of this Contract for the reporting of Grievance and Appeal data.

C. Contractor must maintain records of Grievances and Appeals and must have policies and procedures in place governing the review of the information as part of its ongoing QIS. Contractor must identify systemic patterns of wrongful denials and impose Corrective Action as necessary. The records must be accurately maintained in a manner accessible to the State and available to CMS upon request. Records must include all required information set forth in 42 CFR section 438.416(b). Contractor must ensure that all documents and records, whether in a written or electronic format, generated or obtained by Contractor in the course of responding to ABDs, Grievances, Appeals, and IMRs are retained for at least 10 years pursuant to 42 CFR section 438.3(u).

Exhibit A, ATTACHMENT III

5.0 Services – Scope and Delivery

DHCS has a longstanding commitment to ensure Members have access to high-quality services. The provisions in this Article lay out DHCS expectations of Contractor for promoting access to medical, behavioral, and social services; increasing integration and collaboration across delivery systems and with local partners; and ultimately improving health outcomes.

Through the provisions in this Article, several key goals of California Advancing and Innovating Medi-Cal (CalAIM) are addressed. For example, Contractor must manage the health care needs of the Member over time through a comprehensive array of person-centered health and social services spanning all levels of intensity of care, from birth to dignified end of life. This Article also includes provisions related to Advance Directives and ensuring that Contractor informs Members of what an Advance Directive is and how to put a valid one in place. This Article contains key provisions related to information Members must receive to help them navigate the health care system including information that must be included in the Member Handbook and Provider Directory.

This Article also addresses access to evidence-based Behavioral Health care, with a focus on integration with physician health and earlier identification and engagement in treatment for Children, youth, and adults. Provisions included here also implement No Wrong Door policies and outline expectations that Contractor ensure Members receive timely mental health services without delay—regardless of the delivery system where they seek care. Contractors are expected to ensure Members maintain treatment relationships with trusted Providers without interruption, to the extent feasible.

This Article lays out expectations for services and access to community-based Providers that provide social support including Dyadic Care Services, Doula services, and Community Health Workers. The intent for enabling access to these provider types is to improve health outcomes by meeting the Behavioral Health (including emotional health and wellbeing), and physical health needs of culturally diverse populations.

DHCS recognizes the importance of coordination and collaboration with other local partners in order to meet the needs of the whole person. Accordingly, DHCS sets forth requirements for Contractor to engage with local entities to promote Member needs for not only Medically Necessary health care services but also any supportive services as needed to treat the whole person. This entails partnerships with Local Health Departments, Local Educational and Government Agencies, and other local programs and services including social

services, Child welfare departments, and justice departments. This Article also establishes oversight of Memorandum of Understanding (MOU) requirements and requires referrals to ensure Member care is coordinated and community-based resources, including Community Supports, are availed. Beyond the MOU requirements, DHCS seeks to embed the whole person care approach within its Population Health Management (PHM) strategy and requires the same of Contractor. As such, this Article includes provisions requiring Contractor engagement with community representatives of diverse cultural and ethnic backgrounds to develop its PHM strategies.

To empower Members to become active participants in their care, DHCS has enhanced existing processes and created new channels for engagement for Members, families, and the community. Historically, Medi-Cal managed care plans are required to maintain a Community Advisory Committee (CAC), which serves to inform Contractor's Cultural and Linguistic services program. DHCS seeks to elevate the CAC by clarifying its role and member composition and prescribing Contractor's role in providing support for CAC members in order to maximize participation and involvement.

Exhibit A, ATTACHMENT III

5.1 Member Services

5.1.1 Member Rights and Responsibilities
5.1.2 Member Services Staff
5.1.3 Member Information
5.1.4 Primary Care Provider Selection
5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests

5.1 Member Services

5.1.1 Member Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor must develop, implement, and maintain written policies and procedures that set forth the Member's rights and responsibilities and must communicate its policies to its Members, Providers, and, upon request, Potential Members.

1) Contractor's written policies and procedures must include the following Member rights:

a) To be treated with respect, giving due consideration to the Member’s right to privacy and the need to maintain confidentiality of the Member’s Protected Health Information (PHI) and private information.

b) To be provided with information about Contractor’s organization and all services available to Members.

c) To be able to choose their Primary Care Provider (PCP) within Contractor's Network unless the PCP is unavailable or is not accepting new patients.

d) To participate in decision-making regarding their health care, including the right to refuse treatment.

e) To submit Grievances, either verbally or in writing, about Contractor, Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination (ABD).

f) To request an Appeal of an ABD within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and request how to continue benefits during the in-plan Appeal process through the State Hearing, when applicable.

g) To request a State Hearing, including information on the circumstances under which an expedited State Hearing is available.

h) To receive interpretation services and written translation of critical informing materials in their preferred Threshold Language, including oral interpretation and American Sign Language.

i) To have a valid Advance Directive in place, and an explanation to Members of what an Advance Directive is.

j) To have access to family planning services and Sexually Transmitted Disease (STD) services, from a Provider of their choice, without referral or Prior Authorization, either in or outside of Contractor's Network. To have Emergency Services provided in or outside of Contractor's Network, as required pursuant to federal law.

k) To have access to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Indian Health Care Providers (IHCP) outside of Contractor's Network, pursuant to federal law.

l) To have access to, and receive a copy of, their Medical Records, and request that they be amended or corrected, as specified in 45 Code of Regulations (CFR) sections 164.524 and 164.526.

m) To change Medi-Cal managed care plans upon request, if applicable.

n) To access Minor Consent Services.

o) To receive written Member informing materials in alternative formats, including Braille, large size print no smaller than 20 point font, accessible electronic format, and audio format, upon request and in accordance with 42 CFR section 438.10 and 45 CFR sections 84.52(d) and 92.102.

p) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

q) To receive information on available treatment options and alternatives, presented in a manner appropriate for the Member's condition and ability to understand available treatment options and alternatives.

r) To freely exercise these Member rights without retaliation or any adverse conduct by Contractor, Subcontractors, Downstream Subcontractors, Network Providers, or the State.

2) Contractor must provide its written policies and procedures regarding Member rights and responsibilities to its staff and all Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure that its staff, Network Providers, Subcontractors, and Downstream Subcontractors are trained and knowledgeable on Members' rights as required under Exhibit A, Attachment III, Section 3.2 (*Provider Relations*).

B. Member's Right to Confidentiality

Contractor must have policies and procedures in place to ensure Members' rights to confidentiality of PHI and Personal Information (PI) in accordance with 45 CFR parts 160 and 164, and in accordance with Civil Code section 1798 *et seq*.

1) Contractor must ensure that all Subcontractors, Downstream Subcontractors, and Network Providers have policies and procedures in place to guard against unlawful disclosure of PHI, PI, and any other Confidential Information to any unauthorized persons or entities.

2) Contractor must inform and advise Members on the right to confidentiality of their PHI and PI. Contractor must obtain the Member's prior written authorization to release Confidential Information, unless such prior written authorization is not required by 22 CCR section 51009.

C. Member's Right to Advance Directives

Contractor must have written policies and procedures to ensure Members are informed of what an Advance Directive is and how to put a valid Advance Directive in place. Contractor must have policies and procedures in place to ensure all involved in the Member's care comply with the terms of a Member's valid Advance Directive in accordance with the requirements of 42 CFR sections 422.128 and 438.3(j).

1) Contractor must ensure that its process for a Member's right to have an Advance Directive in place is included in the Member Handbook. Information in the Member Handbook must include the

Member's right to be informed by Contractor of State law regarding Advance Directives, and to receive information from Contractor regarding any changes to that law. Contractor must ensure that the following statement, or similar language provided by DHCS is included:

Advance care planning for Members enrolled in Medi-Cal palliative care in accordance with All Plan Letter (APL) 18-020, must include documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, Advance Directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.

2) Information on Advance Directives must comply with all State and federal law requirements and must be updated to reflect any changes to laws governing Advance Directives.

3) Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors are trained on complying with valid Advance Directives in accordance with 42 CFR sections 422.128 and 438.3(j).

D. Interoperability Requirements for Member Records

Contractor must implement and maintain a Patient Access Application Programming Interface (API) as specified in 42 CFR section 431.60 as if such requirements applied directly to Contractor, and as set forth in APL 22-026. The Patient Access API must also meet the technical standards in 45 CFR section 170.215. Data maintained on or after January 1, 2016, must be made available to facilitate the creation and maintenance of a Member's cumulative health record.

1) At a minimum, Contractor must permit third-party applications to retrieve, with the approval and at the direction of the Member, the following Member records:

a) Adjudicated claims data from Contractor, and from any Subcontractors, Downstream Subcontractors and Network Providers, including claims data and cost data that may be Appealed, or are in the process of Appeal, Provider remittances, and Member cost-sharing pertaining to such claims, within one (1) Working Day after a claim is

processed;

b) Encounter Data, including Encounter Data from any capitated Subcontractors, Downstream Subcontractors, and Network Providers, within one (1) Working Day after receiving the data from Providers;

c) Clinical data, including diagnoses and related codes, and laboratory test results, within one (1) Working Day after the data is received by Contractor; and

d) Information about coverage for drugs administered in an outpatient setting as part of medical services, and updates to such information, including, if applicable, Member costs and any preferred drug list information, within one (1) Working Day after the effective date of any such information or updates to such information.

2) Contractor may deny or discontinue any third-party application's connection to an API if it reasonably determines, consistent with its security risk analysis under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule set forth in 45 CFR part 160 and 45 CFR part 164, subparts A and C, that continued access presents an unacceptable level of risk to the security of PHI on its systems. The determination must be made using objective verifiable criteria that are applied fairly and consistently across all applications and developers, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.

5.1.2 Member Services Staff

A. Contractor must employ and train a sufficient number of staff knowledgeable about Contractor's policies and procedures and capable of providing information to Members or Potential Members.

B. Contractor must ensure its Member services staff are trained and educated on all contractually required services for Members including policies and procedures on the scope of services required to be offered under this Contract, how to utilize services in the Medi-Cal program, how to access carved out services, and how obtain referrals to appropriate community resources and other agencies.

C. Contractor must ensure its Member services staff are educated on assisting Members with disabilities, chronic conditions, and components of Health Equity in accordance with Exhibit A, Attachment III, Subsection 5.2.11.C. (*Cultural and Linguistic Programs and Committees*). This includes assisting Members with access barriers, disability access issues, referral to appropriate clinical services, Grievance and Appeal resolution, and State Hearings.

D. Contractor's Member services staff must refer Potential Members to the DHCS Enrollment broker when Potential Members request Enrollment with Contractor.

E. Contractor's Member services staff must refer Potential Members to their local county office for Medi-Cal eligibility determinations or redeterminations.

F. Contractor must ensure its Member services staff assist Members with a warm hand-off to Subcontractors and Downstream Subcontractors when Member services functions are delegated under a Subcontractor Agreement or Downstream Subcontractor Agreement.

5.1.3 Member Information

A. Contractor must provide all new Members, and Potential Members upon request, with information in compliance with 42 CFR section 438.10, W&I section 14406, 22 CCR section 53895, and as set forth in this provision.

B. Contractor must provide information as required in 42 CFR section 438.10, W&I section 14406, and 22 CCR section 53895 no later than seven calendar days after the effective date of a Member's Enrollment.

C. Contractor must distribute the information required by Exhibit A, Attachment III, Subsection 5.1.3 (*Member Information*), Paragraphs A-B annually, and upon a Member's request. Contractor must ensure the information is current and has prior approval for distribution from DHCS.

D. All Member Information must be in a format that is easily understood and in a font size no smaller than 12-point, in compliance with all requirements in 42 CFR sections 438.10, 438.404, and 438.408, W&I section 14029.91, and 22 CCR section 53876. Member Information is defined in this Contract and discussed in detail in APL 21-004. Member Information includes, but is not limited to, the Member Handbook (also called the Evidence of Coverage, or EOC), Provider Directory, and all mailings and notices critical to obtaining services, including form letters, Notices of

Action (NOAs), NABDs, Grievances or Appeals, welcome packets, Marketing information, preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.

E. If a Member or Potential Member requests Member Information in a format other than as printed materials, Contractor must provide the Member Information in the alternate formats, including Braille, large-size print font no smaller than 20-point, accessible electronic format, or audio format.

F. Contractor must ensure that all Member Information is provided to Members at a sixth grade reading level and approved by DHCS before distribution. Member Information must inform Members on Contractor's processes and the Member's right to make informed health decisions.

1) Contractor must submit to DHCS for review and approval their policy and process for collecting requests and disseminating materials in an alternative format when requested by Member.

2) For Members with disabilities, including visual impairment, Contractor must provide Member Information in all Threshold Languages, alternative formats as specified by DHCS and in APL 21-004 and APL 22-002 (including Braille, large-size print font no smaller than 20-point, accessible electronic format, audio compact disc (CD) format, or data CD format), and through Auxiliary Aids at no cost and upon request. Contractor must provide Member Information in a timely fashion appropriate for the format being requested and taking into consideration the special needs of Members with disabilities or Limited English Proficiency (LEP) Members.

a) Contractor must inform Members who exhibit or mention difficulty reading print communications of their right to receive Auxiliary Aids and services, including alternative formats.

b) For Members who request an electronic alternative format to receive Member Information, Contractor must inform the Member that, unless they request a password-protected format, the Member Information will be provided in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Contractor must clearly communicate to Members that they may request an encrypted electronic format with

unencrypted instructions on how the Member can access the encrypted information.

c) Contractor must accommodate the communication needs of qualified individuals with disabilities, which may include communication with the Member's Authorized Representative (AR) or someone with whom it is appropriate for Contractor to communicate, such as a Member's disabled spouse. For these qualified individuals, Contractor must facilitate alternative format requests as identified in this Paragraph, as well as requests for other Auxiliary Aids and services.

3) Contractor must establish policies and procedures to ensure Members receive all Member Information in a Threshold Language or alternative format of their choice as required by 42 CFR section 438.10, W&I section 14029.91, and Exhibit A, Attachment III, Subsection 5.2.10.B (*Access Rights*).

4) Contractor must post a DHCS-approved nondiscrimination notice. Contractor must also post a notice with language taglines in a conspicuously visible font size in English, at least the top 15 non-English languages in the State, and any other languages, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and the notice with taglines must include Contractor's toll-free and Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services, and must be posted as follows:

a) In a conspicuous place in all physical locations where Contractor interacts with the public;

b) In a location on Contractor's website that is accessible on Contractor's home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and

c) In the Member Handbook/EOC, and in all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members,

applicants, and the public at large, in accordance with APL 21-004 and APL 22-002, 42 CFR section 438.10(d)(2)-(3), and W&I section 14029.91(a)(3) and (f).

5) Contractor's nondiscrimination notice must include all information required by W&I section 14029.91(e), any additional information required by DHCS, and must provide information on how to file a Discrimination Grievance with:

a) Both Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and

b) The United States Department of Health and Human Services (U.S. DHHS) Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability, per W&I section 14029.91(e)(5).

G. Member Information Noticing in Electronic Format

1) Contractor has the option to send Members a notice in Member welcome packets or annual informational mailings to inform Members of how to obtain their Provider Directory and Member Handbook electronically or in a paper version if preferred. The notice can be an insert, flyer, or other form of noticeable communication.

a) Contractor may provide Seniors and Persons with Disabilities (SPDs) a notice in lieu of a paper Member Handbook in Member welcome packets. Contractor must still provide all SPDs with the paper form of the Provider Directory. The paper form of the Provider Directory may be a personalized, shorter version of the full-sized Provider Directory.

b) Contractor may provide their non-SPD, dual eligible Members a notice on how to access the Provider Directory

and Member Handbook electronically in lieu of a paper version in Member welcome packets.

c) Contractor may provide all Members, except SPDs, a notice in lieu of a paper Provider Directory and Member Handbook for annual informational mailings.

2) Prior to using a notice, Contractor must submit the following to DHCS for approval:

a) A written proposal on Contractor's letterhead addressed to "DHCS Contract Manager" requesting to use a notice instead of mailing the informing materials. The proposal must include the following:

i. An overview of Contractor's process for utilizing the notice and how Contractor will meet all notice requirements.

ii. An explanation of the notice's purpose, including a description of the Member population(s) who will receive the notice.

iii. Time frame for implementation.

iv. A statement that Contractor is complying with all applicable State and federal laws, the requirements of this Contract, and other DHCS guidance, including APLs and Policy Letters (PLs).

v. For Member packages only, a proposal of how Contractor will move toward creating a personalized Provider Directory, with a timeline included that covers the cycle of production to delivery of personalized Provider Directories.

vi. Any other pertinent information necessary for DHCS to review.

b) A written policy and procedure describing in detail the process Contractor will utilize for the notice and how Contractor will continue to meet all language and format requirements set forth in 42 CFR section 438.10(d)(3), Provider Directory and website requirements in accordance

with 42 CFR section 438.10(h), and sub-contractual relationship and delegation requirements set forth in 42 CFR section 438.230.

c) A sample of Contractor's proposed notice regarding electronic communications. The notice must be easily identifiable by the Member, state the purpose of each piece of Member material offered, and identify the options Members will have for receiving their Member materials.

3) The notice must be compliant with all the requirements of this Contract and DHCS policy, and federal and State statutes and regulations on Member Information, including 42 CFR sections 438.10 and 438.404, and W&I section 14029.91. DHCS will approve Contractor's notices on a case-by-case basis.

4) DHCS reserves the right to require Contractor to revert to sending printed copies of the Provider Directory and Member Handbook to its Members, at any time.

H. Provider Directory

1) Contractor must submit its complete Provider Directory to DHCS for review and approval prior to initial operations.

2) Contractor must make its Provider Directory available to all Members and to DHCS for distribution as required.

3) Contractor's Provider Directory must be available in both paper and electronic formats. Provider Directory information must be included with Contractor's written Member Information for new Members, and thereafter available upon request. An electronic Provider Directory must be posted on Contractor's website in a machine readable and accessible file and format.

4) Contractor must update and submit its paper and electronic Provider Directories to DHCS in accordance with 42 CFR section 438.10(h)(3)(i)(A)-(B). Contractor must submit under the following timelines:

a) A paper Provider Directory must be updated at least monthly, if Contractor does not have a mobile-enabled, electronic Provider Directory; or quarterly, if Contractor has a mobile-enabled, electronic Provider Directory; and

b) An electronic Provider Directory must be updated no later than one week after Contractor receives updated provider information.

5) Contractor's Provider Directory submission must include complete, accurate and updated Provider Directory and Network information and data and submit as required by 42 CFR section 438.10(h)(3). Contractor's Provider Directory must also comply with all requirements in Policy Letter (PL) 11-009. DHCS is authorized to require changes or corrections to Contractor's Provider Directory at any time.

6) Contractor must implement and maintain a publicly accessible standards-based Provider Directory API, as described in 42 CFR section 431.70 and APL 22-026, which must include the information required here in Exhibit A, Attachment III, Subsection 5.1.3.H (*Member Information*). The Provider Directory API must meet the technical standards in 45 CFR section 170.215, excluding the security protocols related to user authentication and authorization.

7) Provider Directories must comply with 42 CFR section 438.10(h) and Health and Safety Code (H&S) section 1367.27, and must include the following information for in-Network PCP, Specialists, hospitals, Enhanced Care Management (ECM), Community Support Providers, Behavioral Health Providers, and any other Providers (e.g., Community Health Workers contracted for Medi-Cal Covered Services:

a) The Provider's or site's location name and any group affiliation(s), National Provider Identifier (NPI) number, street address(es), all telephone numbers associated with the practice site, and, if applicable, website URL for each Service Location;

b) Provider's specialty type and paneling status that allows them to treat specific populations, including but not limited to, whether they are a California Children's Services (CCS) paneled provider;

c) Whether the Provider is accepting new patients;

d) Information on the Provider's affiliated medical group or Independent Physician/Provider Associations (IPA), NPI

number, address, telephone number, and, if applicable, website URL for each Physician Provider of affiliated group or IPA;

e) The hours and days when each Service Location is open, including the availability of evening or weekend hours;

f) The services and benefits available, including accessibility symbols approved by DHCS confirming whether the office/facility (exam room(s), equipment, etc.) can accommodate Members with physical disabilities as required by PL 11-009;

g) The Provider's Cultural and Linguistic capabilities, including whether non-English languages and American Sign Language are offered either by the Provider or a skilled medical interpreter at the Provider's facility;

h) The telephone number to call after normal business hours;

i) Identification of Network Providers or sites that are not available to all or new Members

j) The link to the Medi-Cal Rx Pharmacy Locator, which can be found on the dedicated Medi-Cal Rx website described in APL 22-012.

I. Member Handbook

Contractor must comply with the requirements in 22 CCR section 53895(b) by distributing a Member Handbook, also known as an Evidence of Coverage and Disclosure Form (EOC/DF) to each Member and to Potential Members, upon request. The Member Handbook must meet all requirements in 42 CFR section 438.10(g), 22 CCR section 53881, and any other requirements in State and federal law, and this Contract. In addition, the Member Handbook must meet all applicable requirements contained in 42 CFR section 438.10(d), W&I section 14029.91, 22 CCR section 53876 for Limited English Proficiency (LEP) Members and Potential Members and H&S section 1363 as to translation, print size, readability, and understandability of text.

1) Contractor must provide to each Member, or Member's family unit, a Member Handbook that constitutes a full and fair disclosure of the Member's right to obtain and Contractor's provision of all Medi-Cal

services that are available and accessible to the Member. Contractor must post its most recent Member Handbook to its website.

2) Contractor must use the DHCS template for its Member Handbook. Contractor must submit its information that is specific to Contractor, where applicable. Contractor must submit its completed Member Handbook, with all Contractor-specific information included in redline, for review and approval by DHCS before distribution to Members.

3) Contractor must make the revised Member Handbook available to Members based on the timeframes required by State and federal law and at any time DHCS, a Member, or a Potential Member requests a copy.

4) Although Contractor is required to use the DHCS Member Handbook template, Contractor remains solely responsible for ensuring that Members receive the following information through the Member Handbook:

   a) Contractor's name, address, toll-free telephone number(s) for Member services, Medi-Cal Rx telephone number(s) and website information, any other Contractor staff providing services directly to Members, and information on Contractor's Service Area;

   b) Information on how to access services in the Medi-Cal managed care system, including a description of the full amount, duration, and scope of Covered Services and how to obtain services under this Contract. The Member Information must also include information on services that require Prior Authorization and how to request it, health education and how to access appropriate community resources and other agencies, interpretive services provided by Contractor's staff and at service sites, and an explanation of "carved- out" services, including Specialty Mental Health Services, and any service limitations and exclusions from coverage or charges for services. The Member Handbook must also include information on services to which Contractor, Subcontractor, Downstream Subcontractor, or a Network Provider may have a moral objection to perform or support and alternative methods for obtaining those services;

c) Procedures for accessing Covered Services, which explain that Covered Services will be obtained through Contractor's Network Providers unless otherwise allowed under this Contract;

d) A description of the Member identification card issued by Contractor, if applicable, and an explanation of its use in authorizing or assisting Members in obtaining services;

e) Procedures for selecting or requesting a change in PCP at any time, any requirements for a Member to change their PCP, reasons for which a request for a specific PCP may be denied, and reasons why a PCP may request a change;

f) The purpose and value of scheduling and completing an Initial Health Appointment (IHA);

g) The availability and procedures for obtaining after-hours services 24 hours a day, seven days a week, including the appropriate Network Provider locations and telephone numbers to obtain services. This must include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after-hours services;

h) Definition of what constitutes an Emergency Medical Condition, Emergency Services, and post-stabilization services. The Member Handbook must expressly state that Prior Authorization is not required to receive Emergency Services and include the use of 9-1-1 for obtaining Emergency Services;

i) The right to receive Emergency Services in any hospital or other setting, and procedures for obtaining Emergency Services from specified Network Providers or from out-of-Network Providers, including Emergency Services outside of Contractor's Service Area. This includes the right to the provision of at least a 72-hour supply of Medically Necessary medication in an emergency situation is provided;

j) Process for referral to Specialists, including an explanation of the Prior Authorization process, in sufficient detail so the Member can understand how the process works, including authorization and referral timeframes and alternative access

standards as required by W&I section 14197.04, APL 23-001, and APL 21-011;

k) Procedures for obtaining Emergency Medical Transportation (EMT) and non-Emergency transportation services to service sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of medical transportation, including EMT, Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services, and how Contractor coordinates access to appropriate transportation, when needed;

l) The right to file a Grievance and request an Appeal with Contractor, and procedures for filing either orally, in writing, or over the phone. Contractor must inform Members of all Appeal and State Hearing rights when it makes a decision to deny, delay or modify a Member's request for services as set forth in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

m) Information on disenrollment from Contractor. Contractor must ensure that the following information is included:

   i. The causes for which a Member may lose eligibility to receive services under this Contract as set forth in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*), and the procedures for disenrollment due to the loss of eligibility.

   ii. An explanation of the expedited disenrollment process for Members qualifying under conditions specified under 22 CCR section 53889(j), which includes Children receiving services under the Foster Care or Adoption Assistance Programs, Members who require out-of-Network transplant services if they are unavailable in-Network, and Members already enrolled in another Medi-Cal, Medicare, or commercial managed care plan.

n) An explanation of the Member's right to disenroll at any time, and reenroll in the competing Medi-Cal managed care plan in the county (in counties where another Medi-Cal managed care plan is available), subject to the requirements in 22

CCR 53889, 22 CCR 53891(c) and any restricted disenrollment period;

o) Information on the Member's right to a Medi-Cal State Hearing, the process for obtaining a State Hearing, the timeframe to request a State Hearing, and the rules that govern representation in a State Hearing. Contractor must ensure the following information is included:

i. The circumstances under which an expedited State Hearing is possible;

ii. Information stating that Contractor will assist in completing the State Hearing request when a health care service requested by the Member or Provider has been denied, delayed, or modified, as required by APL 21-011;

iii. The timelines which govern a Member's right to a State Hearing, pursuant to W&I section 10951 and for an expedited State Hearing pursuant to W&I section 10951.5;

iv. The Department of Social Services (DSS) Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a State Hearing; and

v. Contractor's obligation to continue the disputed service(s) until there is a final decision on the State Hearing as long as if the Member requests a State Hearing in the specified timeframe(s) as required by 42 CFR section 438.420.

p) The availability of, and procedures for obtaining services at FQHCs, RHCs and IHCPs;

q) The Member's right to seek family planning services from any qualified family planning Provider in the Medi-Cal program, including out-of-Network Providers; how to access these services; that a referral is not necessary; and a description of the limitations on the services that Members may seek out-of-Network. The DHCS Office of Family Planning toll-free telephone number (1-800-942-1054) that provides consultation and referral to family planning clinics

must also be included. Contractor must ensure that the following statement, or similar language provided by DHCS, is included:

Family planning services are provided to Members of childbearing age to enable them to determine the number and spacing of Children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Providers and OB/GYN Specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name] without having to get permission from [Plan Name]. [Plan Name] will pay that doctor or clinic for the family planning services you get.

r) Procedures for providing female Members with direct access to an in-Network women's health Specialist for women's preventive and routine health care services without requiring Prior Authorization. Access to a women's health Specialist must be provided in addition to the Member's designated PCP if the PCP is not a women's health Specialist;

s) Information on the availability of, and procedures for, obtaining Certified Nurse Midwife (CNM) and Nurse Practitioner services, pursuant to Exhibit A, Attachment III, Subsection 5.2.8.G. (*Specific Requirements for Access to Programs and Covered Services*);

t) Information on how to access the DHCS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the DMHC HMO Consumer Service toll-free telephone number (1-800-400-0815) for resolution of Member concerns and complaints;

u) Information on the provision and availability of services covered under the CCS Program from out-of-Network Providers, and how to access CCS Program;

v) Information on how to obtain Minor Consent Services through Contractor's Network, an explanation of those services, and information on how Minor Consent Services

can also be obtained from out-of-Network Providers without requiring Prior Authorization;

w) Information on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for Members less than 21 years of age, and that it includes all Medically Necessary health care, diagnostic services, treatments, and other measures listed in 42 USC section 1396d(a) and (r), whether or not covered under the California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract;

x) An explanation on how to use the Medi-Cal Fee-For-Service (FFS) system when Medi-Cal services are excluded or limited under this Contract, and how to obtain additional information;

y) An explanation that an American Indian Member's status as a Member is voluntary and that an American Indian Member cannot be required to enroll in a Medi-Cal managed care plan and has the right to access IHCP, choose an IHCP within Contractor’s Network as a PCP, and disenroll from Contractor at any time, without cause;

z) Language regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor, pursuant to H&S section 7158.2. This information must be provided in the Member Handbook as well as Contractor’s newsletter and any other direct communication with Members, and must be provided the Members annually under H&S section 7158.2;

aa) Confirmation of whether Contractor offers financial bonuses or other incentives to its Network Providers. This information must inform the Member of the right to request additional information about these bonuses or incentives from Contractor, their Network Provider, or the Network Provider’s medical group or IPA, pursuant to H&S section 1367.10;

bb) Instructions on how a Member can request a copy of, or the website link to locate, Contractor’s non-proprietary clinical and administrative policies and procedures;

cc) That oral interpreter services are available for any language spoken by the Member, and that the Member can inform Contractor of their preferred language to receive written translations of Member materials in the identified Threshold Languages, both free of charge, with instruction on Contractor's obligations to ensure these services are provided;

dd) That Auxiliary Aids and services are available upon request and at no cost for Members with disabilities, and how to access these services;

ee) Information on how to report suspected Fraud, Waste and Abuse; and

ff) Information on how to request Community Supports.

J. Member Identification Card

Contractor must provide an identification card to each Member, which identifies the Member and authorizes them to access Covered Services. The card must inform the Member that they may seek Emergency Services from out-of-Network Providers. The card must inform the Member of the Medi-Cal Rx telephone number. The Member identification card must also inform the Member that Emergency Services are covered by Contractor without Prior Authorization, and at no cost to the Member.

5.1.4 Primary Care Provider Selection

A. Contractor must implement and maintain DHCS-approved procedures to ensure that each new Member who is not enrolled in comprehensive Other Health Coverage (OHC) has an appropriate and available PCP. Comprehensive OHC refers to:

1) Members with the OHC Code indicator C, H, F, K, or P as listed in the 834 file, or,

2) OHC with a scope of coverage of at least Outpatient, Inpatient, and Medical/Allied (OIM) Services found in positions 119 through 126 in the Health Insurance System Database (HISDB) file.

B. Contractor must provide each new Member an opportunity to select a PCP within the first 30 calendar days of Enrollment. Contractor must make best efforts to ensure the Member is assigned to the PCP the Member selected

at the time of their Enrollment, unless the PCP is unavailable or is not accepting new patients.

C. If the Member does not select a PCP within 30 calendar days of the effective date of Enrollment, Contractor must assign that Member to a PCP and notify the Member and the assigned PCP no later than 40 calendar days after the Member's Enrollment. Contractor must ensure that adverse selection does not occur when Members are assigned to PCPs.

1) Contractor must allow Members to select a clinic that provides Primary Care in lieu of selecting a specific PCP, where available.

2) If Contractor's Network includes NP, CNMs, obstetrician-gynecologist, or Physician Assistants, the Member may select one of these practitioners as their PCP within 30 calendar days of Enrollment to provide Primary Care services in accordance with 22 CCR section 53853(a)(4).

3) SPD Members may select a Specialist or clinic as a PCP if the Specialist or clinic agrees to serve as the Member's PCP and is qualified to treat the health conditions of the SPD Member, in accordance with W&I section 14182(b)(11).

4) Contractor must ensure that Members are allowed to change their PCP, CNP, CNM, or Physician Assistant assignment, upon request, by selecting a different PCP from Contractor's Network.

D. Contractor must inform Members through direct outreach to provide an explanation for the reason the Member could not be assigned to their selected PCP.

E. Contractor must ensure that Members who have an established relationship with a Network Provider, and who want to continue their patient-Provider relationship, are assigned to that Provider without disruption in the Member's care if the Member's existing relationship meets the requirements set forth in APL 22-032.

F. Contractor must ensure that Members can choose Traditional and Safety-Net Providers as their PCP, and that American Indian Members may choose an IHCP within Contractor's Network as their PCP.

G. Contractor is not obligated to require full benefit dual eligible Members to select a Medi-Cal PCP. Nothing in this section must be construed to

require Contractor to pay for services that would otherwise be paid for by Medicare.

H. If a Member does not select a PCP within 30 calendar days of the effective date of Enrollment, Contractor must use utilization data or other data sources in its possession or provided by DHCS to select a PCP for the Member. This includes review of electronic data to confirm existing Provider relationships for the purpose of PCP assignment, including a Specialist or clinic for an SPD if they have indicated they have a preference for either to act as their PCP. Contractor must comply with all federal and State privacy laws in the provision and use of this data.

I. Contractor must notify the PCP that a Member has selected or been assigned to the Provider within ten calendar days from the date selection or assignment is complete.

J. Contractor must maintain procedures that proportionately include contracting with Traditional and Safety-Net Providers in the assignment process for Members who do not choose a PCP. Contractors in public hospital health system counties must assign PCPs in compliance with W&I section 14199.1.

5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests

Contractor must notify Members of a decision to deny, defer, or modify requests for Prior Authorization, in accordance with 42 CFR section 438.210(c) and 22 CCR sections 51014.1 and 53894 by providing a NOA to Members and/or their AR, regarding any denial, deferral, or modification of a request for approval to provide a health care service. This notification must be provided in accordance with all requirements set forth in Exhibit A, Attachment III, Subsection 4.6.4 (*Notice of Action*).

Exhibit A, ATTACHMENT III

5.2 Network and Access to Care

5.2.1 Access to Network Providers and Covered Services
5.2.2 Network Capacity
5.2.3 Network Composition
5.2.4 Network Ratios
5.2.5 Network Adequacy Standards
5.2.6 Access to Emergency Service Providers and Emergency Services
5.2.7 Out-of-Network Access
5.2.8 Specific Requirements for Access to Programs and Covered Services
5.2.9 Network and Access Changes to Covered Services
5.2.10 Access Rights
5.2.11 Cultural and Linguistic Programs and Committees
5.2.12 Continuity of Care for Seniors and Persons with Disabilities
5.2.13 Network Reports
5.2.14 Site Review
5.2.15 Street Medicine

5.2 Network and Access to Care

5.2.1 Access to Network Providers and Covered Services

A. Primary Care

1) Contractor must ensure that each Member has an assigned Primary Care Provider (PCP) who is available and physically present at the Service Location for sufficient time to ensure access and appointments for the assigned Member when medically required. This requirement does not preclude an appropriately licensed Provider from being a substitute for the Member's assigned PCP in the event of vacation, illness, or other unforeseen circumstances.

2) Contractor must have processes in place to assist Members in selecting PCPs who are accepting new patients.

3) Contractor must consider the requirements in W&I section 14182(b)(11) when assigning Members who are Seniors and Persons with Disabilities (SPD) to a PCP. Additionally, Contractor must ensure that Members have the option of selecting an Indian Health Care Provider (IHCP), Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC), as their PCP, where available.

B. Specialists

1) Contractor must ensure that Members have access to Specialists for Medically Necessary Covered Services in accordance with W&I section 14197, 22 CCR section 53853, and 28 CCR section 1300.67.2.2.

2) Contractor must maintain an adequate Network that includes adult and pediatric Specialists, and at a minimum, the core Specialists required in W&I section 14197(h)(2), within its Network to ensure Medically Necessary specialty care is available in accordance with 22 CCR section 53853(a), and W&I sections 14182(c)(2) and 14197.

C. Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors have adequate Networks and staff within its Service Area, including Physicians, nurses, and administrative and other support staff to ensure that they have sufficient capacity to provide and

coordinate care for Covered Services are provided in accordance with W&I section 14197, 22 CCR section 53853, 28 CCR section 1300.67.2.2, and all requirements in this contract.

D. Contractor must monitor Subcontractors and Downstream Subcontractors to ensure they can adequately deliver culturally and linguistically competent care including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language.

E. Contractor must ensure that Members have access to all Non-specialty Mental Health and Substance Use Disorder (SUD) Covered Services in accordance with 42 CFR section 438.900 *et seq.* Contractor must coordinate care for all Specialty Mental Health Services (SMHS) and SUD services and provide referrals including mechanisms to track completion of follow up visits, to the county Mental Health Plan (MHP) and Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services as outlined in Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*)

5.2.2 Network Capacity

A. Contractor must maintain a Network adequate to provide the full scope of benefits to 60 percent of all Potential Members or current Member Enrollment, whichever is higher, within its Service Area. Contractor must increase the capacity of the Network as necessary to accommodate all Enrollment growth beyond the 60 percent.

B. Contractor may request to renegotiate its Network capacity requirement with DHCS if utilization by Contractor’s Members does not exceed 75 percent of the required Network capacity, after the first 12 months of operation. Any such change is subject to DHCS review and approval.

5.2.3 Network Composition

A. Contractor must maintain an adequate Network within its Service Area, in compliance with W&I section 14197, and if necessary to ensure contract compliance with Network adequacy. Contractor may offer to contract with Providers in adjoining Service Areas but must make good faith efforts to contract with Providers within Contractor’s Service Area. Contractor’s Network must include at a minimum adult and pediatric PCPs, obstetrics and gynecology (OB/GYNs), adult and pediatric Behavioral Health Providers, adult and pediatric Non-specialty outpatient Mental Health Service (NSMHS) Providers, adult and pediatric Specialists, hospitals, and

Long-Term Care (LTC) Providers to ensure adequate access to all Medically Necessary Covered Services for all Members and to meet all Network adequacy requirements.

B. Contractor must maintain an adequate Network of Allied Health Personnel, supportive paramedical personnel, public hospitals and health care systems, care navigators, caseworkers, and public health nurses, and an adequate number of accessible service sites to ensure adequate access to all Medically Necessary Covered Services for all Members.

C. Contractor must include in its Network, where available, IHCP, FQHC, RHCs, Freestanding Birthing Centers (FBC), Certified Nurse Midwives (CNMs), and Licensed Midwives (LM) in accordance with W&I section 14087.325, Medicaid State Health Official Letter #16-006, All Plan Letter (APL) 18-022, and APL 23-001.

1) If Contractor is a local initiative health plan model, it must offer to contract with all FQHCs and RHCs in its county(ies), in accordance with W&I section 14087.325. Local initiative health plans must maintain and provide supporting documentation of all contracting efforts with each FQHC and RHC in its county(ies) to DHCS upon request, even if Contractor has a minimum of one active contract with an FQHC and RHC in their county(ies).

2) If Contractor is not a local initiative health plan model, it must contract with a sufficient number of and include at least one FQHC, one RHC, and one FBC in the Network, where available in Contractor’s Service Area, to the extent that the FQHC, RHC, and FBC Providers are licensed and recognized under State law.

D. Contractor must offer to contract with all IHCP available in each county(ies) in which Contractor operates in accordance with 22 CCR section 55120. If Contractor is unable to contract with an IHCP, Contractor must allow eligible Members to obtain services from out-of-Network IHCP in accordance with 42 CFR section 438.14.

E. Contractor must make good faith efforts to contract with at least one cancer center within their Networks and subcontracted Networks, if applicable, within each county in which Contractor operates for the provision of Covered Services to any eligible Member diagnosed with complex cancer diagnosis in accordance with W&I section 14197.45.

F. Contractor must continually ensure that the composition of its Network meets the ethnic, cultural, and linguistic needs of Contractor's Members.

G. Contractor must have an adequate number of NSMHS Providers to provide Medically Necessary NSMHS based on current and anticipated utilization trends for its Members.

H. Contractor must include in its Network any traditional and Safety-Net Provider that is willing to contract under the same terms and conditions that Contractor offers to any other similar Provider in accordance with 22 CCR section 53800(b)(2)(C)(1).

I. Contractor must ensure that every LTC Provider in its Service Area that is licensed by the California Department of Public Health (CDPH) as a qualified LTC Provider is included in Contractor's Network, to the extent that the LTC Provider remains licensed, certified, operating, and is willing to enter into a Network Provider Agreement with Contractor on mutually agreeable terms and meets Contractor's Credentialing and quality standards. If Contractor determines that additional LTC Providers are necessary to meet the needs of its Members, Contractor must offer to contract or enter into a letter of agreement with any additional CDPH licensed LTC Providers in its Service Area or in adjoining Service Areas.

J. Contractor must receive a preapproval or assessment of suitability from CDPH prior to the execution of a Network Provider Agreement for LTC Providers undergoing a change of ownership. Network Provider Agreements must have a clause that LTC Providers must notify Contractor if it is undergoing a change of ownership so Contractor can obtain preapproval or assessment of suitability from CDPH.

K. Contractor must contract with a sufficient number of Community-Based Adult Services (CBAS) Providers to timely meet the needs of Members who are CBAS-eligible. Contractor must have an adequate number of CBAS Providers that are geographically located within one hour's transportation time of its CBAS-eligible Members and that are appropriate for and proficient in addressing CBAS-eligible Members' specialized health needs and acuity, communication, cultural, and language needs and preferences. Contractor must also meet expected CBAS-utilization without a waitlist. Contractor may, but is not obligated to, contract with CBAS Providers licensed as Adult Day Health Care (ADHC) and certified by California Department of Aging to provide CBAS on or after April 1, 2012.

5.2.4 Network Ratios

A. Contractor must continually comply with 22 CCR sections 53853(a)(1) - (2) and ensure that its Network meets the following full-time equivalent (FTE) Physician to Member ratios:

1) FTE PCPs that are Physicians: Member: 1:2,000

2) FTE Total Physicians: Member 1:1,200

B. Contractor must ensure that FTE non-physician medical practitioner's Member caseload does not exceed 1,000 patients in accordance with 22 CCR section 53853(a)(3).

C. Contractor must ensure compliance with 22 CCR sections 51240 and 51241, and Business and Professions Code sections 3516 and 2836.1. Contractor must ensure full-time equivalent Physician supervisor to non-physician medical practitioner ratios do not exceed the following:

1) Physician Supervisor: Nurse Practitioners (NPs) 1:4

2) Physician Supervisor: Physician Assistants 1:4

3) A Physician supervisor may not supervise more than four non-physician medical practitioners in any combination.

5.2.5 Network Adequacy Standards

A. Timely Access

1) Contractor must continuously monitor and enforce Network Providers', Subcontractors', and Downstream Subcontractors' compliance with the requirements in W&I section 14197 (d)(1)(A), 28 CCR section 1300.67.2.2, and the requirements in this Contract.

2) Contractor must develop, implement, and maintain procedures to monitor and ensure that Contractor, Network Providers, Subcontractors, and Downstream Subcontractors:

a) Comply with requirements for Members to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, Children's preventive

periodic health assessments, and adult Initial Health Appointments (IHAs) in accordance with W&I section 14197, and 28 CCR section 1300.67.2.2:

i. Urgent Care appointment for services that do not require Prior Authorization within 48 hours of a request;

ii. Urgent Care appointment for services that do require Prior Authorization within 96 hours of a request;

iii. Non-urgent appointments for Primary Care within ten business days of request;

iv. Non-urgent appointments with Specialists within 15 business days of request;

v. Non-urgent appointment with a non-physician mental health Provider within ten business days of request;

vi. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, or illness within 15 business days of request;

vii. Availability of LTC Providers for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara within five business days of request;

viii. Availability of LTC Providers for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura within seven business days of request; and

ix. Availability of LTC Providers for the following counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare,

Tuolumne, Yolo, and Yuba within 14 business days of request.

b) Offer Members appointments for Covered Services within a time frame appropriate for their health condition but no longer than the appointment timeframes set forth in 28 CCR section 1300.67.2.2, unless the Member's preference is to wait for a later appointment from a specific Network Provider. The applicable waiting time for a particular appointment may be extended if the following conditions are met:

i. The Member's Medical Record notes that waiting will not have a detrimental impact on the Member's health, as determined by the referring or treating licensed health care Provider, or by the health professional providing triage or screening services, who is acting within the scope of their practice consistent with professionally recognized standards of practice;

ii. The Provider's decision to extend the applicable waiting time is noted in the Member's Medical Record and made available to DHCS upon request; and

iii. Contractor ensures that the Member receives notice of the Provider's decision to extend the applicable waiting time with an explanation of the Member's right to file a Grievance disputing the extension.

c) Contractor must provide the appointment time standards to Network Providers, Subcontractors, and Downstream Subcontractors, and monitor appointment waiting times in Network Providers' offices pursuant to 42 CFR section 438.206, W&I section 14197, and 28 CCR section 1300.67.2.2. Contractor must also ensure that Network Providers comply with requirements for follow up on missed appointments;

d) Offer hours of operation to Members that are no less than the hours of operation offered to non-Medi Cal patients, or to Medi-Cal Fee-For-Service (FFS) beneficiaries if the Network Provider serves only Medi-Cal beneficiaries; and

e) Maintain procedures for triaging Members' telephone calls, providing telephone medical advice, and accessing telephone interpreters 24 hours a day, seven days a week.

3) During normal business hours, the waiting time for a Member to speak by telephone with Contractor's customer service representative must not exceed ten minutes.

4) Contractor must ensure its customer service representatives have knowledge and competency to assist in resolving Members' questions and concerns.

5) Contractor must have a medical director or licensed Physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to assist with access issues.

B. Time or Distance

1) Contractor must ensure that its Network Providers, Subcontractors, and Downstream Subcontractors meet the time or distance standards for adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, adult and pediatric mental outpatient health Providers, and hospitals, as required by W&I section 14197(b) and (c).

2) Contractor must either exhaust all other reasonable options for contracting with Providers, including offering to contract with Providers in adjoining Service Areas, or provide evidence to DHCS demonstrating that its delivery structure is capable of delivering the appropriate level of care and access as required by W&I section 14197 prior to submitting an Alternate Access Standard (AAS) request to DHCS.

3) If Contractor is unable to comply with the time or distance standards set forth in W&I section 14197, Contractor must submit an AAS request to DHCS for review and approval in accordance with APL 23-001 detailing how it intends to arrange for Covered Services in accordance with W&I section 14197(e)(3).

4) Contractor must publish on its website its approved AAS requests in accordance with W&I section 14197.04.

5) If Contractor has received an AAS approval from DHCS for a core Specialist, upon a Member's request, Contractor must assist the

Member in obtaining an appointment with the appropriate core Specialist in accordance with W&I section 14197.04. Contractor must either make its best effort to establish a Member-specific case agreement with an out-of-Network Provider or arrange for an appointment with a Network Provider in an adjoining Service Areas within the time or distance standards in accordance with W&I section 14197.04. If needed, Contractor must assist in arranging transportation for the Member. Contractor must not be held liable for fulfilling these requirements if either there is no core Specialist within the time or distance standards of this Contract, or the core Specialist has refused to contract in the previous 12 months.

5.2.6 Access to Emergency Service Providers and Emergency Services

A. Contractor must have within its Network, at a minimum, a designated Emergency Services facility, providing care 24 hours a day, seven days a week. This designated Emergency Services facility must have one or more Physicians and one nurse on duty in the facility at all times.

B. Contractor must ensure that Members with Emergency Medical Conditions are seen on an emergency basis and that Emergency Services are available and accessible within Contractor's Service Area seven days a week, 24 hours a day, in accordance with 42 USC sections 1395dd and 1396u-2(b)(2), 42 CFR sections 438.114 and 438.206(c)(1)(iii), and 28 CCR 1300.67(g)(1).

C. Contractor must reimburse the costs of Emergency Services without Prior Authorization pursuant to 42 USC section 1395dd, 42 CFR section 438.114, 28 CCR section 1300.67(g), and 22 CCR section 53216 and 53855.

D. Contractor must have a medical director or licensed physician acting on behalf of Contractor's medical director, who is available 24 hours a day, seven days a week to authorize Medically Necessary Post-Stabilization Care Services, to respond to hospital inquiries within 30 minutes, and to coordinate the transfer of a Member whose Emergency Medical Condition is stabilized.

E. Contractor must ensure that Members have timely access to Medically Necessary follow-up care including, but not limited to, appropriate referrals to Primary Care, Behavioral Health Services, and social services for Members who have been screened in the emergency room and do not require Emergency Services.

F. Contractor must coordinate access to Emergency Services in accordance with Contractor's DHCS-approved emergency department protocol, as required in Exhibit A, Attachment III, Section 3.2 (*Provider Relations*).

G. If Contractor delegates its Emergency Services and Post-Stabilization Care Services oversight obligations to Network Providers, Subcontractors, or Downstream Subcontractors, it must ensure a licensed physician is available seven days a week, 24 hours a day, to authorize Medically Necessary Post-Stabilization Care Services and coordinate the transfer of stabilized Members in an emergency department to an appropriate Network Provider, if necessary, as required under Health & Safety Code (H&S) section 1371.4.

5.2.7 Out-of-Network Access

A. Contractor must authorize and arrange for out-of-Network access in the following circumstances:

1) Contractor does not meet Network adequacy requirements set forth in W&I section 14197;

2) Contractor does not have an AAS approved by DHCS and fails to meet the Network adequacy standards set forth in W&I section 14197;

3) Contractor fails to comply with the requirements for timely access to appointments; or

4) Contractor must arrange for access to out-of-Network LTC when Medically Necessary for a Member in cases where Contractor does not have in-Network LTC capacity.

B. Contractor must authorize and arrange for services from out-of-Network Providers when the Provider type is unavailable within the Network but available in an adjoining county(ies). If there is no Network Provider in the adjoining county(ies), Contractor must authorize out-of-Network services to the most appropriate Provider as close to time or distance requirements as possible.

C. Contractor must provide Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) to the out-of-Network Provider, at no cost to the Member. Contractor must inform Members of their right to obtain NEMT or NMT services to access out-of-Network services in accordance with W&I section 14197.04.

D. Contractor must adequately and timely cover and reimburse Providers for out-of-Network services rendered to its Members for as long as Contractor is unable to provide these services in its Network. Contractor must ensure that the Member is not charged for services furnished out-of-Network. Contractor must also ensure that Members are not balance-billed for any service provided out-of-Network.

5.2.8 Specific Requirements for Access to Programs and Covered Services

A. Family Planning Services

1) Contractor must ensure Members have access to family planning services through any available family planning Provider regardless of whether they are in or out of the Network, without requiring Prior Authorization. Contractor must provide family planning services in a manner that ensures Members have the freedom to choose their preferred method of family planning consistent with 42 CFR section 441.20.

2) Contractor must not restrict a Member's Provider choice for family planning services covered pursuant to 42 CFR section 431.51(a)(3) and W&I section 14132.07.

3) Contractor's Member Handbook must inform Members of their right to access any qualified family planning Provider regardless of whether the Provider is in the Network and without Prior Authorization, in addition to requirements included in Exhibit A, Attachment III, Section 5.1 (*Member Services*).

4) Contractor must ensure that Members are advised of their options for all contraceptive methods to allow them to provide informed consent for their choice of contraceptive method, including sterilization, as required by 22 CCR sections 51305.1 and 51305.3. Members of childbearing age may access the following services from an out-of-Network family planning Provider to temporarily or permanently prevent or delay pregnancy:

a) Health education and counseling necessary to make informed choices and understand contraceptive methods;

b) Limited history and physical examination;

c) Laboratory tests if medically indicated as part of the decision-making process in choice of contraceptive methods, except pap smears if Contractor provides pap smears to meet the United States Preventive Services Taskforce (USPSTF) guidelines, http://www.uspreventiveservicestaskforce.org;

d) Follow-up care for complications associated with contraceptive methods provided or prescribed by the family planning Provider;

e) Provision of contraceptive pills, devices, and supplies;

f) Tubal ligation;

g) Vasectomies; and

h) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases

Contractor must ensure Members have access to Sexually Transmitted Disease (STD) services from any Network Provider or out-of-Network Provider without requiring Prior Authorization or referral. Contractor must allow Members to access out-of-Network STD services through Local Health Department (LHD) clinics, family planning clinics, or through other community STD service Providers.

C. HIV Testing and Counseling

Contractor must ensure that Members have access to confidential Human Immunodeficiency Virus (HIV) counseling and testing services from any Network Provider or out-of-Network Provider without requiring Prior Authorization.

D. Minor Consent Services

Contractor must ensure access to Minor Consent Services for Members less than 18 years of age from any Network Provider or out-of-Network Provider without requiring Prior Authorization. Contractor must ensure Members are informed of the availability of these services without Prior Authorization. Minors less than 18 years of age do not need parent, legal guardian, or Authorized Representative (AR) consent to access these services, and Contractor, Network Providers, Subcontractors, or

Downstream Subcontractors are prohibited from disclosing any information relating to Minor Consent Services without the express consent of the minor Member. Minor Consent Services include treatment for the following:

1) Sexual assault, including rape;

2) Drug or alcohol abuse for Children ages 12 and over;

3) Pregnancy;

4) Family planning;

5) STDs in Children ages 12 and over;

6) Diagnosis or treatment of infectious, contagious, or communicable diseases in minors 12 years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and

7) NSMHS for Children ages 12 and over who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924.

E. Immunizations

Members may access LHD clinics for immunizations regardless of whether the LHD is in the Network or out-of-Network, without Prior Authorization. Upon request, Contractor must provide updated information on the status of the Member's immunizations to the LHD clinic. Contractor must reimburse LHD clinics that provide immunizations to its Members after receipt of claims and supporting immunization records.

F. Indian Health Care Providers

Contractor must ensure qualified Members have timely access to IHCPs within its Network, where available, as required by 42 USC section 1396j. IHCPs, whether in the Network or out-of-Network, can provide referrals directly to Network Providers without requiring a referral from a Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). Contractor must also allow for access to an out-of-Network IHCPs without requiring a referral from a Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b).

G. Certified Nurse Midwife and Nurse Practitioner Services

1) Contractor must ensure that its Members have access to CNM services as required by 42 USC section 1396d(a)(17) and 22 CCR section 51345.

2) Contractor must ensure its Members have access to Nurse Practitioner (NP) services as required in 22 CCR section 51345.1.

3) Contractor must inform its Members that they have a right to obtain out-of-Network CNM services if CNM services are not available in-Network.

H. Services to Which Network Provider, Subcontractor, or Downstream Subcontractor Has a Moral Objection

1) If a Network Provider, Subcontractor, or Downstream Subcontractor has religious or ethical objections to perform or otherwise support the provision of Covered Services, Contractor must timely arrange for, coordinate, and ensure the Member receives the Covered Services through referrals to a Provider that has no religious or ethical objection to performing the requested service or procedure, at no additional expense to DHCS or the Member.

2) Contractor's Member Handbook must identify services to which a Network Provider, Subcontractor, or Downstream Subcontractor may have a moral objection and explain that the Member has a right to obtain such services from another Provider. Contractor must also inform the Member that it will assist the Member in locating a Network Provider who will perform the service or procedure.

I. Federally Qualified Health Center, RHC, and Freestanding Birthing Center Services

Contractor must meet federal requirements for access to a, RHC, and FBC services consistent with 42 USC section 1396b(m) and Medicaid State Health Official Letter #16-006.

J. Community Based Adult Services

Contractor must provide Members with access to CBAS as set forth in the California Advancing and Innovating Medi-Cal (CalAIM) Special Terms and Conditions (STC), or as set forth in any subsequent demonstration

amendment or renewal, or successor demonstration, waiver, or other Medicaid authority. Without limitation, Contractor must do the following:

1) Provide and coordinate the provision of unbundled CBAS services for affected CBAS recipients as needed for continuity of care if there is a 5 percent reduction in CBAS Provider capacity in a county within the Service Area relative to the capacity that existed on April 1, 2012; and

2) Arrange Medically Necessary Covered Services for Members with similar clinical conditions as CBAS recipients if there is insufficient CBAS Provider capacity in a county in which ADHC was available prior to April 1, 2012, and coordinate their access to community resources to assist them to remain in the community.

5.2.9 Network and Access Changes to Covered Services

A. DHCS Notification Requirements

1) Contractor must provide notification to DHCS immediately upon discovery of a Network Provider initiated termination or at least 60 calendar days before any change occurs in the availability or location of services Contractor's Covered Services. Contractor must provide this notice if the change impacts more than 2,000 Members or impacts Contractor's ability to meet Network adequacy standards in accordance with APL 21-003. In the event of an emergency or other unforeseeable circumstance, Contractor must notify DHCS of the change in the availability or location of services as expeditiously as possible.

2) Contractor must provide notification to DHCS immediately, or within 10 calendar days of learning of a Provider's exclusionary status from any database or list included in APL 21-003.

3) Contractor must notify DHCS when it is unable to contract with a certified CBAS Provider or upon termination of a CBAS Network Provider Agreement. If Contractor and the CBAS Provider cannot come to an agreement on terms, Contractor must notify DHCS within five Working Days of Contractor's decision to exclude the CBAS Provider from its Network. DHCS may attempt to resolve the contracting issue when appropriate.

4) In accordance with APL 21-003, Contractor must notify DHCS within 60 calendar days of termination of a LTC Network Provider

or immediately if the termination is a result of the LTC Network Provider having been decertified by CDPH. DHCS will attempt to resolve the contracting issue when appropriate. If termination of a LTC Network Provider Agreement is for a cause related to Quality of Care or patient safety concerns, Contactor may expedite termination of the LTC Network Provider Agreement and transfer Members to an appropriate, contracted LTC Provider in an expeditious manner. DHCS must be notified of the termination within 72 hours of said termination. Contractor must not continue to assign or refer Members to a LTC Network Provider during the 60 calendar days between notifying DHCS and the termination effective date.

B. Member Notification Requirements

1) Contractor must ensure Members are notified in writing of any changes in the availability or location of Covered Services, of any termination of a Network Provider, Subcontractor, or Downstream Subcontractor either 30 calendar days prior to the effective date of the contract termination or at least 15 calendar days after receipt of issuance of the termination notice, whichever is longer, unless directed by DHCS. The notification must be provided to each Member who received Primary Care from, or was seen on a regular basis by, the terminated Provider. This notification must also be submitted to DHCS in writing for approval before its release.

2) Contractor must obtain DHCS approval before sending a notice of termination to its Members no later than 60 calendar days prior to the effective date of the termination. Contractor may use a member notice template previously approved by DHCS. Any changes from the approved template must be submitted to DHCS 60 calendar days prior to the effective date of the termination for review and approval before mailing the notice. In the event of an emergency or other unforeseeable circumstance, Contractor must provide notice of the emergency or other unforeseeable circumstance to DHCS as soon as possible.

5.2.10 Access Rights

A. Equal Access for Linguistic Services

Contractor must ensure equal access to the provision of high quality interpreter and linguistic services for Limited English Proficient (LEP) Members and Potential Members, and for Members and Potential

Members with disabilities, in compliance with federal and State law, and APL 21-004.

B. Linguistic Services

1) Contractor must comply with W&I section 14029.91 and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Members receive 24-hour interpreter services at all key points of contact, as defined in Paragraph B.4 of this provision, either through interpreters, telephone language services, or other legally compliant electronic options.

2) Contractor must ensure that any lack of interpreter services does not impede or delay a Member's timely access to care.

3) Contractor must comply with Title VI of the Civil Rights Act of 1964 and 42 CFR section 438.10(d) and have the capacity to provide, at minimum, the following linguistic services at no cost to Members or Potential Members:

a) Oral interpreters, sign language Providers, or bilingual Network Providers, Network Provider staff, Subcontractors, and Downstream Subcontractors at all key points of contact. These services must be provided in all languages spoken by Medi-Cal Members and Potential Members and not limited to those that speak the threshold or concentration standards languages.

b) Full and immediate translation of written materials pursuant to 42 CFR sections 438.10(d)(3), 438.404(a), and 438.408(d); W&I section 14029.91; and 22 CCR section 53876 for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages, fully translated Member Information, including: the Member Handbook, Provider Directory, welcome packets, Marketing information, Member rights information, form letters and individual notices, including Notice of Action (NOA) letters, all notices related to Grievances and Appeals including Grievance and Appeal acknowledgement and resolution letters, and any other materials as required by Title VI of the Civil Rights Act of 1964 and APL 21-004;

c) Referrals to culturally and linguistically appropriate community service programs; and

d) Auxiliary Aids such as Telephone Typewriters (TTY)/ Telecommunication Devices for the Deaf (TDD), qualified interpreters including American Sign Language interpreters, and information in alternative formats including Braille, large print text (20-point font or larger), audio, and electronic formats, in accordance with written informing materials in alternative formats, selected by the Member, as specified in APL 21-004 and APL 22-002.

4) Key points of contact include:

a) Medical care settings, such as telephone, advice and Urgent Care transactions, and outpatient Encounters with Providers; and

b) Non-medical care settings, such as Member services, orientations, and appointment scheduling.

C. Access for Persons with Disabilities

Contractor must comply with the requirements of Titles II and III of the Americans with Disabilities Act of 1990 (42 USC sections 12131 et seq. and 12181 et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), California Government Code (GC) sections 7405 and 11135, and all applicable implementing regulations, and must ensure access for people with disabilities including, without limitation, accessible web and electronic content, ramps, elevators, accessible restrooms, designated parking spaces, and accessible drinking water.

5.2.11 Cultural and Linguistic Programs and Committees

A. Cultural and Linguistic Program

1) Contractor must develop and implement policies and procedures for assessing the performance of its employees, contracted staff, and other individuals who provide linguistic services, addressing any identified gaps in the provision of Cultural and Linguistic (C&L) services by Contractor's staff, and for overall monitoring and evaluation of its C&L services programs.

2) Contractor must have in place and continually monitor, improve, and evaluate C&L services that support the delivery of Covered Services to Members. Contractor must ensure it has proper policies and procedures in place to provide appropriate C&L services for all of its Members.

3) Contractor must take immediate action to improve the delivery of culturally and linguistically appropriate services when deficiencies are noted.

4) Contractor must be active in recruiting and retaining C&L competent Providers that reflect the needs of the Medi-Cal population in Contractor's Service Area.

5) Contractor must have a C&L services program, as required by 22 CCR section 53876, that incorporates all requirements of applicable federal and State law, including without limitation those requirements cited in Exhibit A, Attachment III, Subsection 5.2.10 (*Access Rights*), 42 CFR section 438.206(c)(2), 22 CCR sections 51202.5 and 51309.5(a), and 28 CCR sections 1300.67.04(c)(2)(A) - (B) and 1300.67.04(c)(2)(G)(v) - (c)(4). Contractor must ensure immediate translation of all critical Member Information as required by 42 CFR sections 438.10, 438.404(a), and 438.408(d), and W&I section 14029.91.

6) Contractor must review and update its C&L services programs to align with the Population Needs Assessment (PNA). Contractor must ensure its Network Providers, Subcontractors, and Downstream Subcontractors cultural and Health Equity linguistic services programs also align with the PNA.

7) Contractor must implement and maintain a written description of its C&L services program which must include, at a minimum, the following:

   a) Its organizational commitment to deliver culturally and linguistically appropriate health care services;

   b) Services that comply with Title VI of the Civil Rights Act of 1964 (42 USC section 2000e et seq.), section 1557 of the Affordable Care Act of 2010 (42 USC section 18116), 42 CFR section 438.10, APL 21-004, and Exhibit A, Attachment III, Subsection 5.2.10 (*Access Rights*).

c) Use of national standards for culturally and linguistically appropriate services for reference;

d) An organizational chart showing the key staff with overall responsibility for C&L services programs;

e) A narrative explaining the organizational chart and describing the oversight and direction to the Community Advisory Committee (CAC), requirements for Contractor's support staff, and reporting relationships. Qualifications of Contractor's staff, including appropriate education, experience, and training must also be included;

f) The role of the PNA to inform Contractor's C&L services program priorities are in compliance with Exhibit A, Attachment III, Subsection 4.3.2 (*Population Needs Assessment*);

g) The implementation and maintenance of annual sensitivity, diversity, communication skills, Health Equity, and cultural competency/humility training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical), as determined by Section C of this provision, Diversity, Equity, and Inclusion Training; and

h) Contractor's administrative oversight and compliance monitoring of the C&L services program and requirements for the delivery of culturally and linguistically appropriate health care services.

B. Linguistic Capability of Employees and Contracted Staff

Contractor must assess and track the linguistic capability of its interpreters or bilingual staff and contracted staff (clinical and non-clinical). Contractor must implement a system to provide adequate training regarding its language assistance programs to all employees and contracted staff who have routine contact with LEP Members or Potential Members and systematically address any identified gaps in Contractor's ability to address Members' C&L needs. The training must include instruction on:

1) Contractor's policies and procedures for language assistance;

2) How to work effectively with LEP Members and Potential Members;

3) How to work effectively with interpreters in person and through video, telephone, and other media; and,

4) Understanding the cultural diversity of Members and Potential Members, and sensitivity to cultural differences relevant to delivery of health care interpretation services, in accordance with Exhibit A, Attachment III, Subsection 5.2.11 (*Cultural and Linguistic Programs and Committees*).

C. Diversity, Equity, and Inclusion Training

Contractor must provide annual sensitivity, diversity, cultural competency/humility and Health Equity training for its employees and contracted staff as detailed in APL 23-025. Training must consider structural and institutional racism and Health Inequities and their impact on Members, staff, Network Providers, Subcontractors, and Downstream Subcontractors. Contractor must ensure Network Providers and Allied Health Personnel receive pertinent information regarding the PNA findings and the identified targeted strategies. Contractor must use the most appropriate communication method(s) to assure the information can be accessed and understood. The training must include the following requirements:

1) Promote access and delivery of services in a culturally competent manner to all Members and Potential Members, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code section 422.56; and

2) Information about the Health Inequities and identified cultural groups in Contractor's Service Area which includes, but is not limited to: the groups' beliefs about illness and health; need for gender affirming care; methods of interacting with Providers and the health care structure; traditional home remedies that may impact what the Provider recommends to treat the patient; and language and literacy needs.

D. Community Engagement

Contractor must develop a policy and procedure for a Member and family engagement strategy that involves Members and their families as partners

in the delivery of Covered Services. This includes, but is not limited to the following:

1) Maintaining an organizational leadership commitment to engaging with Members and their families in the delivery of care;

2) Routinely engaging with Members and families through focus groups, listening sessions, surveys and/or interviews and incorporating results into policies and decision-making, as described in Exhibit A, Attachment III, Subsection 2.2.7.A (*Quality Improvement and Health Equity Annual Plan*);

3) Developing processes and accountability for incorporating Member and family input into policies and decision-making;

4) Developing processes to measures and/or monitor the impact of Member and family input into policies and decision-making;

5) Developing processes to share with Members and families how their input impacts policies and decision-making;

6) Conducting consumer surveys and incorporating results in Quality Improvement (QI) and Health Equity activities as described in Exhibit A, Attachment III, Subsection 2.2.9.C (*Consumer Satisfaction Survey*);

7) Partnering with community based organizations to cultivate Member and family engagement;

8) Maintaining a CAC whose composition reflects Contractor's Member population and whose input is actively utilized in policies and decision-making by Contractor, as outlined below in Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees*).

E. Community Advisory Committee (CAC)

1) Contractor must have a diverse CAC pursuant to 22 CCR section 53876(c), comprised primarily of Contractor's Members, as part of Contractor's implementation and maintenance of Member and community engagement with stakeholders, community advocates, traditional and Safety-Net Providers, and Members.

2) CAC Membership

a) Contractor must convene a CAC selection committee tasked with selecting the members of the CAC. Contractor must demonstrate a good faith effort to ensure that the CAC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAC:

   i. Persons who sit on Contractor's Governing Board, which should include representation in the following areas: Safety Net Providers including FQHCs, Behavioral Health Providers, Regional Centers (RC), Local Education Agencies (LEAs), dental Providers, IHCPs, and Home and Community-Based Service (HCBS) program Providers; and

   ii. Persons and community-based organizations who are representatives of each county within Contractor's Service Area adjusting for changes in membership diversity.

b) The CAC selection committee must ensure the CAC membership reflects the general Medi-Cal Member population in Contractor's Service Area, including representatives from IHCPs, and adolescents and/or parents and/or caregivers of Children, including foster youth, as appropriate and be modified as the population changes to ensure that Contractor's community is represented and engaged. The CAC selection committee must make good faith efforts to include representatives from diverse and hard-to-reach populations on the CAC, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

c) Contractor's CAC selection committee must select all of its CAC members promptly no later than 180 calendar days from the effective date of this contract.

d) Should a CAC member resign, is asked to resign, or is otherwise unable to serve on the CAC, Contractor must make its best effort to promptly replace the vacant seat within 60 calendar days of the CAC vacancy.

e) Contractor must designate a CAC coordinator and maintain a written job description detailing the CAC coordinator's responsibilities, which must include having responsibility for managing the operations of the CAC in compliance with all statutory, rule, and contract requirements, including, but not limited to:

i. Ensuring CAC meetings are scheduled and committee agendas are developed with the input of CAC members;

ii. Maintaining CAC membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CAC;

iii. Actively facilitating communications and connections between the CAC and Contractor leadership, including ensuring CAC members are informed of Contractor decisions relevant to the work of the CAC;

iv. Ensuring that CAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP Members to effectively communicate and participate in CAC meetings;

v. Ensuring compliance with all CAC reporting and public posting requirements; and

vi. The CAC coordinator may be an employee of Contractor, Subcontractor, or Downstream Subcontractor. Contractor's CAC coordinator must not be a member of the CAC or a Member enrolled with Contractor.

3) CAC Meetings

a) Contractor must hold its first regular CAC meeting promptly after all initial CAC members have been selected by the CAC selection committee and quarterly thereafter.

b) Contractor must make the regularly scheduled CAC meetings open to the public, posting meeting information publicly on Contractor's website in a centralized location 30 calendar days prior to the meeting, and in no event later than 72 hours prior to the meeting.

c) Contractor must provide a location for CAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings.

d) CAC must draft written minutes of each of its meetings and the associated discussions. All minutes must be posted on Contractor's website and submitted to DHCS no later than 45 calendar days after each meeting. Contractor must retain the minutes for no less than ten years and provide to DHCS, upon request.

e) Contractor must ensure that CAC members are supported in their roles on the CAC, including, but not limited to, providing resources to educate CAC members to ensure they are able to effectively participate in CAC meetings, providing transportation to CAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest CAC member participation possible.

f) Contractor must demonstrate that CAC input is considered in annual reviews and updates to relevant policies and procedures, including CAC input pursuant to Exhibit A, Attachment III, Subsection 5.2.11.E. (*Cultural and Linguistic Programs and Committees)* that is relevant to policies and procedures affecting quality and Health Equity. Contractor must provide a feedback loop to inform CAC members how their input has been incorporated.

4) Duties of the CAC

The CAC must carry out the duties as set forth in this Contract. Such duties include, but are not limited to:

a) Identifying and advocating for Preventive Care practices to be utilized by Contractor;

b) Contractor must ensure that the CAC is included and involved in developing and updating C&L policy and procedure decisions including those related to QI, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. The CAC may also advise on necessary Member or Provider targeted services, programs, and trainings;

c) The CAC must provide and make recommendations to Contractor regarding the cultural appropriateness of communications, partnerships, and services;

d) The CAC must review PNA findings and have a process to discuss improvement opportunities with an emphasis on Health Equity and Social Drivers of Health (SDOH). Contractor must allow its CAC to provide input on selecting targeted health education, C&L, and QI strategies;

e) Contractor must provide sufficient resources for the CAC to support the required CAC activities outlined above, including supporting the CAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys; and

f) The CAC must provide input and advice, including, but not limited to, the following:

i. Culturally appropriate service or program design;

ii. Priorities for health education and outreach program;

iii. Member satisfaction survey results;

iv. Findings of the PNA;

v. Plan Marketing Materials and campaigns.

vi. Communication of needs for Network development and assessment;

vii. Community resources and information;

viii. Population Health Management (PHM);

ix. Quality;

x. Health Delivery Systems Reforms to improve health outcomes;

xi. Carved Out Services;

xii. Coordination of Care; and

xiii. Health Equity;

xiv. Accessibility of Services

5) Contractor's Annual CAC Demographic Report

a) To ensure Contractor's CAC membership is representative of the Communities in Contractor's Service Area, Contractor must complete and submit to DHCS annually an Annual CAC Member Demographic Report by April 1 of each year. The Annual CAC Member Demographic Report must include descriptions of all of the following:

i. The demographic composition of CAC membership;

ii. How Contractor defines the demographics and diversity of its Members and Potential Members within Contractor's Service Area;

iii. The data sources relied upon by Contractor to validate that its CAC membership aligns with Contractor's Member demographics;

iv. Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within Contractor's Service Area;

v. Ongoing, updated, and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within Contractor's Service Area; and

vi. A description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, C&L services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Contractor initiatives and/or policies.

5.2.12 Continuity of Care for Seniors and Persons with Disabilities

A. For newly enrolled Seniors and Persons with Disabilities (SPD) who request continuity of care, Contractor must provide continued access for up to 12 months to an out-of-Network Provider with whom the SPD Member has an ongoing relationship, as long as Contractor has no Quality of Care issues with the Provider and the Provider will accept either Contractor's or the Medi-Cal FFS Rates, whichever is higher, pursuant to W&I section 14182(b)(13) - (14). Contractor must use Medi-Cal FFS utilization data from DHCS to confirm that the SPD Member has an ongoing relationship with the Provider.

B. Contractor must allow all Members to request continuity of care in accordance with 42 CFR section 438.62 and APL 22-032.

C. Contractor must provide for the completion of Covered Services at the request of a Member in accordance with H&S section 1373.96. All Members with pre-existing Provider relationships who make a continuity of care request must be given the option to continue treatment for up to 12 months with an out-of-Network Provider, if the following criteria are met:

1) The Member has seen the out-of-Network Provider at least once within the 12 months before Enrollment with Contractor;

2) The out-of-Network Provider accepts Contractor's rate offered in accordance with H&S section 1373.96(d)(2) or (e)(2); and

3) The out-of-Network Provider meets Contractor's applicable professional standards and has no disqualifying Quality of Care issues.

D. Contractor must conduct Person-Centered Planning for SPD Members as follows:

1) Upon the Enrollment of a SPD Member, Contractor must provide, or ensure the provision of, Person-Centered Planning and

treatment approaches that are collaborative and responsive to the SPD Member's continuing health care needs.

2) Contractor must include identifying each SPD Member's preferences and choices regarding treatments and services, and abilities.

3) Contractor must allow or ensure the participation of the SPD Member, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services.

4) Contractor must ensure that SPD Members receive all necessary information regarding treatment and services so that they may make an informed choice.

5) Complex Case Management services for SPD Members must include the concepts of Person-Centered Planning.

E. Contractor must ensure the provision of Discharge Planning when a SPD Member is admitted to a hospital or institution and continuation into the post-discharge period. Discharge Planning must include ensuring that necessary care, services, and supports are in place in the community for the SPD Member once they are discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the SPD Member and/or caregiver. The minimum criteria for a Discharge Planning checklist must include:

1) Documentation of pre-admission status, including living arrangements, physical and mental function, social support, Durable Medical Equipment (DME), and other services received.

2) Documentation of pre-discharge factors, including an understanding of the medical condition by the SPD Member or an AR of the SPD Member as applicable, physical and mental function, financial resources, and social supports.

3) Services needed after discharge, the type of placement preferred by the SPD Member or their AR and hospital/institution, type of placement agreed to by the SPD Member or their AR, the specific agency or home recommended by the hospital, the specific agency or home agreed to by the SPD Member or their AR, and the pre-discharge counseling that is recommended.

4) Summary of the nature and outcome of the SPD Member's, or their AR's, involvement in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital or institution.

5.2.13 Network Reports

A. Network Certification Report

1) Contractor must submit its Network certification report to DHCS. The report must demonstrate Contractor's capacity to serve the current and expected membership for its Service Area in accordance with 42 CFR section 438.207(b), W&I section 14197(f)(1), and APL 23-001.

2) Contractor must demonstrate good faith compliance with contracting and referral requirements with certain cancer centers in accordance with W&I section 14197.45.

3) Contractor must demonstrate how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if Contractor does not meet time or distance standards for adult and pediatric PCPs and core Specialist and outpatient mental health Providers in accordance with W&I section 14197(f)(2).

4) Contractor must submit Network certification in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e). Contractor must submit its Network certification report as outlined in APL 23-001.

B. Periodic Reporting Requirements

1) Contractor must report to DHCS any time there is a Significant Change to Contractor's Network that affects Network capacity and Contractor's ability to provide health care services, such as the following:

a) Change in Covered Services or benefits;

b) Change in geographic Service Area;

c) Change in the composition of, or the payments to, its Network Providers, Subcontractors, or Downstream Subcontractors; or

d) Enrollment of a new population.

2) Contractor must provide supporting documentation detailing any Significant Change to DHCS. DHCS will determine what information Contractor must provide after Contractor reports a Significant Change to its Network pursuant to 42 CFR section 438.207.

C. Network Change Report

1) Contractor must submit to DHCS, in a format specified by DHCS, a report summarizing changes in the Network.

2) Contractor must submit the report 30 calendar days following the end of the reporting quarter.

D. Subcontractor and Downstream Subcontractor Network Certification Report

1) Contractor must develop, implement, and maintain a process to annually certify the Network(s) of its Subcontractor(s) and Downstream Subcontractor(s) that provide Medi-Cal Covered Services for compliance with Network Ratios set forth in Exhibit A, Attachment III, Subsection 5.2.4 (*Network Ratios*), Network Adequacy Standards set forth in Subsection 5.2.5 (*Network Adequacy Standards*), and Network Composition requirements set forth in Exhibit A, Attachment III, Subsection 5.2.3 (*Network Composition*) of this Contract in accordance with APL 23-006.

2) Contractor must submit complete and accurate Network Provider Subcontractor and Downstream Subcontractor Network Provider Data to confirm its Subcontractor Network(s) is compliant with all applicable network adequacy requirements, as set forth in Exhibit A, Attachment III, Subsection 2.1.4 (*Network Provider Data Reporting*).

3) Contactor must have a process in place to impose Corrective Action and sanctions and report to DHCS when Subcontractor and Downstream Subcontractors that provide Covered Services fail to meet Network adequacy standards as set forth in APL 23-006.

Contractor must ensure all Members assigned to a Subcontractor or Downstream Subcontractor Network that is under a Corrective Action continue access to Medically Necessary Covered Services within timely access standards and applicable time or distance standards as set forth in Exhibit A, Attachment III, Subsection 5.2.5 (*Network Adequacy Standards*) by supplementing the Subcontractor or Downstream Subcontractor Network until the Corrective Action is resolved.

4) Contractor must submit Network certification in accordance with the requirements placed upon DHCS pursuant to 42 CFR section 438.66(e). Contractor must submit the results of its Subcontractor and Downstream Subcontractor Network Certification to DHCS in a format specified by DHCS and post its submitted certification on its website.

5.2.14 Site Review

A. General Requirement

1) Contractor must conduct Facility Site Reviews (FSR) and Medical Record reviews, initially and every three years, on all PCP sites in accordance with APL 22-017. Contractor must ensure that Network Providers, Subcontractors, and Downstream Subcontractors have the capacity to provide Primary Care services, appropriate Preventive Care services, and coordination and continuity of care in accordance with 42 CFR section 438.207.

2) Contractor must ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. Contractor must also conduct facility site physical accessibility reviews on PCP sites, Provider sites which serve a high volume of SPD Members, and all Provider sites including CBAS and ancillary service Providers, in accordance with Policy Letter (PL) 12-006 and W&I section 14182(b)(9).

B. Pre-Operational Site Reviews

The number of Site Reviews to be completed prior to initiating Contractor operation in a Service Area must be based upon the total number of new Primary Care sites in the Network. For more than 30 sites in the Network, a 5 percent sample size or a minimum of 30 sites, whichever is greater in number, must be reviewed six weeks prior to Contractor operation. Site

Reviews must be completed on all remaining sites within six months of Contractor operation. For 30 or fewer sites, reviews must be completed on all sites six weeks prior to Contractor operation.

C. Credentialing Site Review

A Site Review is required as part of the Credentialing process when both the facility and the Provider are added to Contractor's Network. If a Provider is added to Contractor's Network, and the Provider site has a current passing Site Review survey score, a site survey need not be repeated for Provider Credentialing or recredentialing purposes.

D. Corrective Action

Contractor must ensure that a Corrective Action plan is developed to correct cited deficiencies and that corrections are completed and verified within the established guidelines as specified in APL 22-017. PCP sites that do not correct cited deficiencies must be terminated from Contractor's Network; Contractor must assign Members to other Network Providers in accordance with APL 21-003.

E. Data Submission

Contractor must submit the Site Review data to DHCS up to quarterly, or in a manner or timeframe specified by DHCS. All data elements defined by DHCS must be included in the data submission report.

F. Continuing Oversight

Contractor must retain accountability for all Site Review activities even if this function is delegated.

G. Medical Record Documentation

1) General Requirement

Contractor must ensure the documentation of appropriate Medical Records for Members and that Medical Records are available to Providers at each Encounter in accordance with 42 USC section 1396a(w), 28 CCR section 1300.67.1(c), and APL 20-006.

2) Medical Records

Contractor must have policies and procedures for developing, implementing, and maintaining written procedures for all forms of Medical Record retention including, but not limited to:

a) For storage and filing of Medical Records including: collection, processing, maintenance, storage, retrieval, identification, and distribution;

b) To ensure that Medical Records are protected and confidential in accordance with all federal and State law;

c) For the release of information and obtaining consent for treatment; and

d) To ensure maintenance of Medical Records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

3) On-Site Medical Records

Contractor must have policies and procedures to ensure that an individual is delegated the responsibility for securing and maintaining the security of Medical Records at each site.

4) Member Medical Record

Contractor must ensure that a complete, legible Medical Record is maintained for each Member in accordance with 22 CCR section 53861, which reflects all aspects of patient care, including, but not limited to, ancillary services, and at a minimum includes:

a) Member identification on each page; personal/biographical data in the record;

b) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services in accordance with Title VI of the Civil Rights Act of 1964;

c) All entries dated with the author identified. For Member visits, all entries must include at a minimum, the documentation of subjective complaints, the objective findings, the plan for diagnosis and treatment, and follow-up care;

d) A problem list, a complete record of immunizations and health maintenance or preventive services rendered, and documentation of any outreach efforts surrounding any missed appointments;

e) Allergies and adverse reactions prominently noted;

f) All appropriate informed consent documentation, including the human sterilization consent procedures required by 22 CCR sections 51305.1 – 51305.6, if applicable;

g) Reports of Emergency Services provided (directly by the Network Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions, including any follow-up after the provision of Emergency Services or hospitalizations;

h) Consultations and referrals, including for Complex Care Management, Enhanced Care Management, and Specialists, as well as evidence of review of specialty referrals, pathology, and laboratory reports. Any abnormal results must have an explicit notation in the Medical Record, including follow-up or outreach;

i) For Medical Records of adults, documentation of whether the individual has been informed and has executed an Advance Directive, such as a durable power of attorney, for health care for Members ages 18 and over;

j) Health education behavioral assessment and referrals to health education services where appropriate; and

k) Documentation of blood lead screening, immunizations, and other preventive services provided in accordance with the Bright Futures Periodicity Schedule, the United States Preventive Services Task Force Grade A and B recommendations, the American College of Obstetrics and Gynecologists, and the Advisory Committee on Immunization Practices recommendations. Member refusal to receive blood lead screening, immunizations, or other preventive services must also be documented in the Member's Medical Record as described in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*).

5.2.15 Street Medicine

Contractor may provide medical and other Covered Services as described in APL 22-023 via a Street Medicine program for Members experiencing unsheltered homelessness through contracted Street Medicine Providers. Street Medicine Providers are Providers or entities that Contractor has determined can provide Street Medicine services to eligible Members in an effective manner consistent with Street Medicine industry protocols and practices. Street Medicine Providers may act in the role of the Member's assigned PCP, through a direct contract with Contractor, as an Enhanced Care Management (ECM) Provider, a Community Supports Provider, a referring or treating contracted Provider, or Community Health Worker as set forth in APL 22-023. This Subsection refers only to Street Medicine programs and Street Medicine Providers that Contractor may choose to offer.

A. Contracted Street Medicine Providers acting in the role of a Member's assigned PCP are licensed physician and non-physician medical practitioners (e.g., Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), NP, and CNM. For a non-physician medical practitioner (PA, NP, and CNM), Contractors must ensure compliance with State law and Contract requirements regarding physician supervision of non-physician medical practitioners. Additionally, given the unique and specialized nature of Street Medicine, a supervising Physician must be a practicing Street Medicine provider, with knowledge of, and experience in, Street Medicine clinical guidelines and protocols. Street Medicine Providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, such as Basic Population Health Management; Care Coordination and health promotion; support for Members, their families, and their ARs; referrals to Specialists, including Behavioral Health, community, and social support services, when needed; use of Health Information Technology to link services, as feasible and appropriate; and provision of primary and preventative services to assigned Members. If the Street Medicine Provider does not have the capability to provide Primary Care services on the street, the Street Medicine Provider must be affiliated with a facility that has a physical location.

B. Contractor must ensure Street Medicine Providers have the capability to, and comply with, referral and Care Coordination, administrative, billing and claim, data sharing, and reporting requirements.

C. Contractor must ensure Street Medicine Providers acting in the capacity of an ECM and/or Community Supports Providers comply with requirements as set forth in APL 21-012 and/or APL 21-017. Contractor is to ensure Street Medicine Providers receive appropriate Provider training and manuals and have adequate systems in place to adhere to such requirements.

D. Contractor must submit contractually required policies and procedures exhibiting compliance with program policy and requirements, and receive approval from DHCS, before operating a Street Medicine program.

Exhibit A, ATTACHMENT III

5.3 Scope of Services

5.3 Scope of Services

5.3.1 Covered Services

A. Contractor must provide or arrange for all Covered Services for Members, in accordance with the definition of Covered Services set forth in Exhibit A, Attachment I, Article 1.0 (*Definitions*). Contractor must ensure that Covered Services and other services required in this Contract are provided to a Member in an amount no less than what is offered to Medi-Cal beneficiaries in Medi-Cal Fee-For-Service (FFS), as defined in the most current Medi-Cal Provider Manual and consistent with current, evidence-based medical standards. Contractor has the primary responsibility to provide all Covered Services, including services that exceed the services provided by Local Education Agencies (LEAs), Regional Centers (RCs), or local governmental health programs.

B. Contractor must ensure that services provided are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the Covered Services are furnished. Contractor must not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity or utilization control for services that are not medical services (such as Community Support services), provided the services furnished are reasonably expected to achieve their purpose and are provided in a manner that reflects the Member's ongoing needs, including, but not limited to, services for chronic conditions.

C. Except as set forth in Attachment 3.1.B.1 of the California Medicaid State Plan or as otherwise authorized by W&I section 14133.23, drug benefits for Members who are eligible for drug benefits under 42 USC section 1395w-101 *et seq*. are not a Covered Service under this Contract. Contractor must comply with all applicable provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, Policy Letter (PL) 108–173, approved December 8, 2003 (117 Stat. 2066.)

D. Unless expressly excluded under this Contract, Contractor must cover any services necessary for compliance with the requirements for parity in mental health and Substance Use Disorder (SUD) benefits, and ensure that Members are given access to all mental health and SUD services in accordance with 42 CFR section 438.900 *et seq*. The types, amount, duration, and scope of these services must be consistent with the parity compliance analysis conducted by either DHCS or Contractor.

1) If Contractor provides Members with mental health or SUD services in any classification of benefits as described in 42 CFR section 438.910(b)(2), then Contractor must provide to Members those services in every classification that is listed therein and is covered by Contractor. In determining the classification in which a particular benefit belongs, Contractor must apply the same reasonable standards for medical/surgical benefits to mental health or SUD benefits.

2) Contractor must provide referrals and Care Coordination for all non-covered mental health and SUD services, as required in Exhibit A, Attachment III, Subsections 4.3.12 (*Mental Health Services*) and 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*).

E. Covered Services may be provided to Members through Telehealth, as defined in W&I section 14132.72, and as follows:

1) Contractor is responsible for ensuring that Covered Services provided via a Telehealth modality meet DHCS guidelines in outlined in the Provider Manual.

2) Contractor must oversee that Providers only provide Covered Services that can be appropriately delivered via Telehealth, and that they not provide Covered Services that would otherwise require the in-person presence of the Member for any reason, such as those that are performed in an operating room or while the Member is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices.

3) Contractor must ensure all Providers furnishing applicable Covered Services via audio-only synchronous interactions also offer those same services via video synchronous interactions.

4) Contractor must ensure all Providers furnishing services through video synchronous interactions or audio-only synchronous interactions must do one of the following:

a) Offer those same services via in-person, face-to-face contact.

b) Arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.

5) Contractor is responsible for ensuring Members are informed prior to the initial delivery of Covered Services via Telehealth about the use of Telehealth. Contractor must also ensure Providers obtain and document verbal or written consent from Members for the use of Telehealth as an acceptable mode of delivering services prior to the initial delivery of Covered Services. Consent must be documented in the Member's Medical Record and made available to DHCS upon request.

6) Contractor must communicate to Providers any periodical updates to Covered Services and Provider types and requirements that may be appropriately delivered through Telehealth.

5.3.2 Medically Necessary Services

Contractor must apply the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity for Members less than 21 years of age, as set forth in 42 USC section 1396d(r)(5) and All Plan Letter (APL) 23-005. The terms Medically Necessary, or Medical Necessity, are defined in Exhibit A, Attachment I, Article 1.0 (*Definitions*), based upon whether a Member is less than 21 years of age, or ages 21 and over.

5.3.3 Initial Health Appointment

Contractor must ensure provision of an Initial Health Appointment (IHA) in accordance with 22 CCR sections 53851(b)(1), 53910.5(a)(1), and APL 22-030. An IHA at a minimum must include: a history of the Member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the Member's Primary Care Provider (PCP) determines that the Member's Medical Record contains complete information, updated within the previous 12 months, consistent with the assessment requirements. Contractor must continue to hold Network Providers accountable for providing all preventive screenings for adults and Children as recommended by the United States Preventive Services Taskforce (USPSTF) but will no longer require all of these elements to be completed during the IHA, so long as Members receive all required screenings in a timely manner consistent with USPSTF guidelines.

A. Contractor must cover and ensure the provision of an IHA for each new Member within timelines stipulated in Exhibit A, Attachment III, Subsections 5.3.4 (*Services for Members Less Than 21 Years of Age*) and 5.3.5 (*Services for Adults*) below.

B. Contractor must ensure that a Member's completed IHA is documented in their Medical Record and that appropriate assessments from the IHA are available during subsequent health visits.

C. Contractor must make reasonable attempts to contact a Member to schedule an IHA. Contractor must document all attempts to contact a Member. Documented attempts that demonstrate Contractor's efforts to unsuccessfully contact a Member and schedule an IHA will be considered evidence in meeting this requirement. Contractor may delegate these activities, but Contractor remains ultimately responsible for all delegated functions, as outlined in Exhibit A, Attachment III, Subsection 3.1.1 (*Overview of Contractor's Duties and Obligations*).

5.3.4 Services for Members Less Than 21 Years of Age

Contractor must cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age required under the EPSDT benefit described in 42 USC section 1396d(r), W&I section 14132(v), and APL 23-005. The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments, and other services listed in 42 USC section 1396d(a), whether or not covered under the California Medicaid State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract.

A. Provision of IHA for Members Less Than 21 Years of Age

1) For Members less than 18 months of age, Contractor must ensure the provision of an IHA within 120 calendar days following the date of Enrollment or within periodicity timelines established by the Bright Futures/American Academy of Pediatrics (AAP) for ages two and younger, whichever is sooner.

2) For Members ages 18 months and older, Contractor must ensure an IHA is performed within 120 calendar days of Enrollment.

3) The IHA must provide, or arrange for provision of, all immunizations necessary to ensure that the Member is up to date for their age, Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings.

4) If the provisions of the IHA are not met, then Contractor must ensure case management and Care Coordination are working

directly with the Member to receive appropriate services to include but not limited to health screenings, immunizations, and risk assessments.

B. Children's Preventive Services

1) Contractor must provide preventive health visits for all Members less than 21 years of age at times specified by the most recent Bright Futures Periodicity Schedule and anticipatory guidance as outlined in the Bright Futures Periodicity Schedule. Contractor must provide, as part of the periodic preventive visit, all age-specific assessments and services required by Bright Futures/AAP.

2) Where a request is made for Children's preventive services by the Member, the Member's parent, legal guardian, or Authorized Representatives (ARs), or through a referral, an appointment must be made for the Member to have a visit within ten Working Days of the request, unless Member declines a visit within ten Working Days of the request and another appointment date is chosen by the Member.

3) At each non-emergency Primary Care visit with a Member less than 21 years of age, the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, must be advised of the Children's preventive services due and available from Contractor. Documentation must be entered in the Member's Medical Record which indicates the receipt of Children's preventive services in accordance with Bright Futures/AAP standards. If the services are refused, documentation must be entered in the Member's Medical Record which indicates the services were advised, and the Member's (if an emancipated minor), or the parent, legal guardian, or AR of the Member's voluntary refusal of these services.

4) All Children's preventive services, including all confidential screening and billing reports for EPSDT screening, treatment, and Care Coordination, must be reported as part of the Encounter Data submittal required in Exhibit A, Attachment III, Subsection 2.1.2 (*Encounter Data Reporting*). Contractor must ensure appropriate acquisition for missed reporting of Children's preventive services.

C. Immunizations

1) Contractor must cover vaccinations, except for vaccinations expressly excluded in DHCS guidance to Medi-Cal managed care health plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by Advisory Committee on Immunization Practices (ACIP). Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement. When practical, reasons for failed attempts should be medically coded.

2) At each non-emergency Primary Care visit with Members less than 21 years of age, the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, must be advised of the vaccinations due and available from Contractor immediately, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which indicates the vaccinations were advised, and the Member's (if an emancipated minor), or the parent, legal guardian, or AR of the Member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

3) Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area as part of the Statewide Immunization Information System. Reports must be made following the Member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting must be in accordance with all applicable State and federal laws.

4) Within 30 calendar days of Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, Contractor must develop policies and procedures for the provision and administration of the vaccine. Contractor must cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies

and procedures must be in accordance with Medi-Cal guidelines issued prior to final ACIP recommendations.

5) Contractor must provide information to all Network Providers regarding the VFC Program and is encouraged to promote and support Enrollment of applicable Network Providers in the VFC program as see appropriate.

D. Screening for Childhood Lead Poisoning

1) Contractor must cover and ensure the provision of blood lead screening tests to Members at the ages and intervals specified in 17 CCR sections 37000 – 37100, and in accordance with APL 20-016. Contractor must ensure its Network Providers follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local public health department.

   a) While requirements for appropriate follow-up activities, including referral, case management, and reporting, are set forth in the CLPPB guidelines, a Network Provider may determine that additional services that fall within the EPSDT benefit are Medically Necessary.

   b) Contractor must ensure that Members less than 21 years of age receive all Medically Necessary care as required under EPSDT.

2) Contractor must identify, at least quarterly, all Members less than six years of age with no record of receiving a required blood lead screening test. Contractor must identify the age(s) at which a required blood lead screening test was missed, including Members under the age of six, without any record of a completed blood lead screening test at each age. On a quarterly basis, Contractor must notify the Network Provider responsible for the care of an identified Member of the requirement to test the Member and provide the written or oral anticipatory guidance as required pursuant to 17 CCR section 37100. For a period of no less than ten years, Contractor must maintain records of all Members identified quarterly as having no documentation of receiving a required blood lead screening test, and provide those records to DHCS at least annually, as well as upon request.

3) If the Member, or the Member's parent, legal guardian, or AR, refuses the blood lead screening test, Contractor must ensure a signed statement of voluntary refusal by the Member (if an emancipated minor), or the parent, legal guardian, or AR of the Member, is documented in the Member's Medical Record.

4) If Contractor is unable to ensure a signed statement of voluntary refusal is documented in the Member's Medical Record because the Member, or the Member's parent, legal guardian, or AR refuses or declines to sign, or is unable to sign, such as when services are provided through a Telehealth modality, Contractor must ensure that the reason for not obtaining a signed statement of voluntary refusal is documented in the Member's Medical Record.

5) DHCS will consider unsuccessful attempts to provide the required blood lead screening tests that are documented in the Member's Medical Record in accordance with the requirements in Exhibit A, Attachment III, Subsection 5.3.4.D. (*Services for Members Less Than 21 Years of Age*) as evidence of Contractor's compliance with blood lead screening test requirements.

E. EPSDT Services

1) For Members less than 21 years of age, Contractor must comply with all requirements identified in APL 23-005. Contractor must provide, or arrange and pay for, all Medically Necessary EPSDT services, including all Medicaid services listed in 42 USC section 1396d(a), whether or not included in the California Medicaid State Plan, unless expressly excluded in this Contract. Covered Services will include, without limitation, in-home nursing provided by home health agencies or individual nurse Providers, as required by APL 20-012, Care Coordination, case management, and Targeted Case Management (TCM) services. If Members less than 21 years of age are not eligible or accepted for Medically Necessary TCM services by a RC or local government health program, per requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*), Contractor must arrange for comparable services for the Member under the EPSDT benefit in accordance with APL 23-005.

2) Contractor must arrange for any Medically Necessary diagnostic and treatment services identified at a preventive screening or other visit indicating the need for diagnosis or treatment, either directly or through referral to appropriate agencies, organizations, or

individuals, as required by 42 USC section 1396a(a)(43)(C), APL 23-005, and APL 20-012. Contractor must ensure that all Medically Necessary EPSDT services, including all Covered Services set forth in Exhibit A, Attachment III, Subsection 5.3.4.E.1) (*Services for Members Less Than 21 Years of Age*), above, as well as EPSDT services carved out of this Contract, are provided in a timely manner, as soon as possible but no later than 60 calendar days following the preventive screening or other visit identifying a need for diagnosis or treatment. Without limitation, Contractor must identify available Providers, including if necessary out-of-Network Providers and individuals eligible to enroll as Medi-Cal Providers, to ensure the timely provision of Medically Necessary EPSDT services. Contractor must provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Covered Services and pharmacy services. NMT must also be provided for services not covered under this Contract.

3) Covered Services do not include California Children's Services (CCS), pursuant to Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), or Specialty Mental Health Services (SMHS), pursuant to Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*). Contractor must ensure that the case management for Medically Necessary services authorized by CCS, county Mental Health Plans (MHPs), Drug Medi-Cal or Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans under this Subsection is equivalent to that provided by Contractor for Covered Services for Members less than 21 years of age under this Contract and must, if indicated or upon the Member's request, provide additional Care Coordination and case management services as necessary to meet the Member's medical and Behavioral Health needs.

F. Behavioral Health Treatment Services

For Members less than 21 years of age, Contractor must cover Medically Necessary Behavioral Health Treatment (BHT) services regardless of diagnosis in compliance with APL 22-006 and APL 23-010.

1) Contractor must provide Medically Necessary BHT services in accordance with a recommendation from a licensed physician, surgeon, or a licensed psychologist and must provide continuation of BHT services under continuity of care.

2) The Member's treatment plan must be reviewed, revised, and/or modified no less than every six months by a BHT service Provider. The Member's behavioral treatment plan may be modified or discontinued only if it is determined that the services are no longer Medically Necessary under the EPSDT Medical Necessity standard.

3) Contractor has primary responsibility for the provision of Medically Necessary BHT services and must coordinate with LEAs, RCs, and other entities that provide BHT services to ensure that Members timely receive all Medically Necessary BHT services, consistent with the EPSDT benefit. Contractor must provide Medically Necessary BHT services across settings, including home, school, and in the community, that are not duplicative of BHT services actively provided by another entity. Contractor must coordinate with, and make good faith attempts to enter into Memorandum of Understandings (MOUs) with RCs and LEAs, and Contractor must enter into MOUs with county MHPs in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*), to facilitate the coordination of services for Members with Developmental Disabilities, including Autism Spectrum Disorder, as permitted by federal and State law, and specified by DHCS in APL 18-009, APL 22-005, and APL 22-006. If Contractor is unable to enter into an MOU or a one-time case agreement with a RC, as required by APL 18-009, Contractor must inform DHCS why it could not reach an agreement with the RC and must demonstrate, by providing all evidence of contracting efforts, a good faith effort to enter into an agreement with the RC.

G. Local Education Agency Services

Contractor must reimburse Local Education Agencies (LEAs), as appropriate, for the provision of school-linked EPSDT services, including, but not limited to, BHT as specified in Exhibit A, Attachment III, Subsection 4.3.16 (*School-Based Services).*

H. Rapid Whole Genome Sequencing

Rapid whole genome sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a Covered Service for any Medi-Cal Member who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit as required in W&I section 14132(ae).

5.3.5 Services for Adults

A. Initial Health Appointment for Adults Ages 21 and over

1) Contractor must cover and ensure that IHAs for adult Members are performed within 120 calendar days of Enrollment.

2) Contractor must ensure that the IHA for adults includes, but is not limited to, an evaluation of applicable preventive services provided in accordance with the https://uspreventiveservicestaskforce.org/uspstf/home USPSTF grade A and B recommendations.

B. Adult Preventive Services

Contractor must cover and ensure the provision of all preventive services and Medically Necessary diagnostic and treatment services for adult Members as follows:

1) Contractor must ensure provision of all applicable preventive services identified as USPSTF grade A and B recommendations for adult Members in accordance with the Guide to Clinical Preventive Services published by the USPSTF.

2) Contractor must cover and ensure the provision of all Medically Necessary diagnostic, treatment, and follow-up services which are necessary given the findings or risk factors identified in the IHA, or during visits for routine, urgent, or emergent health care situations. Contractor must ensure that these services are initiated as soon as possible but no later than 60 calendar days following discovery of a problem requiring follow up.

3) Contractor must comply with APL 22-025 and ensure the provision of an annual cognitive health assessment for Members who are 65 years of age or older and are otherwise ineligible to receive a similar assessment as part of a Medicare annual wellness visit.

C. Immunizations

1) Contractor must cover vaccinations, except for vaccinations expressly excluded by DHCS in guidance to Medi-Cal managed care health plans, at the time of any health care visit and ensure the timely provision of vaccines in accordance with the most recent

adult immunization schedule and recommendations published by the ACIP. Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination will be considered sufficient in meeting this requirement.

2) In addition, Contractor must cover and ensure the provision of age and risk appropriate vaccinations in accordance with the findings of the IHA, or other preventive screenings.

3) At each non-emergency Primary Care Encounter the Member must be advised of the vaccinations due and available from Contractor, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which indicates the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which indicates the vaccinations were advised, and the Member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

4) Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area as part of the Statewide Immunization Information System. Reports will be made following the Member's IHA and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting will be in accordance with all applicable State and federal laws.

5.3.6 Pregnant and Postpartum Members

A. Prenatal and Postpartum Care

Contractor must cover and ensure the provision of all Medically Necessary services for Members who are pregnant and postpartum. Contractor must utilize the most current standards or guidelines of American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Perinatal Services Program (CPSP) to ensure Members receive quality perinatal and postpartum services.

B. Risk Assessment

Contractor must implement a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. Contractor must maintain the results of this assessment as part of the Member's obstetrical record, which must include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. If administration of the risk assessment tool is missed at the appropriate timeframes, then Contractor must ensure case management and Care Coordination are working directly with the Member to accomplish the assessment. Contractor must follow up on all identified risks with appropriate interventions consistent with ACOG standards and CPSP standards and document those interventions in the Member's Medical Record. The risk assessment may be completed virtually through a Telehealth visit with the Member's consent.

C. Referral to Specialists

Contractor must ensure that pregnant Members are referred to medically appropriate Specialists, including, as appropriate, perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives, Licensed Midwives, and ensure access to genetic screening with appropriate referrals. Contractor must ensure that pregnant and postpartum Members are referred to Doulas as required under W&I section 14132.24. Doula services are a preventive benefit for Medi-Cal Members, and services include but are not limited to personal support to pregnant individuals and families throughout pregnancy, labor, and the postpartum period. Contractor must also ensure that appropriate hospitals are available within the Network to provide necessary high-risk pregnancy services.

5.3.7 Services for All Members

A. Health Education

1) Contractor must implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion, and patient education for all Members.

2) Contractor must ensure administrative oversight of the health education system by a qualified full-time health educator.

3) Contractor must provide evidence-based health education programs and services to Members, directly, or through Subcontractors, Downstream Subcontractors, or Network Providers.

4) Contractor must ensure organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health. Contractor may offer Members non-monetary incentives for participating in incentive programs, focus groups, and Member surveys authorized by W&I section 14407.1 pursuant to APL 16-005.

5) Contractor must ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience in accordance with APL 18-016.Contractor must review health education materials to ensure documents are up-to-date.

6) Contractor must ensure availability of Community Health Workers (CHWs) to all Members. CHWs should provide services to include but are not limited to assisting Members with health care system navigation, communicating cultural and language preferences to providers, accessing health care services, educating health needs, and connecting individuals and families with community-based resources.

7) Contractor must maintain a health education system, or use a DHCS-sponsored system if available, that provides educational interventions addressing health categories and topics that align with the Population Health Management (PHM) Strategy, in accordance with Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions.

8) Contractor must ensure that Members receive point of service education as part of preventive and primary health care visits. Contractor must provide education, training, and program resources to Network Providers for the delivery of health education services.

9) Contractor must maintain health education policies, procedures, standards, and guidelines. Contractor must maintain documentation that demonstrates effective implementation of the health education requirements.

10) Contractor must monitor the health education system including accessibility for Limited English Proficient (LEP) Members and the performance of Providers that are contracted to deliver health education services. Contractor must ensure appropriate allocation of health education resources and conduct appropriate levels of program evaluation.

B. Hospice Care

1) Contractor must cover and ensure the provision of hospice care services as defined in 42 USC section 1396d(o)(1) and as required by APL 13-014. Contractor must ensure that Members and their families are fully informed of the availability of hospice care as a Covered Service and the methods by which they may elect to receive these services. In accordance with APL 13-014, a hospice must obtain written certification of terminal illness for each hospice benefit period. “Terminally ill,” as defined in 42 CFR section 418.3, means that an individual has a medical prognosis that their life expectancy is six months or less if the illness runs its normal course. Services are limited to Members who directly or through their AR voluntarily elect to receive hospice care in lieu of other care as specified. However, for Members less than 21 years of age, a voluntary election of hospice care does not constitute a waiver of any rights of that Member to be provided with, or to have payment made for, Covered Services that are related to the treatment of that Member’s condition for which a diagnosis of terminal illness has been made.

2) For Members who have elected hospice care, Contractor must arrange for continuity of care, including maintaining established patient-Provider relationships, to the greatest extent possible. Contractor must cover the cost of all hospice care provided. Contractor must also cover all Medically Necessary care not related to the terminal condition.

C. Palliative Care

Contractor must cover and ensure the provision of palliative care, as required by W&I section 14132.75 and as set forth in APL 18-020, and as

required for Members less than 21 years of age under the EPSDT benefit and standard of Medical Necessity. Contractor must continue to cover all Medically Necessary Covered Services for Members receiving palliative care. For Members less than 21 years of age, Contractor must cover palliative care concurrently with hospice care and other Medically Necessary Covered Services if hospice care is elected by the Member.

D. Vision Care – Lenses

Contractor must cover and ensure the provision of eye examinations to include screening examinations and prescriptions for corrective lenses as appropriate for all Members. Contractor must arrange for the fabrication of optical lenses for Members through Prison Industry Authority (PIA) optical laboratories except when the Member requires lenses not available through PIA. Contractor must cover the cost of the eye examination and dispensing of the lenses fabricated by PIA. DHCS will reimburse PIA for the fabrication of the optical lenses in accordance with the contract between DHCS and PIA. Contractor must cover the cost of fabrication and dispensing of lenses not available through PIA.

E. Mental Health and SUD Services

Contractor must cover all Medically Necessary mental health and SUD services specified in Exhibit A, Attachment III, Subsection 5.5.2 (*Non-Specialty Mental Health Services and Substance Use Disorder Services*) in compliance with mental health parity requirements in 42 CFR section 438.900 *et seq*., and Exhibit A, Attachment III, Section 5.5 (*Mental Health and Substance Use Disorder Benefits*).

F. Organ and Bone Marrow Transplant Surgeries

Contractor must cover all Medically Necessary organ and bone marrow transplant surgeries as set forth in the Medi-Cal Provider Manual, including all updates and amendments to the Manual.

1) Contractor must refer and authorize organ and bone marrow transplant surgeries to be performed in transplant programs that meet criteria set forth by DHCS in the Medi-Cal Provider Manual.

2) Contractor must authorize and cover costs for organ or bone marrow transplants for Members. Contractor must cover all pre-and-post-operative transplant-related costs such as, but not limited to, evaluation, hospitalization, and all Medically Necessary services

such as transportation and prescriptions not covered by and billable to Medi-Cal Rx.

3) Contractor must refer Members identified as potential organ or bone marrow transplant candidates to a transplant program evaluation that meets criteria set forth by DHCS within 72 hours of receiving the referral. If the transplant program considers the Member to be a suitable transplant candidate, Contractor must authorize the request for transplant services on an expedited 72-hour basis or less if the Member's condition requires it, or if the organ or bone marrow the Member will receive is at risk of being unusable due to any delay in obtaining Prior Authorization or any delay in obtaining the organ or bone marrow.

4) Contractor must refer Members less than 21 years of age identified as a potential organ or bone marrow transplant candidate to the local CCS Program for eligibility, if necessary, unless Contractor is responsible for the CCS benefit (Whole Child Model (WCM) contracts only). Major Organ Transplants (MOT) for Members less than 21 years of age must be performed only in a CCS-approved Special Care Center (SCC). If the CCS Program determines that the Member is not eligible for the CCS Program or the MOT is not related to the Member's CCS eligible medical condition, but the MOT is Medically Necessary, Contractor must refer the Member to a transplant program within 72 hours of receipt of the eligibility determination and is responsible for authorizing the MOT, as appropriate.

5) For Members less than 21 years of age, Contractor must provide Prior Authorization for requests for transplant services on an expedited, 72-hour basis, or less if the Member's condition requires it or if the organ or bone marrow the Member will receive is at risk of being unusable due to any delay in obtaining Prior Authorization or any delay in obtaining the organ or bone marrow.

6) Contractor must authorize and cover costs for organ or bone marrow donors, including cadavers and living donors regardless of a living donor's Medi-Cal eligibility. Contractor must cover transplant-related costs such as evaluation, hospitalization for the living donor, organ or bone marrow removal, and all Medically Necessary services related to organ or bone marrow removal including complications, transportation, and prescriptions not covered by and billable to Medi-Cal Rx.

7) Contractor must ensure coordination of care between all Providers, organ or bone marrow donation entities, and transplant centers to ensure the transplant is completed as expeditiously as possible. This coordination of care must include care for all living donors.

8) Contractor must ensure the provision of Discharge Planning as defined in this Contract for Members and living donors.

9) Contractor must cover all readmissions and other health care costs related to any complications the Member or the living donor experiences from the organ or bone marrow transplant.

10) Contractor must cover all Medically Necessary physician administered drugs provided to a Member or the living donor administered by a health care professional in a clinic, physician's office, or outpatient setting and is needed for the Member receiving an organ or bone marrow transplant, such as anti-rejection medication, and any other Medically Necessary Prescription Drug not covered by Medi-Cal Rx.

G. Long-Term Care Services

Contractor must authorize and cover Long-Term Care (LTC) services as set forth in APL 23-004. Contractor must ensure that Members in need of LTC services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs, unless the Member has elected hospice care.

1) Contractor must ensure that Members, other than Members requesting hospice services, in need of LTC services are placed in a LTC facility that provides the level of care most appropriate to the Member's medical needs. Contractor must make Member placement decisions based on the appropriate level of care, as set forth in the definitions in 22 CCR sections 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6 and the criteria for admission set forth in 22 CCR sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR section 51003(e).

2) Contractor must place Members in LTC facilities that are licensed and certified by the California Department of Public Health (CDPH). Contractor must ensure that contracted LTC facilities have not been decertified by CDPH or otherwise excluded from participation in the Medi-Cal Program.

3) Contractor must provide continuity of care to Members through continued access to the LTC facility in which the Member is residing at time of Enrollment for up to 12 months. During this time, Contractor may attempt to place Members at LTC facilities within its Network only with approval from the Member or individual authorized to make health care decisions on their behalf.

4) Contractor must cover a Member stay in a facility with availability regardless of Medical Necessity if placement in a Medically Necessary appropriate lower level of care is not available, unless otherwise provided by contract. Contractor must continue to attempt to place the Member in a facility with the appropriate level of care, including offering to contract with facilities within and outside of the Service Area.

5) Contractor must provide Transitional Care Services as specified in Exhibit A, Attachment III, Subsection 4.3.11 (*Targeted Case Management Services*).

6) Hospice Services as defined in 22 CCR section 51180 rendered in a Skilled Nursing Facility (SNF) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICFD/DD-H), and ICF/DD-Nursing (ICF/DD-N) are not LTC services consistent with 22 CCR section 51544(h).

H. Pharmaceutical Services

1) Drug Use Review (DUR)

Contractor must develop and implement effective DUR and treatment outcome process, as directed in APL 17-008, APL 19-012, and APL 22-012 (excluding prospective DUR activities), to ensure that drug utilization is appropriate, Medically Necessary, and not likely to result in adverse events.

a) Contractor's DUR must meet or exceed the requirements described in 42 USC section 1396r-8(g) and 42 CFR section 438.3(s), to the extent that Contractor provides covered outpatient drugs, and Section 1004 requirements of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patient and Communities Act.

b) Contractor's DUR must implement:

i. A retrospective claims review automated process that monitors when a Member is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

ii. A program to monitor and manage the appropriate use of antipsychotic medications by all Children 18 years of age and under including foster Children enrolled under the California Medicaid State Plan, as required in 42 USC section 1396a(oo)(1)(B), APL 19-012, and APL 22-012; and

iii. Fraud and Abuse identification processes for potential Fraud or Abuse of controlled substances by Members, Providers, and pharmacies.

c) Contractor must annually submit to DHCS a detailed report in a format specified by DHCS on their DUR Program activities.

2) Contractor must not impose Quantitative Treatment Limitation (QTL) or Non-Quantitative Treatment Limitation (NQTL) more stringently for mental health and SUD drugs prescriptions than for medical/surgical drugs, in accordance with 42 CFR section 438.900 *et seq*.

I. Transportation

Contractor must cover transportation services as required in this Contract and directed in APL 22-008 to ensure Members have access to all Medically Necessary services.

1) Contractor must cover Emergency Medical Transportation (EMT) services necessary to provide access to all emergency Covered Services.

2) Contractor must cover NEMT services necessary for Members to access Covered Services, subject to a prescription and Prior Authorization when required, in accordance with 22 CCR section 51323.

a) Contractor must require Members to have an approved Physician Certification Statement (PCS) form prescribing NEMT by their provider before Prior Authorization can be granted for NEMT services. For Covered Services requiring recurring appointments, Contractor must provide authorization for NEMT for the duration of the recurring appointments, not to exceed 12 months, and ensure the Member has a standing order guaranteeing assigned rides for the duration of the recurring appointments. Contractor cannot modify the form once the provider prescribes the mode of NEMT.

b) Contractor must refer and coordinate NEMT services for Medi-Cal services that are not covered under the Contract. However, Contractor must provide NEMT services for their Members for all pharmacy prescriptions prescribed by the Member's Medi-Cal provider(s) and those authorized under Medi-Cal Rx.

c) Contractor must have a process in place to ensure transportation brokers and providers are meeting these requirements and to impose Corrective Action if non-compliance is identified through oversight and monitoring activities.

3) As provided for in W&I section 14132(ad), Contractor must authorize all NMT for Members to obtain Covered Services in accordance with the requirements and guidelines set forth in APL 22-008. Nothing in this provision will be construed to prohibit Contractor from developing policies and procedures that may include reasonable Prior Authorization requirements for NMT. Contractor must also provide NMT for all Medi-Cal services not covered under this Contract. These services include, but are not limited to, SMHS, SUD services, dental, pharmacy, pharmaceutical services, and any other benefits delivered through Medi-Cal FFS.

4) Contractor must provide NEMT or NMT for a parent, legal guardian, or AR when the Member is a minor. With the written consent of a parent, legal guardian, or AR, Contractor may arrange NEMT or NMT services for a minor who is unaccompanied by a parent, legal guardian, or AR. Contractor must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. Contractor must ensure all necessary written consent forms are

collected prior to arranging transportation for an unaccompanied minor and cannot arrange NEMT or NMT services for an unaccompanied minor without the necessary consent forms unless State or federal law does not require parental consent for minor's service.

5) Consistent with 42 CFR sections 440.170(a) and 431.53, W&I section 14132(ad), and APL 22-008, Contractor must also cover transportation-related travel expenses for Members obtaining Medically Necessary services. Transportation-related travel expenses are subject to retroactive reimbursement.

J. Care Management and Care Coordination

1) Contractor must provide all Members with Care Coordination services as specified in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*).

2) Contractor must provide care management services to all Members as specified in Exhibit A, Attachment III, Subsection 4.3.8 (*Basic Population Health Management*) and Exhibit A, Attachment III, Subsection 4.3.7 (*Care Management Programs*). Care management services include, Basic Population Health Management, Complex Care Management, and Enhanced Care Management (ECM).

K. Dyadic Services

Contractor must provide Dyadic Services and the Family Therapy benefit for Members less than 21 years of age and/or their caregivers in an outpatient setting as Medically Necessary as set forth in APL 22-029 and detailed below.

1) Dyadic Services may be provided by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners (NPs), and Psychiatrists. Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render services under a supervising clinician. Appropriately trained nonclinical staff, including CHWs, are not precluded from screening Members for issues related to Social Drivers of Health (SDOH) or performing other nonclinical support tasks as a component of the

Dyadic Behavioral Health (DBH) visit, as long as the screening is not separately billed.

a) Under the supervision of a supervising Provider from one of the provider types listed above, CHWs can assist a dyad to gain access to needed services to support their health through the CHW benefit for health navigation services

b) Contractor is responsible for ensuring appropriate supervision of Dyadic Services Providers and educating all Network Providers on the Dyadic Services benefit.

2) Member Eligibility for Dyadic Services

a) Children and their parent(s)/ caregiver(s) are eligible for DBH well-Child visits when delivered according to the Bright Futures Periodicity Schedule for behavioral/social/emotional screening assessment, and when medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards in 42 USC section 1396d(r).

i. Under EPSDT standards, a diagnosis is not required to qualify for services.

ii. The DBH well-Child visits do not need a particular recommendation or referral and must be offered as an appropriate service option even if the Member does not request them.

b) The family is eligible to receive Dyadic Services so long as the Child is enrolled in Medi-Cal. The parent(s) or caregiver(s) does not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the Child.

3) Covered Services

a) Contractor may offer the Dyadic Services benefit through Telehealth or in-person with locations in any setting including, but not limited to, pediatric Primary Care settings, doctor's offices or clinics, inpatient or outpatient settings in hospitals, the Member's home, school-based sites, or

community settings. There are no Service Location limitations.

b) Covered Dyadic Services are Behavioral Health Services for Children and/or their parent(s) or caregiver(s), and include:

i. DBH Well-Child Visits

a. The DBH well-Child visit must be limited to those services not already covered in the medical well-Child visit.

b. When possible and operationally feasible, the DBH well-Child visit should occur on the same day as the medical well-Child visit. When this is not possible, Contractor must ensure the DBH well-Child visit is scheduled as close as possible to the medical well-Child visit, consistent with timely access requirements.

c. Contractor may deliver DBH well-Child visits as part of the HealthySteps program, a different DBH program, or in a clinical setting without a certified DBH program as long as all of the following components are included:

aa. Behavioral Health history for Child and parent(s) or caregiver(s), including parent(s) or caregiver(s) interview addressing Child's temperament, relationship with others, interests, abilities, and parent or caregiver concerns.

bb. Developmental history of the Child.

cc. Observation of behavior of Child and parent(s) or caregiver(s) and interaction between Child and parent(s) or caregiver(s).

dd. Mental status assessment of parent(s) or caregiver(s).

ee. Screening for family needs, which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.

ff. Screening for SDOH such as poverty, food insecurity, housing instability, access to safe drinking water, and community level violence.

gg. Age-appropriate anticipatory guidance focused on Behavioral Health promotion/risk factor reduction.

hh. Making essential referrals and connections to community resources through Care Coordination and helping caregiver(s) prioritize needs.

ii. Dyadic Comprehensive Community Supports Services, separate and distinct from the California Advancing and Innovating Medi-Cal (CalAIM) Community Supports, help the Child and their parent(s) or caregiver(s) gain access to needed medical, social, educational, and other health-related services, and may include any of the following:

a. Assistance in maintaining, monitoring, and modifying covered services, as outlined in the dyad's service plan, to address an identified clinical need.

b. Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team, for the purpose of offering assistance in accessing an identified clinical service.

c. Assistance in finding and connecting to necessary resources other than covered services to meet basic needs.

d. Communication and coordination of care with the Child's family, medical and dental health care Providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies.

e. Outreach and follow-up of crisis contacts and missed appointments.

f. Other activities as needed to address the dyad's identified treatment and/or support needs.

c) Dyadic Psychoeducational Services for psychoeducational services provided to the Child less than 21 years of age and/or parent(s) or caregiver(s). These services must be planned, structured interventions that involve presenting or demonstrating information with the goal of preventing the development or worsening of Behavioral Health conditions and achieving optimal mental health and long-term resilience.

d) Dyadic Family Training and Counseling for Child Development for family training and counseling provided to both the Child less than 21 years of age and parent(s) or caregiver(s). These services include brief training and counseling related to a Child's behavioral issues, developmentally appropriate parenting strategies, parent/Child interactions, and other related issues.

e) Dyadic Parent or Caregiver Services

Dyadic parent or caregiver services are services delivered to a parent or caregiver during a Child's visit that is attended by the Child and parent or caregiver, including the following assessment, screening, counseling, and brief intervention services provided to the parent or caregiver for the benefit of the Child as appropriate:

i. Brief Emotional/Behavioral Assessment

ii. ACE's screening

iii. Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment

iv. Depression Screening of Health Behavior Assessments and Interventions

v. Psychiatric Diagnostic Evaluation

vi. Tobacco Cessation Counseling

4) Family Therapy as a Behavioral Health Benefit

a) Family therapy is type of psychotherapy covered under Medi-Cal's NSMHS benefit, including for Members less than 21 years of age who are at risk for Behavioral Health concerns and for whom clinical literature would support that the risk is significant such that Family Therapy is indicated, but may not have a mental health diagnosis. The primary purpose of Family Therapy is to address family dynamics as they relate to the Member's mental status and behavior(s).

b) Family Therapy is composed of at least two family members receiving therapy together provided by a mental health Provider to improve parent/Child or caregiver/Child relationships and encourage bonding, resolving conflicts, and creating a positive home environment.

c) All family members do not need to be present for each service. For example, parents or caregivers can qualify for Family Therapy without their infant present, if necessary.

d) Both Children and adult Members can receive Family Therapy mental health services that are medically necessary. Contractor is required to provide Family Therapy to the following Medi-Cal Members to improve parent/Child or caregiver/Child relationships and bonding, resolve conflicts, and create a positive home environment:

i. Members less than 21 years of age with a diagnosis of a mental health disorder;

ii. Members less than 21 years of age with persistent mental health symptoms in the absence of a mental

health disorder;

iii. Members less than 21 years of age with a history of at least one of the following risk factors:

a. Neonatal or pediatric intensive care unit hospitalization;

b. Separation from a parent or caregiver (for example, due to incarceration, immigration, or military deployment);

c. Death of a parent or caregiver of Foster home placement;

d. Food insecurity, housing instability;

e. Maltreatment;

f. Severe and persistent bullying; and

g. Experience of discrimination, including but not limited to discrimination on the basis of race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disability.

iv. Members less than 21 years of age who have a parent(s) or caregiver(s) with one or more of the following risk factors:

a. A serious illness or disability;

b. A history of incarceration;

c. Depression or other mood disorder;

d. Post-Traumatic Stress Disorder or other anxiety disorder;

e. Psychotic disorder under treatment;

f. SUD;

g. Job loss;

h. A history of intimate partner violence or interpersonal violence; and

i. Is a teen parent.

e) Contractor must provide Family Therapy services if needed to correct or ameliorate a Child's mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the condition and are thus covered as EPSDT services.

f) Members less than 21 years of age may receive up to five Family Therapy sessions before a mental health diagnosis is required. Contractor must provide Family Therapy without regard to the five-visit limitation for Members less than 21 years of age with risk factors for mental health disorders or parents/caregivers with related risk factors, including separation from a parent/caregiver due to incarceration, immigration, or death; foster care placement; food insecurity; housing instability; exposure to domestic violence or trauma; maltreatment; severe/ persistent bullying; and discrimination.

5) Billing and Claims

a) Dyadic Services Providers must be reimbursed in accordance with their Network Provider contract.

b) Contractor must not require Prior Authorization for Dyadic Services.

c) Contractor must not establish unreasonable or arbitrary barriers for accessing coverage.

d) Encounters for Dyadic Services must be submitted with allowable CPT codes as outlined in the Medi-Cal Provider Manual.

e) Multiple Dyadic Services are allowed on the same day and may be reimbursed at the FFS rate.

f) The DBH well-Child visit must be limited to those services that are not already covered in the medical well-Child visit, and any other service codes cannot be duplicative of services that have already provided in a medical well-Child visit or a DBH well-Child visit.

g) Dyadic caregiver service codes (screening, assessment, and brief intervention services provided to the parent or caregiver for the benefit of the Child) may be billed by either the medical well-Child Provider or the DBH well-Child visit Provider, but not by both Providers, when the dyad is seen on the same day by both Providers.

h) Tribal Health Programs, Rural Health Clinics (RHCs), and Federal Qualified Health Centers (FQHCs) are eligible to receive their All-Inclusive Rate from Contractor if Dyadic Services are provided by a billable Provider per APL 17-002 and APL 21-008.

i. Dyadic Services may be reimbursed at the FFS rate established for services, if the service provided does not meet the definition of a THP, RHC, or FQHC visit, or exceeds frequency limitations.

ii. THP, RHC, and FQHC Providers can bill FFS for Dyadic Services delivered in a clinical setting by Provider types named in the Non-Specialty Mental Health Services (NSMHS): Psychiatric and Psychological Services section of the Medi-Cal Provider Manual.

iii. THP, RHC, and FQHC Providers cannot double bill for Dyadic Services that are duplicative of other services provided through Medi-Cal.

iv. All Dyadic Services must be billed under the Medi-Cal identity of the Member less than 21 years of age.

L. Practice Guidelines

Contractor must adopt practice guidelines in accordance with 42 CFR section 438.236, and this Contract. Contractor's decisions for Utilization Management (UM), Member education, provision of Covered Services, and other areas covered by practice guidelines must be consistent with

these guidelines. Contractor must also provide their practice guidelines, upon request, to Members and Potential Members.

M. Asthma Preventive Services

Contractor must ensure availability of Asthma Preventive Services (APS), including clinic-based and home-based asthma self-education, and in-home environmental trigger assessments for all Members with a diagnosis of asthma. APSs may be provided by a Physician or a Non-Physician Medical Practitioner, or a licensed practitioner of the healing arts within their scope of practice. APSs may also be provided by unlicensed Providers, which may include CHW, who have met the qualifications of an APS Provider and are providing these services under a supervising Physician or Non-Physician Medical Practitioner, clinic, hospital, local health jurisdiction, or community-based organization.

N. Community Health Workers Services

1) Contractor must ensure availability of CHW Services to all Members that meet the eligibility criteria in accordance with 42 CFR section 440.130(c).

2) Contractor must adhere to DHCS guidance on service definitions, eligible populations, and CHW Provider parameters as stated in APL 22-016.

a) CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below.

b) CHW services are considered Medically Necessary for Members with one or more chronic health conditions (including Behavioral Health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services.

3) Community Health Worker Provider and Supervising Provider Requirements

a) Contractor must determine, verify, and validate CHW Providers can provide CHW Services in an effective manner consistent with culturally and linguistically appropriate care.

b) CHW Providers must have lived experience that aligns with and provides a connection between CHW and the Member population being served in.

c) CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population being served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

d) Contractor must contract with a Supervising Provider to oversee CHW providers and the services delivered to Members. CHW providers can be supervised by a community-based organization (CBO) or a local health jurisdiction (LHJ) that does not have a licensed Provider on staff in alignment with the Provider Manual and APL 22-016.

e) Contractor must ensure that Network Providers and Subcontractors contracting with or employing CHWs to provide Covered Services have adequate supervision and training.

f) Contractor must ensure CHW Providers demonstrate, and Supervisor Providers maintain evidence of, minimum qualifications through the CHW certificate pathway, Violence Prevention certificate pathway, or Work experience pathway.

i. Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the

following certificates: CHW Certificate: A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and SDOH, as determined by the Supervising Provider. Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in APL 22-016, including violence prevention services.

ii. Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training form the Urban Peace Institute. A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

iii. Work Experience Pathway: An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member.

g) Contractor must have a process for verifying qualifications and experience of Supervising Providers, which must extend

to individuals employed by, or delivering CHW Services on behalf of, the Supervising Provider.

h) Contractor must ensure Supervising Providers and CHW Providers comply with all applicable State and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and PLs.

O. Community Health Workers Provider Capacity

1) Contractor must ensure and monitor appropriate, adequate Networks within its Service Area, including for CHW Services as stated in APL 21-006.

2) Contractor must use data-driven approaches to determine and understand priority populations eligible for CHW Services, including but not limited to, using past and current Member utilization/Encounters, frequent hospital admissions or emergency department visits, demographic and SDOH data, referrals from the community, and needs assessments.

P. Identifying Members for Community Health Workers

1) Contractor must require a referral for CHW Services submitted by a Physician or other licensed practitioner of the healing arts within their scope of practice under State law.

2) Contractor must accept recommendations for CHW Services from other licensed practitioners, whether they are in the Network or out-of-Network Providers, within their scope of practice, including physician assistants, NPs, clinical nurse Specialists, podiatrists, nurse midwives, Licensed Midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

Q. Cancer Biomarker Testing

Contractor must comply with APL 22-010 and cover Medically Necessary biomarker testing for Members with advanced or metastatic stage three or four cancer and cancer progression or recurrence in the Member with

advanced or metastatic stage three or four cancer. Contract is prohibited from imposing Prior Authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage three or four cancer.

R. COVID-19 Coverage

Contractor must cover COVID-19 related services to include prevention, testing, and treatment as detailed in APL 22-009.

5.3.8 Investigational Services

Contractor must cover investigational services as defined in 22 CCR section 51056.1(b) when a service is determined to be investigational pursuant to 22 CCR section 51056.1(c), and all requirements in 22 CCR section 51303(h) are met and documented in the Member's Medical Record.

Exhibit A, ATTACHMENT III

5.4 Community Based Adult Services

5.4.1 Covered Services
5.4.2 Coordination of Care
5.4.3 Required Reports for the Community Based Adult Services Program
5.4.4. Community Participation
5.4.5. Community Based Adult Services Program Integrity

5.4 Community Based Adult Services

5.4.1 Covered Services

In addition to Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Contractor must cover Community Based Adult Services (CBAS) in accordance with the California Advancing and Innovating Medi-Cal (CalAIM) 1115(a) Demonstration, Number 11-W-00193/9 Special Terms and Conditions (STCs), including Sections V.A.19 through 30 and Attachments H and S, or in accordance with any subsequent demonstration amendment or renewal or successive demonstration, waiver, or other Medicaid authority governing the provision of CBAS. Contractor must cover CBAS and ensure provision of the following services:

A. Arrange for the provision of CBAS to Members determined eligible to receive CBAS core services, and additional services as needed, in accordance with the CalAIM STCs Section V.A.20.a and b, Attachment H, and Exhibit A, Attachment III, Subsection 5.4.2.C. (*Coordination of Care*);

B. Consider a Member's relationship with a previous Provider of services similar to CBAS when referring a Member to a CBAS Provider;

C. Cover CBAS as a bundled service through a CBAS Provider or arrange for the provision of unbundled CBAS based on the assessed needs of Members eligible for CBAS if a certified CBAS Provider is not available or not contracted, or there is insufficient CBAS Provider capacity in the area, as required by Exhibit A, Attachment III, Subsection 5.2.8.J. (*Specific Requirements for Access to Programs and Covered Services*). Arranging for unbundled CBAS services includes authorizing Covered Services and coordinating with community resources to assist Members whose CBAS Providers have closed, and Members who have similar clinical conditions as CBAS Members, to remain in the community, in accordance with the following requirements listed below.

    1) Unbundled CBAS Covered Services are limited to the following:

        a) Professional Nursing Services;

        b) Nutrition;

        c) Physical Therapy;

        d) Occupational Therapy;

e) Speech and Language Pathology Services;

f) Nonmedical Emergency Transportation (NEMT) and Non-Medical Transportation (NMT), only between the Member's home and the CBAS unbundled service Provider; and

g) Non-Specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) services that are Covered Services;

2) Contractor must coordinate care for unbundled CBAS services that are not Covered Services based on the assessed needs of the Member eligible for CBAS, including:

a) Personal Care Services;

b) Social Services;

c) Physical and Occupational Maintenance Therapy;

d) Meals;

e) Specialty Mental Health Services (SMHS); and

f) SUD Services

D. Ensure that Member access to Medicare Providers or services is not impeded or delayed through Contractor's provision of CBAS; and

E. Ensure continuity of care, in accordance with Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), when Members switch Medi-Cal managed care plans and/or transfer from one CBAS Provider to another.

F. Arrange for the provision of CBAS Emergency Remote Services (ERS), in response to a Member's needs, and in accordance with CalAIM STCs Section V.A.21 and All Plan Letter (APL) 22-020. CBAS ERS must be provided in alternative Service Locations and/or via Telehealth, including telephone or virtual video conferencing, as clinically appropriate.

1) The circumstances for ERS are time-limited and vary based on the unique and identified needs documented in the Member's Individualized Health and Support Plan (IHSP). Contractor must assess Members at least every three months for ERS as part of the

reauthorization of the Member's Individual Plan of Care (IPC) and review for continued need for ERS.

2) Telehealth delivery of ERS must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, and the methodology must be approved by Contractor. Contractor must demonstrate compliance with the Electronic Visit Verification (EVV) System requirements for personal care services and home health services in accordance with section 12006 of the 21st Century CURES Act and APL 22-014.

3) Contractor must provide ERS under the following circumstances:

   a) State or local emergencies as determined by DHCS or Contractor, such as wildfires and power outages, to allow for the provision of ERS prior or subsequent to an official public health emergency declaration as determined by DHCS or Contractor; and

   b) Personal emergencies, such as time-limited illness or injury, crises, or care transitions that temporarily prevent or restrict Members enrolled in CBAS from receiving CBAS in-person at the CBAS Provider location, subject to approval by Contractor.

5.4.2 Coordination of Care

A. Contractor must provide continuity of care to Members through continued access to a CBAS Provider with whom there is an existing relationship for up to 12 months after Member Enrollment. This requirement includes out-of-Network Providers if there are no Quality of Care issues and the Provider will accept Contractor's rate or the Medi-Cal Fee-For-Service (FFS) rate, whichever is higher, as set forth in Exhibit A, Attachment III, Subsection 5.2.12 (*Continuity of Care for Seniors and Persons with Disabilities*).

B. Contractor must ensure that CBAS IPCs are consistent with the Members' overall care plans and goals, based on Person-Centered Planning and completed in accordance with the CalAIM STCs Section V.A.20., "Individual Plan of Care".

C. Contractor must conduct the initial assessment and subsequent reassessments for Members requesting CBAS in accordance with the CalAIM STCs, Sections VIII.A.19.e and 23.b. In addition, Contractor must:

1) Within 30 calendar days from the initial eligibility inquiry request, Contractor must conduct the CBAS eligibility determination using a DHCS-approved assessment tool. CBAS eligibility determinations shall include a face-to-face review with the Member by a Registered Nurse with level of care determination experience for Members who have not previously received CBAS through Contractor's Medi-Cal managed care health plan. Contractor may forgo a face-to-face review if Contractor has already determined Contractor must not deny, defer, or reduce a requested level of CBAS for a Member without a face-to-face review;

2) Develop and implement an expedited assessment process to determine CBAS eligibility within 72 hours of receipt of a CBAS authorization request for a Member in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or who is at high risk of admission to a hospital or SNF or faces an imminent and serious threat to their health;

3) Conduct a reassessment, with family involvement, when appropriate, and redetermination of the Member's eligibility for CBAS at least every six months after the initial assessment or up to every 12 months when determined by Contractor to be clinically appropriate. When a Member requests that services remain at the same level or requests an increase in services due to a change in their level of need, contractor may conduct the reassessment using only the Member's CBAS IPC, including any supporting documentation supplied by the CBAS Provider;

4) Notify Members in writing of their CBAS assessment determination in accordance with the timeframes identified in the CalAIM STCs, Section VIII.A.23.b.i. Contractor's written notice must be approved by DHCS and include procedures for Grievances and Appeals in accordance with current requirements identified in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

5) Require that CBAS Providers update a Member's CBAS Discharge Plan of Care and provide a copy to the Member and to Contractor whenever a Member's CBAS services are terminated. The CBAS Discharge Plan of Care must include:

   a) The Member's name and ID number;

b) The name(s) of the Member's physician(s);

c) If applicable, the date the Notice of Action (NOA) denying authorization for CBAS was issued;

d) If applicable, the date the CBAS benefit will be terminated;

e) Specific information about the Member's current medical condition, treatments, and medications;

f) Potential referrals for Medically Necessary services and other services or community resources that the Member may need upon discharge;

g) Contact information for the Member's Case Manager; and

h) A space for the Member or the Member's representative to sign and date the Discharge Plan of Care.

D. Contractor must coordinate with the CBAS Provider to ensure the following:

1) CBAS IPCs are consistent with Members' overall care plans and goals developed by Contractor;

2) Timely exchange of the following coordination of care information: Member Discharge Plan of Care, reports of incidents that threaten the welfare, health and safety of the Member, and Significant Changes in the Member's condition;

3) Clear communication pathways between the appropriate CBAS Provider staff and Contractor staff responsible for CBAS eligibility determinations, service authorizations, and care planning, including identification of the lead care coordinator for Members who have a care team and Utilization Management (UM); and

4) The CBAS Provider receives advance written notification and training prior to any substantive changes in Contractor's policies and procedures related to CBAS.

E. In addition to the requirements for unbundled CBAS contained in Exhibit A, Attachment III, Subsection 5.4.1 (*Covered Services*), and in accordance with Exhibit A, Attachment III, Subsection 5.4.2 (*Coordination of Care*), Contractor must coordinate care for unbundled CBAS that are not

Covered Services, based on the assessed needs of the Member eligible for CBAS, including:

1) Personal Care Services

2) Social Services

3) Physical and Occupational Maintenance Therapy

4) Meals

5) SMHS

6) SUD services that are not Covered Services.

5.4.3 Required Reports for the Community Based Adult Services Program

Contractor must submit to DHCS the following reports 30 calendar days following the end of each reporting period and in a format specified by DHCS:

A. How many Members have been assessed for CBAS and the total number of Members currently receiving CBAS, either as a bundled or unbundled service, on a quarterly basis;

B. Identification of CBAS Providers added to or deleted from Contractor's Network, and when there is a 5 percent drop in capacity, in the quarterly Network changes submission required in Exhibit A, Attachment III, Subsection 5.2.13.C. (*Network Reports*);

C. A summary of any complaints surrounding the provision of CBAS; and

D. Reports on the following areas:

1) Appeals related to requesting CBAS and the inability to receive those services or receiving more limited services than requested;

2) Appeals related to requesting a particular CBAS Provider and the inability to access that Provider;

3) Excessive travel times to access CBAS;

4) Grievances regarding CBAS Providers;

5) Grievances regarding Contractor assessment and/or reassessment; and

6) Any reports pertaining to the health and welfare of Members utilizing CBAS.

E. On an annual basis, Contractor must provide a list of its contracted CBAS Providers and its CBAS accessibility standards.

5.4.4. Community Participation

Contractor must ensure that engagement and community participation for Members receiving CBAS is supported to the fullest extent desired by each Member.

5.4.5. Community Based Adult Services Program Integrity

Following a determination that a credible allegation of Fraud exists involving a CBAS Provider, DHCS must notify Contractor of the finding promptly. In addition to the actions required in APL 15-026, Contractor must report to DHCS, in a timeframe and manner specified by DHCS but no less frequently than quarterly, all payments made to the CBAS Provider involved in a credible allegation of Fraud for CBAS benefits provided after the date of notification. DHCS may recoup payments from Contractor in accordance with CalAIM Terms and Conditions, GPR Section V.A.30.b.

Exhibit A, ATTACHMENT III

5.5 Mental Health and Substance Use Disorder Benefits

5.5 Mental Health and Substance Use Disorder Benefits

5.5.1 Mental Health Parity Requirements

Contractor must comply with all mental health parity requirements in 42 CFR section 438.900 *et seq*. Contractor must ensure it is not applying any financial or treatment limitation to mental health or Substance Use Disorder (SUD) benefits in any classification that is more restrictive than the predominant financial or treatment limitation applied to medical and surgical benefits in the same classification.

5.5.2 Non-Specialty Mental Health Services and Substance Use Disorder Services

A. Non-Specialty Mental Health Services (NSMHS) set forth in W&I section 14189 are Covered Services in accordance with W&I section 14184.402, unless otherwise specifically excluded under the terms of this Contract. Contractor must consider equity in the provision of such services.

B. Contractor must cover NSMHS including: individual and group mental health evaluation and treatment, including psychotherapy, Family Therapy, and Dyadic Services; psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; psychiatric consultation; and outpatient laboratory, drugs, supplies, and supplements. Contractor must cover hypnotherapy, health behavior assessments and interventions, psychiatric collaborative care, and other NSMHS services described in the Medi-Cal Provider Manual as mental health evaluation and treatment NSMHS. Contractor must cover mental health screening services described in the Medi-Cal Provider Manual as NSMHS, including but not limited to Adverse Childhood Experiences (ACE) screening, brief emotional/behavioral assessments, depression screening, general developmental screening, Autism Spectrum Disorder (ASD) screening, and other screening services in accordance with Exhibit A, Attachment III, Subsection 5.5.2.F. (*Non-Specialty Mental Health Services and Substance Use Disorder Services*). Contractor must cover SUD services including: drug and alcohol Screening, Brief Intervention, and Referral to Treatment (SBIRT) services; tobacco cessation counseling; medications for addiction treatment (also known as medication-assisted treatment or MAT) when delivered in Primary Care offices, emergency departments, inpatient hospitals, and other contracted medical settings; and Medically Necessary Behavioral Health Services. Covered NSMHS and SUD Services can be delivered in person and via

Telehealth/telephone as specified in Exhibit A, Attachment III, Subsection 5.3.1 (*Covered Services*).

C. If a Member is receiving NSMHS and is determined to meet the criteria for Specialty Mental Health Services (SMHS) as defined by W&I section 14184.402, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-Specialty Mental Health Services and Substance Use Disorder Services*) as required when Members who have established relationships with contracted mental health Providers experience a change in condition requiring SMHS. Likewise, if a Member is receiving SMHS and is determined to meet the criteria for NSMHS as defined by W&I section 14184.402, Contractor must use DHCS-approved standardized transition tools in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-Specialty Mental Health Services and Substance Use Disorder Services*) as required when Members who have established relationships with SMHS Providers experience a change in condition requiring NSMHS. Contractor must continue to cover the provision of NSMHS provided to a Member concurrently receiving SMHS when those services are not duplicative and provide coordination of care with the county Mental Health Plan (MHP) in accordance with Exhibit A, Attachment III, Subsection 5.5.2.K. (*Non-Specialty Mental Health Services and Substance Use Disorder Services*). This provision does not preclude coverage of Behavioral Health Services that are within the scope of practice of licensed mental health care Primary Care Providers (PCPs) and mental health care Providers in accordance with All Plan Letter (APL) 22-006 and APL15-008.

D. For Members ages 21 and over who meet the criteria for NSMHS set forth in the W&I section 14184.402(b)(2), Contractor must cover NSMHS that are Medically Necessary Covered Services in accordance with W&I section 14059.5. For Members ages 21 and over, Contractor must cover SUD services that are Medically Necessary Covered Services in accordance with W&I section 14059.5. Contractor's coverage of NSMHS and SUD services must comply with W&I section 14184.402(f).

E. For Members less than 21 years of age, Contractor must cover NSMHS that are Medically Necessary Covered Services in accordance with W&I section 14184.402(b)(2). For Members less than 21 years of age, Contractor must cover SUD services that are Medically Necessary Covered Services. Medical Necessity determinations for NSMHS and SUD services must be made pursuant to W&I section 14059.5, and as required pursuant to 42 USC section 1396dI. For Members less than 21 years of age, NSMHS and Covered SUD services are Medically

Necessary if they are necessary to correct or ameliorate a mental health or substance use condition discovered by an Early Periodic Screening, Diagnosis and Testing (EPSDT) screening. NSMHS and SUD services need not be curative or restorative to ameliorate a mental health or substance use condition. NSMHS and SUD services that sustain, support, improve, or make more tolerable a mental health or substance use condition are considered to ameliorate the mental health or substance use condition, and Contractor must cover them. Contractor's coverage of NSMHS and SUD services must comply with W&I section 14184.402(f).

F. Contractor must cover mental health and SUD screening, including, but not limited to, tobacco, alcohol and illicit drug screening, in accordance with Bright Futures Periodicity Schedule and United States Preventive Services Taskforce (USPSTF) grade A and B recommendations for adults; ACE screening; brief emotional/behavioral assessments; depression screening; general developmental screening; ASD screening; and SBIRT Services. Contractor must develop and implement policies and procedures for mental health and substance use screenings and services provided by a PCP, including, but not limited to, provision of SBIRT Services, and referrals for additional assessments and treatments as indicated by the discovery of condition or potential conditions from screening services, as required by Exhibit A, Attachment III, Subsections 4.3.12 (*Mental Health Services*) and 4.3.13 (*Alcohol and Substance Use Disorder Treatment Services*).

G. Contractor must cover a mental health assessment without requiring Prior Authorization. Contractor must follow the authorization criteria requirements outlined in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*) of this Contract for authorizing additional mental health and SUD services. Consistent with the No Wrong Door policies set forth in W&I section 14184.402, Contractor must cover the assessment and any NSMHS provided during the assessment period for any Member seeking care, even prior to the determination of a diagnosis, even prior to the determination of whether NSMHS criteria set forth in W&I section 14184.402(b)(2) are met, and even if the Member is later determined to need SMHS and/or SUD services and is referred to the MHP or to the County Department responsible for SUD treatment. Contractor must cover NSMHS even if the service was not included in the individual treatment plan, and even if the Member has a co-occurring mental health condition and SUD.

H. Contractor must develop and implement policies and procedures for tracking mental and Behavioral Health screenings, assessments, and treatment services provided by licensed mental health care Providers.

I. Contractor must cover and pay for all mental health and SUD services that are Medically Necessary Covered Services for the Member, including the following:

1) Emergency room professional services as described in 22 CCR section 53855;

2) Facility charges for emergency room visits;

3) All laboratory and radiology services necessary for the diagnosis, monitoring, or treatment of a Member's mental health condition;

4) Non-Medical Transportation (NMT) services required by Members to access Medi-Cal covered mental health services and SUD services, in compliance with APL 22-008 and this Contract. These services include, but are not limited to, SMHS, Drug Medi-Cal (DMC) services, and Drug Medi-Cal Organized Delivery System (DMC-ODS) services;

5) NMT services and, for Members less than 21 years of age, Non-Emergency Medical Transportation (NEMT) services, to and from DMC services, DMC-ODS services, and SMHS, in compliance with APL 22-008 and this Contract;

6) Medically Necessary Covered Services after Contractor has been notified by a DMC, DMC-ODS, county MHP, or mental health Provider that a Member has been admitted to an inpatient psychiatric facility, including an Institution for Mental Diseases (IMD) as defined by 9 CCR section 1810.222.1, regardless of the age of the Member. These services include, but are not limited to:

a) The initial health history and physical examination required upon admission, consultations, and any Medically Necessary Covered Services; Skilled Nursing Facility (SNF) room and board when IMD services are provided to Members less than 21 years of age or age 65 and over.

b) Contractor must not cover other inpatient psychiatric facility/IMD room and board charges or other services that are reimbursed as part of the inpatient psychiatric facility/IMD per diem rate.

7) All Medically Necessary Medi-Cal covered psychotherapeutic drugs, when administered in the outpatient setting as part of medical services for Members not otherwise excluded under this Contract. This includes reimbursement for Medically Necessary Medi-Cal covered psychotherapeutic drugs administered by out-of-Network Providers for Members not otherwise excluded under this Contract;

8) Reimbursement to pharmacies for psychotherapeutic drugs must be provided through the Medi-Cal Fee-For-Service (FFS) program. To qualify for reimbursement under this provision, a pharmacy must be enrolled as a Medi-Cal Provider in the Medi-Cal FFS program;

9) Contractor must not materially delay access to Covered Services per Paragraphs 3), 4), and 5) above through the application of Utilization Review controls, such as Prior Authorization, or by requiring that Covered Services be provided through Contractor's Network, consistent with Contractor's obligation to provide timely Covered Services under this contract.

J. Contractor must use DHCS-approved standardized screening tools (including standardized screening tools specific for adults and standardized screening tools specific for Children and youth) to ensure Members seeking mental health services who are not currently receiving covered NSMHS or SMHS are referred to the appropriate delivery system for mental health services, either in Contractor's Network or the MHP's network, in accordance with the No Wrong Door policies set forth in W&I section 14184.402(h) and specified in Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*).

K. If a Member becomes eligible for SMHS during the course of receiving covered NSMHS, Contractor must continue the provision of non-duplicative, Medically Necessary NSMHS even if the Member is simultaneously accessing SMHS.

1) Contractor must enter into a Memorandum of Understanding (MOU) with the MHP in accordance with Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*) to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative.

2) Contractor must develop and implement written policies and procedures to ensure that Members meeting criteria for SMHS and

as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred to the MHP in accordance with Exhibit A, Attachment III, Subsection 4.3.12 (*Mental Health Services*). Likewise, Contractor must develop and implement written policies and procedures to ensure that Members meeting criteria for NSMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred by the MHP to Contractor in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*).

L. Contractor must make best efforts to ensure that a Member's existing mental health Provider is notified during an Urgent Care situation, when possible. Contractor must allow the Member's existing mental health Provider to coordinate care with the MHP or emergency room personnel for Urgent Care.

M. Contractor must develop and implement policies and procedures for the provision of psychiatric emergencies during non-business hours.

N. Contractor must monitor and track utilization data for NSMHS as specified in Exhibit A, Attachment III, Subsection 2.3.3 (*Review of Utilization Data*).

5.5.3 Non-Specialty Mental Health Services Providers

A. In addition to Exhibit A, Attachment III, Subsection 5.2.1 (*Access to Network Providers and Covered Services*), Contractor must increase the number of NSMHS Providers within its Network as necessary to accommodate anticipated Enrollment growth, which DHCS will evaluate through the Network certification. Contractor may contract with any mental health care Provider to provide services within their scope of practice. The number of NSMHS Providers available must be sufficient to meet referral and appointment access standards for routine care and must meet the Timely Access Regulation per Health and Safety Code (H&S) section 1367.03, and 28 CCR section 1300.67.2.2, in accordance with the requirements set forth in Exhibit A, Attachment III, Subsection 5.2.3.D (*Network Composition*). Contractor's NSMHS Providers must support current and desired service utilization trends for its Members.

1) Contractor must authorize and arrange for out-of-Network Providers when the provider type is unavailable within time or distance standards. Authorization of out-of-Network Providers in Contractor's

Service Area must be prioritized over authorization of out-of-Network Providers in adjoining counties outside of Contractor's Service Area, unless an out-of-Network Provider in an adjoining county is more conveniently located for a Member or meets time or distance standards.

2) Contractor may contract with a MHP to ensure access to NSMHS.

Contractor must develop and implement policies and procedures for the secure exchange of Member Information with the MHP to facilitate referrals and Care Coordination. The policies and procedures must cover:

a) Sharing Protected Health Information (PHI) with the MHP for SMHS and the County Department responsible for SUD treatment, including when required by law, and obtaining Member authorization to release information that allows treatment history, active treatment, and health information to be exchanged;

b) Data sharing agreements with the MHP for SMHS and the County Department responsible for SUD treatment and, when required by law, a Business Associate Agreement that addresses the sharing of information related to mental health services and SBIRT services; and

c) Collecting and reporting data on Members receiving Medi-Cal NSMHS to the MHP.

B. Notwithstanding Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*), if a NSMHS Provider is accredited by the National Committee for Quality Assurance (NCQA), Contractor may deem the Provider credentialed or re-credentialed. Additionally, Contractor must develop and maintain policies and procedures that ensure that the credentials of licensed NSMHS Providers have been verified in accordance with 42 CFR section 438.214 and APL 22-013.

C. Any time that a Member requires a Medically Necessary NSMHS that is not available within the Network, Contractor must ensure timely access to out-of-Network Providers and Telehealth Providers, in accordance with H&S section 1367.03 and 28 CCR section 1300.67.2, as necessary to meet NSMHS access requirements.

5.5.4 Emergency Mental Health and Substance Use Disorder Services

In addition to the requirements set forth in Exhibit A, Attachment III, Section 5.6 (*MOUs with Local Government Agencies, County Programs, and Third Parties*), Contractor must have a MOU with the MHP to refer Members in need of Urgent Care and Emergency Services, including person-to-person telephone transfers, to the county crisis program during their call center hours. The MOU must be executed in accordance with the requirements specified in Exhibit A, Attachment III, Sections 4.3 (*Population Health Management and Coordination of Care*) and 5.3 (*Scope of Services*).

5.5.5 Mental Health and Substance Use Disorder Services Disputes

If Contractor and an MHP cannot agree on the appropriate place of care, disputes must be resolved pursuant to APL 21-013.

A. Contractor must enter into a MOU with the MHP in accordance with Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) to include a process for resolving disputes between Contractor and the MHP that includes a means for Members to receive Medically Necessary services, including NSMHS, while the dispute is being resolved.

B. Pursuant to 9 CCR section 1850.525, Contractor must not delay the provision of Medically Necessary services during the resolution of a dispute between Contractor and MHP. Contractor must comply with the rules set forth in 9 CCR section 1850.525 for determining the responsibility for managing ongoing care and financial responsibility for services provided to Members during the dispute period. When disputes concern Contractor's contention that the MHP is required to deliver SMHS to a Member either because the Member's condition would not be responsive to physical health care based treatment or because the MHP has incorrectly determined that the Member's does not meet SMHS criteria, Contractor must manage the care of the Member in accordance with 9 CCR section 1850.525 and APL 21-013 until the dispute is resolved.

C. Contractor must provide case management and Care Coordination for all Medically Necessary services, including those services that are the subject of a dispute between Contractor and an MHP.

D. Regardless of MOU status, Contractor and the MHP must adhere to the routine dispute resolution process and expedited dispute resolution process requirements set forth in APL 21-013.

E. If DHCS renders a decision for the dispute that includes a finding that Contractor is financially liable to the MHP for services, Contractor must

comply with the requirements in 9 CCR section 1850.530. If necessary, DHCS will enforce the decision, including withholding funds to meet any financial liability.

F. Contractor must monitor and track the number of disputes with MHPs. Upon request, Contractor must report all disputes to DHCS.

5.5.6 No Wrong Door for Mental Health Services

Contractor must implement policy to ensure that Members receive timely mental health services without delay regardless of the delivery system where they seek care and are able to maintain treatment relationships with trusted Providers without interruption.

A. Contractor must provide or arrange for the provision of the following NSMHS:

1) Mental health evaluation and treatment, including individual, group, and family psychotherapy.

2) Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.

3) Outpatient services for purposes of monitoring drug therapy.

4) Psychiatric consultation, excluding separately billable psychiatric drugs claimed by outpatient pharmacy Providers via Medi-Cal Rx.

5) Outpatient laboratory, drugs, supplies, and supplements.

B. Contractor must provide or arrange for the provision of the NSMHS listed above for the following populations after screening:

1) Members ages 21 and over with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;

2) Members who are less than 21 years of age, to the extent that they are eligible for services through the EPSDT benefit as described in Exhibit A, Attachment III, Subsection 5.3.4.E (*EPSDT Services*) of this Contract, regardless of the level of distress or impairment, or the presence of a diagnosis; and,

3) Members of any age with potential mental health disorders not yet diagnosed.

C. Contractor must cover and pay for emergency room professional services as described in 22 CCR Section 53855.

D. In accordance with APL 21-014, Contractor must, in a Primary Care setting, provide covered SUD services, including alcohol and drug screening, assessments, brief interventions, and referral to treatment for Members aged 11 years old and older, including Members who are pregnant. Contractor must also provide or arrange for the provision of:

1) Medications for Addiction Treatment (MAT), also known as medication-assisted treatment, provided in Primary Care, inpatient hospital, emergency departments, and other contracted medical settings; and

2) Emergency Services necessary to stabilize the Member.

E. Contractor must implement standardized Screening and Transition of Care Tools for Medi-Cal Mental Health Services in accordance with APL 22-005 and APL 22-028. Contractor must update and align policies and procedures and MOUs with MHPs to ensure compliance and communicate updates to Providers as necessary.

1) In accordance with APL 22-005, Members ages 21 and over must be screened using the Adult Screening Tool and transitioned using the Adult Transition of Care Tool.

2) In accordance with APL 22-005, Members less than 21 years of age must be screened using the Youth Screening Tool and transitioned using the Youth Transition of Care Tool.

F. Consistent with W&I section 14184.402(f) and APL 22-005, Contractor must cover clinically appropriate and covered NSMHS prevention, screening, assessment, and treatment services even when:

1) Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;

2) Services are not included in an individual treatment plan;

3) The Member has a co-occurring mental health condition and SUD; or

4) NSMHS and SMHS are provided concurrently, if those services are coordinated and not duplicated.

Exhibit A, ATTACHMENT III

5.6 MOUs with Local Government Agencies, County Programs, and Third Parties

5.6.1 MOU Purpose
5.6.2 MOU Requirements
5.6.3 MOU Oversight and Compliance

5.6 MOUs with Local Government Agencies, County Programs, and Third Parties

Memorandum of Understandings (MOUs), entered into pursuant to this Contract and as set forth in All Plan Letter (APL) 23-029, are binding, contractual agreements between Contractor and third parties that set forth the responsibilities and obligations of Contractor and a third party, including Local Government Agencies (LGAs), county programs, and third-party entities, to coordinate and facilitate the provision of Medically Necessary services to Members, sharing data, and as applicable, avoiding the duplication of services where Members are served by multiple parties.

5.6.1 MOU Purpose

Contractor must coordinate with LGAs, county programs, and third-party entities to ensure that Members receive all Medically Necessary services even if those services are not the financial responsibility of Contractor. In circumstances where Contractor is coordinating care and not financially responsible for the care, Contractor must negotiate in good faith and execute a MOU, incorporating all required provisions of this Contract, APL 23-029, and MOU templates and guidance, with the following LGAs, county programs, and third-party entities and county programs to ensure Care Coordination, data sharing, and non-duplicative services for Members. Contractor and the LGAs, county programs, and third-party entities may incorporate requirements in addition to any requirements set forth in this Contract or any DHCS issued templates so long as such requirements do not conflict with any required provision. Contractor must use good-faith efforts to consult with persons who have direct experience with Members receiving services from the below programs in the development of the MOU.

A. Contractor must execute MOUs with Local Health Departments (LHDs) in each county within Contractor's Service Area for the following programs and services, at a minimum:

1) California Children's Services;

2) Maternal and Child Health (MCH);

3) Tuberculosis (TB) Direct Observed Therapy (DOT);

4) For Community Health Worker services, as appropriate; and

5) All other Medically Necessary services that are the responsibility of LHDs, not otherwise specified.

B. Contractor must execute MOUs with Women, Infants, & Children Supplemental Nutrition Program (WIC) agencies in each county within Contractor's Service Area.

C. Contractor must execute MOUs with LGAs, such as the County Behavioral Health Department and County Social Services Department, in each county within Contractor's Service Area to assist with coordinating the following programs and services, at a minimum:

1) Specialty Mental Health Services (SMHS);

2) Alcohol and Substance Use Disorder (SUD) treatment services including counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS);

3) Targeted Case Management (TCM); and

4) In-Home Supportive Services (IHSS).

D. Contractor must execute MOUs to coordinate programs and services for Members with the following LGAs in each county within Contractor's Service Area, at a minimum:

1) Social services; and

2) Child welfare departments.

E. Contractor must execute MOUs to coordinate services provided by Regional Centers (RCs) for persons with Developmental Disabilities in accordance with APL 18-009 and APL 23-029, including DHCS issued templates.

F. By January 1, 2025 (or such later date determined by DHCS):

1) Contractor must collaborate with and execute MOUs with Local Education Agencies (LEAs) in each county within Contractor's Service Area to ensure that Members' Primary Care Provider (PCP) cooperates and collaborates in the development of Individual Education Plans (IEP) or Individual Family Service Plans (IFSP) as required in Exhibit A, Attachment III, Subsection 4.3.16 (*School-Based Services*).

2) Contractor must collaborate with, execute MOUs with jails, juvenile facilities, and probation departments.

G. Contractor must execute MOUs to coordinate programs and services for Members with the following third-party entities in each county within Contractor's Service Area, at a minimum:

1) Home and Community-Based Services (HCBS) program agencies;

2) Continuum of care programs;

3) First 5 programs;

4) Area Agencies on Aging; and

5) Caregiver Resource Center.

5.6.2 MOU Requirements

A. MOUs must contain all the following components, at a minimum:

1) Identification of services that are the responsibilities of each party under the MOU and the populations that are to be served;

2) Identification of the oversight responsibilities of each party, including the designation of a liaison by each party, and notification to the other party of changes to the liaison;

3) Establishment of policies and procedures for eligibility, screening, assessment, evaluation, Medical Necessity determination, and referral systems;

4) Establishment of policies and procedures for coordinating Member care between the parties, including but not limited to, referrals to applicable Enhanced Care Management (ECM), Community Supports and/or community-based resources;

5) Establishment of policies and procedures for the timely and frequent exchange of Member Information and data, including Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, bi-directional monitoring of data exchange processes, and obtaining Member consent;

6) Establishment of policies and procedures to address and document Quality Improvement (QI) activities for services covered under the MOU, including but not limited to, any applicable performance measures and QI initiatives, reports that track cross-system referrals, Member engagement, and service utilization;

7) Contractor must post on its website the date and time of the quarterly meetings and, as applicable, distribute to meeting participants a summary of any follow-up action items or Corrective Actions that are necessary to fulfill obligations under this Contract and MOU.

8) Contractor must invite other party's executives to participate in quarterly meetings to ensure appropriate committee representation, including local presence, to discuss and address Care Coordination and MOU-related issues.

9) Agreement by both parties, to the extent such non-Contractor party will agree to participate in quarterly meetings to discuss Care Coordination as well as systemic and case-specific concerns including allowing Subcontractors and Downstream Subcontractors to participate, as appropriate;

10) Establishment of policies and procedures detailing how complaints can be raised and how to resolve disputes between the parties, including but not limited to, a mutually agreed upon review process to facilitate timely resolution of disputes, differences of opinion and responsible entity for covering services until the dispute is resolved. The review process must not result in delays in Member access to services pending formal dispute resolution;

11) Establishment of policies and procedures regarding Member access to Medically Necessary services and Network Providers during non-business hours;

12) Policies and procedures for Member, Subcontractor, Downstream Subcontractor, and Network Provider education related to access to services covered under the MOU;

13) Establishment of policies and procedures to address emergency preparedness protocols in accordance with Exhibit A, Attachment III, Article 6.0 (*Emergency Preparedness and Response*); and

14) Provision requiring third-party entities and county programs to participate in Contractor's Population Needs Assessment (PNA).

B. In addition to the MOU requirements listed in Paragraph A of this Subsection, MOUs must contain the following components identified in this Paragraph B, as applicable:

1) MOUs with county Mental Health Plans (MHPs)

a) The requirements contained in W&I section 14715, and APL 18-015 and APL 23-029;

b) Policies and procedures for the delivery of SMHS, including the MHP's provision of clinical consultation with Contractor for Members being treated for mental illness;

c) Policies and procedures for the delivery of Medically Necessary Non-Specialty Mental Health Services (NSMHS) within the PCP's scope of practice;

d) Policies and procedures for the timely and frequent exchange of Member Information and data, including, as applicable, Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, bi-directional monitoring of data exchange processes, and, if necessary, obtaining Member consent;

e) Policies and procedures for the delivery of Medically Necessary Covered Services to Members who require SMHS, including but not limited to:

i. Prescription Drugs when administered in an outpatient setting and not otherwise excluded under this Contract;

ii. Laboratory, radiological and radioisotope services;

iii. Emergency room facility charges and professional services;

iv. Transportation;

v. Home health services;

vi. Drug Medi-Cal; and

vii. Medically Necessary Covered Services for Members who are patients in psychiatric inpatient hospitals or Institutions for Medical Diseases (IMDs).

f) A provision that states any decision rendered by DHCS regarding a dispute between Contractor and the MHP concerning provision of Covered Services is not subject to the dispute procedures specified in Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*);

g) Policies and procedures to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative; and

h) Policies and procedures to ensure that Members meeting criteria for SMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred to the MHP in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*) and Exhibit A, Attachment III, Subsection 5.5.2 (*Non-Specialty Mental Health Services and Substance Use Disorder Services*). Likewise, policies and procedures to ensure that Members meeting criteria for NSMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for Children and youth) are referred by the MHP to Contractor in accordance with Exhibit A, Attachment III, Subsection 4.3.12 *(Mental Health Services*) and Exhibit A, Attachment III, Subsection 5.5.2 (*Non-Specialty Mental Health Services and Substance Use Disorder Services*).

i) Contractor must report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS.

C. If Contractor reimburses the third-party entities or LGAs listed in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) for services rendered, Contractor must execute a Network Provider Agreement, Subcontractor Agreement, and/or Downstream Subcontractor Agreement, as appropriate, in accordance with Exhibit A, Attachment III, Section 3.1

(*Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties*).

D. MOUs must be publicly posted.

E. MOUs cannot be delegated.

5.6.3 MOU Oversight and Compliance

A. MOU Oversight Requirements

Contractor must have processes in place to maintain collaboration among the parties to the MOU and identify strategies to monitor and assess the effectiveness of MOUs as follows:

1) Conduct regular meetings, which include the designated individuals responsible for oversight and performance under the MOU, at least quarterly to address policy and practical concerns that may arise between MOU parties;

2) Resolve conflicts between MOU parties within a reasonable timeframe;

3) Designate a contact person to be responsible for the oversight and supervision of the terms of any MOUs and notify DHCS within five Working Days of any change in the designated MOUs' liaison;

4) Ensure Subcontractors, Downstream Subcontractors, and Network Providers comply with any applicable provisions of the MOU;

5) Provide education and training of MOU as required by Exhibit A, Attachment III, Subsection 5.6.2.A.12 above;

6) If DHCS requests a review of any existing MOU, Contractor must submit the requested MOU within ten Working Days of receipt of the request;

7) Ensure appropriate committee representation, including local presence, for each quarterly meeting and the opportunity to discuss and address Care Coordination and MOU-related issues with county executives;

8) Ensure an appropriate level of leadership on MOU engagements from both Contractor and entity; and

9) Report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS through APL 23-029 and other DHCS guidance.

B. MOU Compliance Requirements

1) At a minimum, executed MOUs listed in this Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*) must be submitted to DHCS.

2) To the extent Contractor does not execute an MOU within four months of the effective date of this Contract or within the timeframe required under this Contract and APL 23-029, Contractor must submit quarterly reports to DHCS documenting its continuing good faith efforts to execute the MOU, until such time as the MOU is executed. Documentation of good faith efforts must include a description of attempts made to execute an MOU and the explanation for why the MOU has not been executed.

3) Contractor, at a minimum, must review its MOUs annually for any needed modifications or renewal of responsibilities and obligations outlined within. Contractor must submit to DHCS' Contract Manager evidence of the annual review of MOUs as well as copies of any MOUs modified or renewed as a result.

4) Contractor must report on its compliance with the MOU to Contractor's compliance officer at least on a quarterly basis.

Exhibit A, ATTACHMENT III

6.0 Emergency Preparedness and Response (To Become Effective on January 1, 2025)

This Article's provisions, which will become effective on January 1, 2025, make explicit DHCS' commitment to ensuring that the Medi-Cal managed care delivery system is prepared for those unforeseen circumstances that require immediate action. Specifically, Contractors must plan for and ensure continuity of business operations, delivery of essential care and services to Members, and mitigate potential harm caused by Emergencies, such as a natural or manmade disaster or public health crisis. This Article includes provisions requiring that Contractor must maintain an Emergency Preparedness and Response Plan, including a Business Continuity Plan and Member Emergency Preparedness Plan. In addition, during a federal, State, or county declared state of Emergency, Contractor must implement protocols that allow Members timely access to Covered Services including by allowing flexibility for Prior Authorization, pre-certification, and referrals.

6.1 Emergency Preparedness and Response

6.1.1 General Requirements
6.1.2 Business Continuity Emergency Plan
6.1.3 Member Emergency Preparedness Plan
6.1.4 California's Standardized Emergency Management System
6.1.5 Reporting Requirements During an Emergency
6.1.6 DHCS Emergency Directives

6.1 Emergency Preparedness and Response

6.1.1 General Requirements

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), "Emergency" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by public health crises, natural and man-made hazards, or disasters.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), "Emergency Preparedness" means a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking Corrective Action in an effort to ensure effective coordination during incident response. Contractor's Emergency Preparedness process is one element of a broader national preparedness system to prevent, respond to, and recover from public health crises, natural disasters, acts of terrorism, and other disasters.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), "Emergency Preparedness and Response Plan" means an Emergency plan put in place by Contractor to ensure continuity of its business operations, to ensure delivery of essential care and services to Members, and to help mitigate potential harm caused by an Emergency.

This Article 6.0 (*Emergency Preparedness and Response*) will not become effective until January 1, 2025. Contractor must immediately comply with all requirements in this Contract relating to this Article 6.0 (*Emergency Preparedness and Response*) set out in Exhibit A, Attachment II, Article 1.0 (*Operational Readiness Deliverables and Requirements*) upon becoming effective January 1, 2025. Nothing in this Article 6.0 (*Emergency Preparedness and Response*) is intended to relieve Contractor of any other duties or requirements that would otherwise apply, such as any duties or requirements under federal and State laws and regulations relating to Emergency Preparedness.

Contractor must have in place an Emergency Preparedness and Response Plan which includes, at a minimum:

A. A Business Continuity Emergency Plan, as described in Exhibit A, Attachment III, Section 6.2 *(Business Continuity Emergency Plan*)*;*

B. A Member Emergency Preparedness Plan, as described in Exhibit A, Attachment III, Section 6.3 *(Member Emergency Preparedness Plan*)*;* and

C. Contractor's policies and procedures for complying with all of the requirements set forth in this Article 6.0 (*Emergency Preparedness and Response*).

Contractor must submit its Emergency Preparedness and Response Plan to DHCS for approval prior to the start of Contractor's operations. Contractor must submit any updates to deliverables identified in this Section to DHCS as requested.

6.1.2 Business Continuity Emergency Plan

Contractor must have a Business Continuity Emergency Plan in place to deal with any Emergency that may affect Contractor's business operations, including, but not limited to, access to Network Providers, Subcontractors, and Downstream Subcontractors; communications; staffing; supplies; and information technology concerns.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), a "Business Continuity Emergency Plan" means a document consisting of the critical information and processes Contractor needs to continue operating during an Emergency.

Contractor must consider the availability of local resources and requirements and, upon request, coordinate with local city and county Emergency Preparedness programs when establishing its Business Continuity Emergency Plan.

At a minimum, Contractor's Business Continuity Emergency Plan must address the following:

A. Communication

Contractor must describe how it will communicate with staff, Network Providers, Subcontractors, Downstream Subcontractors, DHCS, and other essential persons and entities during an Emergency. Contractor must also include how Contractor will provide Member, Network Provider, Subcontractor, and Downstream Subcontractor access to call centers for questions; how Contractor will provide dedicated staff and resources toward the Emergency process; and how Contractor will address the continual and timely resolution of claims. Contractor must maintain Emergency contact information, telephone numbers, and other contact information (including contact name, title or position, physical location address, mailing address, telephone and/or cell phone, text, e-mail, and social media) for staff, Network Providers, Subcontractors, Downstream

Subcontractors, and other essential persons and entities. Contractor must update this contact information as changes occur, but no less than every six months.

B. Emergency Preparedness Risk Assessment

Contractor must identify and assess potential public health crises and natural or man-made Emergencies, including, but not limited to, epidemics, pandemics, earthquakes, fires, floods, storms, hurricanes, tornados, power outages, gas leaks, bomb threats or presence of explosives, explosions, hazardous materials incidents, relocations or evacuations, assaults, intrusions, bioterrorism, injuries, riots, and information technology security incidents that could arise at any location in which Contractor conducts business operations under this Contract. When assessing the risk of a potential Emergency, Contractor must consider the likelihood of the Emergency within its Service Area and how the Emergency may disrupt Contractor's business operations. Contractor must identify and assess any essential supply chain impacts that may disrupt business operations during or after the Emergency. Contractor must update its assessment as changes occur, but at least on an annual basis.

C. Emergency Team Staffing and Responsibilities

1) Contractor must identify an Emergency team and back-up Emergency team members to carry out Contractor's Business Continuity Emergency Plan in the event of an Emergency.

2) Contractor must clearly designate the Emergency team's responsibilities during an Emergency, including, but not limited to, sending out Emergency communications to Contractor's employees, Network Providers, Subcontractors, Downstream Subcontractors, Members, managing site security staff, those staff responsible for securing utilities, and other essential persons and entities.

3) Contractor must ensure that Emergency team members know how to report their status to the Emergency team during and after an Emergency to keep Contractor informed of changing needs.

D. Cooperative Arrangements

Contractor must attempt to establish cooperative arrangements with other local health care organizations to assist and provide mutual aid during an

Emergency when business operations are affected. Contractor must submit to DHCS an attestation that it will update its cooperative arrangements at least annually and submit to DHCS.

E. Training and Drills

1) Contractor must establish an Emergency training program to train new and existing staff on Contractor's Business Continuity Emergency Plan.

2) Contractor must conduct annual Business Continuity Emergency Plan drills to ensure Emergency Preparedness and to detect vulnerabilities that can be addressed before an actual Emergency arises. Contractor must submit a report to DHCS within 30 calendar days of each training drill which identifies drill activities, provides a summary of outcomes, and creates a plan to address any vulnerabilities found.

3) Contractor must, upon request, participate in mock disaster drills coordinated by governmental entities, if available, to ensure coordination during an Emergency.

4) Contractor must ensure that the equipment and supplies necessary to sustain business operations are readily available in the event of an Emergency.

F. Systems Recovery

1) Emergency Operation

Contractor must establish a plan to maintain critical business processes that protects confidential and sensitive electronic and non-electronic information, including, but not limited to, Protected Health Information (PHI), Personal Information (PI), and claims information during an Emergency.

2) Data Backup

Contractor must establish procedures to backup confidential and sensitive electronic information, including, but not limited to, PHI, PI, and claims information to maintain the ability to retrieve such information during an Emergency. Contractor must establish a regular schedule for conducting backup procedures, storing backup information offsite, updating an inventory of backup media, and

formulating an estimate for the time needed to restore lost confidential and sensitive information. At a minimum, Contractor must conduct a full backup process of its confidential and sensitive electronic information on a weekly basis and update its offsite data storage on a monthly basis.

6.1.3 Member Emergency Preparedness Plan

Contractor must establish a Member Emergency Preparedness Plan to address its Members' needs during an Emergency, including for Members in Long-Term Care facilities, Skilled Nursing Facilities, or other institutional settings; and for Members with disabilities, limitations in activities of daily living, and/or cognitive impairments.

For the purposes of this Article 6.0 (*Emergency Preparedness and Response*), a "Member Emergency Preparedness Plan" means a required subsection of the Emergency Preparedness and Response Plan that details the required coordination between Contractor and its Members, Network Providers, Subcontractors, and Downstream Subcontractors to ensure Member access to health care services in the event of an Emergency.

At a minimum, Contractor's Member Emergency Preparedness Plan must address the following:

A. Member Communication

1) Contractor must have the ability to set up a Member services call center for communication with Members before, during, and after an Emergency.

2) Contractor must establish Emergency protocols for its Member services call center. Protocols must include, but are not limited to, call scripts that account for different Member needs, staff training in crisis response, Contractor Emergency protocols that ensure access to Covered Services, and processes for escalating a call through warm hand-off connections to nurses or doctors for Members needing immediate assistance.

3) During and post-Emergency, Contractor must:

a) Instruct Members about how to reach Contractor's nurse advice line, care coordinators, Medi-Cal Rx pharmacy services, Telehealth services, and other Contractor services and resources as deemed appropriate;

b) Notify Members about available alternative primary pharmacy, dialysis center, chemotherapy or other infusion therapy location, and other treatment sites;

c) Inform Members about how Contractor may modify its care protocols and Member benefits to ensure continued access to Medically Necessary services;

d) Provide Members with information on how to obtain medical authorizations, out-of-Network care, medication refills or Emergency supply, Durable Medical Equipment (DME) and replacements, and Medical Records; and

e) Inform Members about how to access behavioral and mental health services.

B. Continuity of Covered Services

1) Contractor must ensure that Members impacted by a federal, State, or county declared state of Emergency continue to have access to Covered Services. Contractor must take actions to ensure continued access, including but not limited to the following:

a) Relaxing time limits for Prior Authorization, pre-certification, and referrals;

b) Extending filing deadlines for Grievances and requests for Appeal in accordance with Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*);

c) Coordinating, transferring, and referring Members to alternate sources of care when Providers are closed, unable to meet the demands of a medical surge, or otherwise affected by an Emergency;

d) Authorizing Members to replace DME or medical supplies out-of-Network;

e) Allowing Members to access appropriate out-of-Network Providers if Network Providers are unavailable due to an Emergency or if the Member is outside of the Service Area due to displacement; and

f) Providing, when directed, a toll-free telephone number for displaced Members to call with questions, including questions about the loss of a Beneficiary Identification Card, access to prescription refills, and how to access health care.

2) Contractor must establish policies and procedures to immediately implement these actions as necessary or as directed by DHCS.

C. Network Provider, Subcontractor, and Downstream Subcontractor Emergency Requirements

1) Education

a) Contractor must educate Network Providers, as a part of training in accordance with Exhibit A, Attachment III, Subsection 3.2.5 (*Network Provider Training*); Subcontractors; and Downstream Subcontractors on Contractor's Emergency policies and procedures.

b) Contractor must provide Network Providers, Subcontractors, and Downstream Subcontractors with an Emergency Preparedness fact sheet and resources on general Emergency Preparedness, response, and communications protocols.

2) Communications During an Emergency

a) Contractor must have a system and process in place to be able to provide and receive information from Network Providers, Subcontractors, and Downstream Subcontractors during an Emergency.

b) Contractor must have a process in place to inform Network Providers, Subcontractors, and Downstream Subcontractors about what modifications need to be implemented during an Emergency to ensure that Members are able to access Covered Services, and how Contractor can assist Network Providers, Subcontractors, and Downstream Subcontractors in those efforts.

3) Network Provider Agreements

a) Contractor's Network Provider Agreements must state that Network Providers are required to:

i. Annually submit evidence of adherence to Centers for Medicare & Medicaid Services Emergency Preparedness Final Rule (FR), 81 FR 63859, and 84 FR 51732;

ii. Advise Contractor as part of the Network Provider's Emergency plan; and

iii. Notify Contractor within 24 hours of an Emergency if the Network Provider closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency.

6.1.4 California's Standardized Emergency Management System

A. Contractor must cooperate with local city and county Emergency Preparedness programs within Contractor's Service Area to ensure provision of health care services.

B. Contractor must, upon request, educate and prepare staff on the California State Emergency Plan and prepare staff to participate in California's Standardized Emergency Management System, or SEMS.

C. Contractor must maintain contact information for local city and county Emergency Preparedness programs within Contractor's Service Area.

D. Contractor must ensure that its medical director and Grievance and Appeals coordinator are able to receive communications from the California Health Alert Network and the California State Warning Center.

6.1.5 Reporting Requirements During an Emergency

A. Within 24 hours of a federal, State, or county declared state of Emergency located within Contractor's Service Area, Contractor must notify DHCS as to whether Contractor has experienced or expects to experience any disruption to its operations.

B. At a minimum, Contractor must report the status of its operations once a day to DHCS, or as directed by DHCS.

C. Contractor's daily report to DHCS must include, at a minimum, the following information:

1) The number of Members in Contractor's Service Area affected by the Emergency, per county, including the number of medium-to-high health risk Members, as identified through the Population Needs Assessment;

2) Information, to the extent available, relating to Network Provider site closures, including:

   a) The number of Network Provider site closures by Provider type, per county;

   b) The number of Members served by each closed Network Provider, per county;

   c) The number of hospitalized Members who need to be transferred;

   d) The location(s) of where Members were transferred; and

   e) For each closed Network Provider, a list of the alternative Providers or facilities where Members can receive care.

3) The number of Contractor offices that are closed;

4) How Contractor is communicating with impacted Members, Network Providers, Subcontractors, and Downstream Subcontractors;

5) The actions Contractor has taken or will take to meet the continued health care needs of its Members; and

6) The Network Provider, Subcontractor, Downstream Subcontractor, or Member issues Contractor has received.

D. Contractor must comply with any guidance from the California Health and Human Services Agency regarding reporting on the status of Contractor's operations during an Emergency.

6.1.6 DHCS Emergency Directives

When a federal, State, or county Emergency is declared, Contractor agrees that DHCS may, in its sole discretion, waive existing contractual requirements and institute new contractual requirements to address an Emergency pursuant to an Emergency directive. DHCS Emergency directives do not require an amendment

to this Contract prior to implementation. Emergency directives to Contractor may be communicated through All Plan Letters, advisory memos, or other similar announcements and are effective when published. Unless otherwise stated, Emergency directives will remain in effect until the Emergency directive is terminated. Contractor must promptly comply with all DHCS Emergency directives.

Exhibit A, Attachment III

7.0 Operations Deliverables and Requirements

To demonstrate the requisite capabilities necessary to execute the obligations of this Contract, DHCS outlines specific deliverables that Contractor must submit to DHCS prior to the implementation of the Contract. This period is considered the Implementation Period at which time DHCS will assess the Medi-Cal managed care plan's readiness to begin operations as a Contractor. These deliverables are identified and set forth in Exhibit A, Attachment II, Section 1.0 (*Operational Readiness Deliverables and Requirements*) of the Contract and the tables that follow that Section.

This Article provides a non-exhaustive list of deliverables required to be submitted by Contractor to DHCS and/or other entity(ies) throughout the term of the Contract to verify Contractor's continued compliance with Contract requirements. Contractor must submit all required deliverables to DHCS in a complete, accurate, and timely fashion. Contractor must submit all required deliverables to DHCS in an Americans with Disabilities Act of 1990 (ADA)-compliant format if identified in the tables below this section as publicly available. Contractor may be responsible for additional deliverable requirements based on changes in State and federal law and/or DHCS program needs. Contractor must meet any additional requirements, not listed in the tables below, upon DHCS' request and in the form and manner specified by DHCS. Contractor must use the calendar year to define annual, monthly, and quarterly submission timeframes unless directed otherwise.

In the event Contractor fails to submit any deliverables in accordance with the milestones and timeframes required by DHCS, DHCS may impose Sanctions and Liquidated Damages in accordance with Exhibit E, Subsection 1.1.19 (*Sanctions*) and Subsection 1.1.20 (*Liquidated Damages*) to Contractor.

EXHIBIT A, ATTACHMENT I – 1.0 DEFINITIONS

No deliverables or requirements listed for this Article.

EXHIBIT A, ATTACHMENT I – 2.0 ACRONYMS

No deliverables or requirements listed for this Article.

EXHIBIT A, ATTACHMENT II – 1.0 OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

See specific contract Sections below for details.

EXHIBIT A, ATTACHMENT III – 1.1 PLAN ORGANIZATION AND ADMINISTRATION

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0001	Key Personnel Disclosure Form	1.1.2	Annually.		DHCS
D.0114	Medical Director Information	1.1.6		Posted on Contractor's website.	Public
D.0002	Key Personnel Change Notification including CEO, CFO, COO, CMO, Chief Medical Director, Health Equity Officer, Compliance Officer, and Government Relations Person	1.1.8	Within ten calendar days. Within 20 calendar days.	Contractor must post Medical director contact information on their provider portal website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 1.2 FINANCIAL INFORMATION

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0003	Monthly Financial Reports	1.2.2	Monthly, no later than 30 calendar days after the close of Contractor's fiscal month.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0004	Quarterly Financial Reports	1.2.2	Quarterly, no later than 45 calendar days after the close of Contractor's fiscal quarter.		DHCS
D.0005	Annual Financial Reports	1.2.2	Annually, no later than 120 calendar days after the close of Contractor's Fiscal Year.		DHCS
D.0006	Annual Forecasts	1.2.2	Annually, no later than 60 calendar days prior to the beginning of Contractor's next Fiscal Year.		DHCS
D.0007	Independent Financial Audit Report	1.2.3	Annually, no later than 120 calendar days after the close of Contractor's Fiscal Year.		DHCS
D.0008	Medical Loss Ratio Report (MLR)	1.2.5; 1.2.5.H	Annually; Timeframe and manner determined by DHCS, but no longer than 12 months after the end of the MLR Reporting Year; and When there is a retroactive change to the Capitation Payments for a MLR reporting year and a new report needs to be submitted to reflect the change.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0009	Community Reinvestment Plan	1.2.7	Annually.	Posted on Contractor's website.	DHCS
D.0010	Community Reinvestment Report	1.2.7	Annually.	Posted on Contractor's website.	DHCS

EXHIBIT A, ATTACHMENT III – 1.3 PROGRAM INTEGRITY AND COMPLIANCE PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0115	Compliance Program	1.3.1.A .9	Annually	On Contractor's website.	DHCS
D.0011	Preliminary Fraud, Waste, and Abuse Reports	1.3.2.D .1	Within ten Working Days of Contractor's discovery of such Fraud, Waste, or Abuse.		DHCS
D.0012	Completed Fraud, Waste, and Abuse Investigation Report	1.3.2.D .2	Within ten Working Days of completing Contractor's Fraud, Waste, or Abuse investigation.		DHCS
D.0013	Quarterly Fraud, Waste, Abuse Status Report	1.3.2.D .3	Quarterly, ten Working Days after the close of every calendar quarter.		DHCS
D.0014	Suspended, Excluded, or Ineligible Provider Notification	1.3.4.A .6	Within ten Working Days of removing a suspended, excluded, or ineligible Provider from its Network.		DHCS
D.0116	Disclosures	1.3.5.C	Within 60 calendar days of when it has identified any Capitation Payments or other payments it has		

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
			received or paid in excess of the amounts specified in this Contract.		
D.0106	Overpayment Recoveries Report	1.3.6.B	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 2.1 MANAGEMENT INFORMATION SYSTEM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0015	Encounter Data Reporting	2.1.2	Within 60 calendar days of the date of adjudication of a claim or receipt of an Encounter as required by this Contract or as otherwise agreed upon by DHCS, or as mandated through federal law; and Within six Working Days of the end of each month following the month of payment.		DHCS
D.0017	Network Provider Data Reporting	2.1.4	Within ten calendar days following the end of each month.		DHCS
D.0018	Program Data Reporting	2.1.5	Within ten calendar days following the end of each month.		DHCS
D.0019	Template Data Reporting	2.1.6	On a regular basis, or as mandated through federal law.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0020	Management Information System/Data Audits	2.1.7	No less frequently than once every three years.		DHCS
D.0016	Data Corrective Action Plans	2.1.8	Within 15 calendar days from the date of the DHCS written notice to Contractor regarding any deficiencies and problem related to Contractor's data or its Management Information System (MIS).	DHCS may publicly disclose on the DHCS website any Contractors that have entered into Corrective Action plans, or that have been subject to sanctions due to non-compliance.	DHCS; public
D.0117	Tracking Member Alternative Format Selections	2.1.9	As Requested by Member in accordance with the requirements in All Plan Letter (APL) 22-002.		DHCS

EXHIBIT A, ATTACHMENT III – 2.2 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0021	Written summary of Quality Improvement and Health Equity Committee (QIHEC) activities and the QIHEC activities of Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors	2.2.3.D	At least quarterly.	On Contractor's website.	DHCS; Public
D.0022	Quality Improvement and Health Equity Plan	2.2.7	Annually.	On Contractor's website.	DHCS; Public
D.0026	NCQA Health Plan Accreditation and Health Equity Accreditation results	2.2.8	After every NCQA accreditation cycle (every 3 years). Within 30 calendar days of the receipt of the completed report from NCQA. Within 15 calendar days of confirmation of the site visit by NCQA.		DHCS
D.0023	Performance Improvement Project reporting	2.2.9.B	At intervals determined by DHCS. At least annually.	On the DHCS website.	DHCS; Public

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0025	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey results and CAHPS results for its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors	2.2.9.C	Annually after January 1, 2026.	On Contractor's website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 2.3 UTILIZATION MANAGEMENT PROGRAM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0027	Appeals Procedure	2.3.1.F	As needed when updated.	On Contractor's website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 3.1 NETWORK PROVIDER AGREEMENTS, SUBCONTRACTOR AGREEMENTS, DOWNSTREAM SUBCONTRACTOR AGREEMENTS, AND CONTRACTOR'S OVERSIGHT DUTIES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0028	Delegation Reporting and Compliance Plan	3.1.3; Exh. J	Annually and at any time there is a material change as specified by DHCS within 30 calendar days from either the beginning of the annual reporting period or the material change.	On Contractor's website.	DHCS; Public

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0029	Non-Federally Qualified Health Maintenance Organizations (HMOs) Subcontractor Agreement, Downstream Subcontractor Agreement, and Network Provider Amendment Approval Request	3.1.5	At least 30 calendar days before the effective date, unless otherwise instructed by DHCS. Within 60 calendar days after the date the overpayment was identified.		DHCS
D.0030	Federally Qualified HMOs Network Provider Agreement, Subcontractor Agreement, or Downstream Subcontractor Agreement	3.1.8	Upon DHCS request.		DHCS
D.0031	Termination Notice of Network Provider Agreement with a Safety-Net Provider	3.1.8	As needed, at least 60 calendar days prior to the effective date of termination or concurrently with the termination if Provider's license has been revoked or suspended or where the health and welfare of a Member is threatened.		DHCS
D.0118	Provider Selection	3.1.10	Upon request.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0119	Delegation Model	3.1.12		On Contractor's website.	

EXHIBIT A, ATTACHMENT III – 3.2 PROVIDER RELATIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0032	Provider Dispute Resolutions Report	3.2.2	Annually.		DHCS
D.0033	Most current Provider Manual	3.2.4	As needed. Annually.	Available to the Provider through Provider portals, the Internet or upon request.	Providers
D.0034	Hospital Inpatient Days Report	3.2.8	As required by W&I section 14105.985(b)(2). Within 30 calendar days of DHCS' request.		DHCS

EXHIBIT A, ATTACHMENT III – 3.3 PROVIDER COMPENSATION ARRANGEMENTS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0035	Alternative and Value-Based Payment Models Report	3.3.1.B; 3.3.1.C	Within 90 calendar days of DHCS' request. Annually.		DHCS
D.0036	Financial Incentive Programs Report	3.3.3	As specified by DHCS.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0037	Identification of Responsible Payor	3.3.4	Upon request and in a manner prescribed by DHCS.		DHCS' fiscal intermediary (FI) contractor
D.0038	Documentation of services for Contractor's Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Network Provider Agreements	3.3.7.B	Within 30 calendar days of DHCS' request.		DHCS
D.0039	Certification of Terms and Conditions for Network Provider Agreements with FQHCs and RHCs	3.3.7.B	Within 30 calendar days of DHCS' request.		DHCS
D.0040	FQHC and RHC Network Provider Agreements	3.3.7.B	Whenever any Network Provider Agreements are executed or amended.		DHCS
D.0041	Disputed Emergency Services/Post-Stabilization Care Claims	3.3.16	As needed. Within 30 calendar days of the effective date of a decision that Contractor is liable for payment of a claim.		DHCS - Office of Administrative Hearings and Appeals

EXHIBIT A, ATTACHMENT III – 4.1 MARKETING

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0042	Conduct Activity Outside of Contract Requirements	4.1.2	As needed, at least 30 calendar days prior to the Marketing event.		DHCS
D.0043	Updates to Marketing Representative Training and Certification Program	4.1.1	Prior to implementation.		DHCS
D.0044	Marketing Materials	4.1.2	Prior to distribution. At least 30 calendar days prior to the Marketing activity, unless DHCS agrees to a shorter review period.		DHCS
D.0045	Marketing Plan	4.1.2	Annually. When there are any changes made to Contractor's Marketing plan.		DHCS

EXHIBIT A, ATTACHMENT III – 4.2 ENROLLMENTS AND DISENROLLMENTS

No deliverables or requirements listed for this Section.

EXHIBIT A, ATTACHMENT III – 4.3 POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0046	Population Health Management Strategy	4.3.1	Annually.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0047	Population Needs Assessment	4.3.2	At least every three years.	On Contractor's website.	DHCS; Public

EXHIBIT A, ATTACHMENT III – 4.4 ENHANCED CARE MANAGEMENT

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0049	Enhanced Care Management Model of Care (MOC)	4.4.5	Contractor must submit to DHCS any Significant changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs.		DHCS

EXHIBIT A, ATTACHMENT III – 4.5 COMMUNITY SUPPORTS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0050	Community Supports Model of Care	4.5.5	Contractor must submit to DHCS any changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including APLs.		DHCS

EXHIBIT A, ATTACHMENT III – 4.6 MEMBER GRIEVANCE AND APPEAL SYSTEM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0051	Receipt of Discrimination Grievances	4.6.2.E	Within five calendar days of receipt of the Grievance.		Member who filed a Grievance
D.0052	Discrimination Grievance Information	4.6.3.C	Within ten calendar days of mailing a Discrimination Grievance resolution letter.	On Contractor's website.	DHCS - Office of Civil Rights;
D.0053	Sample Notice of Action (NOA) Letter	4.6.4.C 4.6.4.E .3	Within 30 calendar days from receipt of information that is reasonably necessary to make a determination. No later than 60 calendar days from the date on the NOA.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0054	Grievance Logs	4.6.9	Upon DHCS request. Monthly.		DHCS and/or CMS

EXHIBIT A, ATTACHMENT III – 5.1 MEMBER SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0055	Member Information Notice	5.1.3	Prior to use.		DHCS
D.0056	Nondiscrimination Notice and Language Taglines	5.1.3	Prior to use.	On Contractor's website – accessible from Contractor's home page.	DHCS
D.0057	Member Information - Provider Directory	5.1.3	Prior to initial Operations; Monthly; Every six months; When Contractor updates the Provider Directory; and One week after Contractor receives updated provider information.	On Contractor's website.	DHCS; Public

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0058	Member Information - Member Handbook/Evidence of Coverage (EOC)	5.1.3	Before distribution to Members; When updated; or Other timeframes provided by DHCS.	On Contractor's website.	DHCS

EXHIBIT A, ATTACHMENT III – 5.2 NETWORK AND ACCESS TO CARE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0059	Alternative Access Standard Requests	5.2.5	At least annually and when Contractor is unable to comply with the time or distance standards set forth in W&I section 14197.04.	Contractor's website for Contractor specific results and the DHCS website with statewide results.	DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0060	Network and Access Changes to Covered Services	5.2.9.A	When Contractor discovers a Provider-initiated termination impacting more than 2,000 Members; When Contractor discovers a Provider-initiated termination that affect Contractor's ability to meet network adequacy standards; When there is a change in the availability or location of Covered Services; and Within ten calendar days of Contractor discovering a Provider's exclusionary status from any database or list.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0061	Notification regarding Community Based Adult Services (CBAS) Network Provider	5.2.9.A	When Contractor is unable to contract with a certified CBAS Provider; Upon termination of a CBAS Network Provider Agreement; and Within five Working Days of Contractor's decision to exclude a CBAS Provider from its Network.		DHCS
D.0062	Notification regarding Long-Term Care (LTC) Network Provider	5.2.9.A .4	Within 60 calendar days of termination of a LTC Provider; Immediately if the termination is a result of LTC Provider decertification by CDPH; and Within 72 hours of applicable termination of a LTC Provider.		DHCS
D.0063	Member Notice regarding Provider Termination	5.2.9.B	Prior to its release to Members.		DHCS
D.0064	Community Advisory Committee (CAC) Demographic Report	5.2.11	Annually, by April 1st.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0065	CAC meeting notices	5.2.11	30 days prior to each quarterly CAC meeting, but in no event later than 72 hours prior to each meeting.	On Contractor's website.	Public
D.0066	CAC meeting minutes	5.2.11. E.3.d.	No later than 45 calendar days after each quarterly meeting.	On Contractor's website.	DHCS; Public
D.0067	Network Certification Report	5.2.13	At least annually.	On the DHCS Website.	DHCS
D.0068	Notification of Significant Change to Network	5.2.13. B	Any time there is a Significant Change to Contractor's Network that affects Network capacity and Contractor's ability to provide health care services.		DHCS
D.0069	Network Change Report	5.2.13	30 calendar days following the end of the reporting quarter.		DHCS
D.0112	Subcontractor and Downstream Subcontractor Certification Report	5.2.13	At least annually, if applicable.	On Contractor's website.	DHCS

EXHIBIT A, ATTACHMENT III – 5.3 SCOPE OF SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0070	Report of Drug Use Review (DUR) Program Activities	5.3.7.H	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 5.4 COMMUNITY BASED ADULT SERVICES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0072	CBAS Member Enrollment Report	5.4.3.A	On a quarterly basis.		DHCS
D.0113	Summary of CBAS Complaints	5.4.3.C	30 calendar days following the end of the reporting period.		DHCS
D.0073	CBAS Grievance and Appeal Reports	5.4.3.D	30 calendar days following the end of the reporting period.		DHCS
D.0120	CBAS Provider List	5.4.3.E	Annually.		DHCS

EXHIBIT A, ATTACHMENT III – 5.5 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

No deliverables or requirements listed for this Section.

EXHIBIT A, ATTACHMENT III – 5.6 MOUs WITH LOCAL GOVERNMENT AGENCIES, COUNTY PROGRAMS, AND THIRD PARTIES

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0075	Status Report	5.6.3	Quarterly, beginning four months after the effective date of this Contract or within the timeframe required under this Contract and relevant APL, until all required MOUs are executed.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0121	Existing MOU	5.3.6.A .6	Within ten Working Days of receipt of the request.		DHCS
D.0076	Copy of Executed MOUs	5.6.3	Upon execution, modification or renewal.	On Contractor's website.	DHCS
D.0077	MOU Review Report	5.6.3.B	Annually.		DHCS, upon request

EXHIBIT A, ATTACHMENT III – 6.0 EMERGENCY PREPAREDNESS AND RESPONSE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0078	Emergency Preparedness and Response Plan	6.1	Prior to the start of Operations.	On Contractor's website.	DHCS
D.0079	Emergency Contact Information Update	6.2.A	No less than every six months; and As changes occur.		DHCS
D.0080	Cooperative Agreements	6.2.D	At least annually.		DHCS
D.0081	Emergency Drill Report	6.2.E	Within 30 calendar days after the drill is completed.		DHCS
D.0082	Member Emergency Preparedness Plan Templates	6.3	Prior to use for each mode of communication. This deliverable is not required until 2025.		DHCS
D.0083	Daily Emergency Reporting	6.5.B	Once a day, at a minimum, throughout the State of Emergency.		DHCS

EXHIBIT B, BUDGET DETAIL AND PAYMENT PROVISIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0084	Supplemental Payments Report	1.7.A	Monthly, no later than the 20th calendar day following the end of each month.		DHCS
D.0085	Supplement Payment Eligibility Data	1.7.A	Within 14 months of the month of the service entitling Contractor to a Supplemental Payment.		DHCS
D.0086	Additional Payments Report	1.8.A	Monthly, no later than the 20th calendar day following the end of each month.		DHCS
D.0087	Additional Payments Report Eligibility Data	1.8.A	Within 14 months of the month of the service entitling Contractor to an additional payment.		DHCS
D.0122	Financial Performance Guarantee	1.12	Annually.		DHCS
D.0088	Medical Loss Ratio Remittance	1.15	When the ratio for the MLR reporting year does not meet the minimum MLR standard.		DHCS

EXHIBIT C, GENERAL TERMS AND CONDITIONS

No deliverables or requirements listed for this Exhibit.

EXHIBIT D(f), SPECIAL TERMS AND CONDITIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0089	List of Equipment/ Property for State to Procure	3.d.1	When Contractor needs to secure equipment/property above the annual maximum limit of $50,000.		DHCS
D.0090	State Equipment and/or Property Inventory Report	4.a.2	Annually.		DHCS
D.0091	State Equipment and/or Property Theft Report	4.d	In the event of State equipment and/or property theft.		DHCS
D.0092	Final Inventory Report of State Equipment and/or Property	4.e	Within 60 calendar days prior to the termination or end of this Contract.		DHCS
D.0093	Automobile Liability Insurance	4	When any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Contract.		DHCS
D.0094	Request for Subcontract Authorization	5.a	Before Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more.		DHCS
D.0095	Prior Approval of Training Seminars, Workshops or Conferences	13	As applicable, prior to the event.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0096	Requests for Disclosure of Confidential Information	14	As applicable.		DHCS
D.0097	Contractor Certification of Federal Fund Expenditure	17	As applicable.		DHCS
D.0098	Financial and Compliance Audit Reports	17.d	Within 30 calendar days after the completion of the audit.		DHCS
D.0099	Contractor Explanation for Debarment and Suspension Certification.	20	As applicable.		DHCS

EXHIBIT E, PROGRAM TERMS AND CONDITIONS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0123	Certifications - Data, Information, and Documentation Submitted to DHCS	1.11	Monthly.		DHCS
D.0100	Contractor's Analysis regarding its financial solvency	1.16	As needed.		DHCS
D.0101	Contractor Termination Notice due to financial insolvency	1.16	As needed, and at least six months prior to expected effective termination date.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0124	Phaseout Transition Requirements	1.17.B	Within no later than 90 calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area.		DHCS
D.0102	Notice of Dispute	1.21.B	Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to Contractor.		DHCS
D.0103	Costs Avoidance Reports	1.25	Within ten calendar days of discovery By the 15th day of each month.		DHCS
D.0104	Post-Payment Recovery Report	1.25.H 1.25.J	At the tenth day of each month; and Within ten calendar days of discovery when Contractor identifies Other Health Coverage (OHC) unknown to DHCS.		DHCS
D.0105	Service and Utilization Information	1.26	Within 30 calendar days of the DHCS' request.		DHCS
D.0125	Litigation Support Records	1.27.A	Upon DHCS request.		DHCS

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0107	DVBE Reporting Requirements	1.31	60 calendar days after receiving final payment, if Contractor made a commitment to achieve DVBE participation.		DHCS

EXHIBIT F, CONTRACTOR'S RELEASE

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0108	Contractor's Release	F	With the submission of final invoice(s).		DHCS

EXHIBIT G, BUSINESS ASSOCIATE ADDENDUM

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0109	Notice to DHCS of Breaches and Security Incidents	18.1	See contract language for details.		DHCS
D.0110	Completed Final Privacy Incident Reporting Form	18.3	Within ten Working Days of the discovery of the security incident or breach.		DHCS

EXHIBIT H, CONFLICT OF INTEREST AVOIDANCE REQUIREMENTS

No deliverables or requirements listed for this Exhibit.

EXHIBIT I, CONTRACTOR'S PARENT GUARANTY REQUIREMENTS

No deliverables or requirements listed for this Exhibit.

EXHIBIT J, DELEGATION REPORTING AND COMPLIANCE PLAN

ID	Deliverable Title	Ref.	Frequency	Publicly Available	Recipient
D.0111	Delegation Reporting and Compliance Plan	3.1.3; Exh. J	Annually and at any time there is a change as specified by DHCS within 30 calendar days following the annual reporting period or the material change	On Contractor's website.	DHCS; Public

EXHIBIT K, EXCLUDED PROVISIONS AS TO CONTRACTORS NOT LICENSED PURSUANT TO THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975

No deliverables or requirements listed for this Exhibit.

EXHIBIT L, REQUIREMENTS SPECIFIC TO CONTRACTOR

Any deliverables for Contractor-specific requirements will be stated in Exhibit L.

Exhibit B – Budget Detail and Payment Provisions

1.0 Budget Detail and Payment Provisions

1.1 Budget Detail and Payment Provisions

1.1.1 Budget Contingency Clause
1.1.2 Contractor Risk
1.1.3 Capitation Payment Rates
1.1.4 Capitation Payment Rates Constitute Payment in Full
1.1.5 Determination and Redetermination of Capitation Payment Rates
1.1.6 Redetermination of Capitation Payment Rates Due to Obligation Changes
1.1.7 Supplemental Payments
1.1.8 Additional Payments
1.1.9 Recovery of Amounts Paid to Contractor
1.1.10 Reinsurance
1.1.11 Catastrophic Coverage Limitation
1.1.12 Financial Performance Guarantee
1.1.13 Medicare Coordination
1.1.14 Special Contract Provisions Related to Payment
1.1.15 Medical Loss Ratio Remittance
1.1.16 State Program Receiving Federal Financial Participation
1.1.17 Community Reinvestment
1.1.18 Quality Achievement Requirement
1.1.19 Enhanced Care Management Risk Corridor

1.1 Budget Detail and Payment Provisions

1.1.1 Budget Contingency Clause

Any requirement of payment or performance by DHCS and Contractor for the period of the Contract will be dependent upon the availability of future appropriations by the Legislature for the purpose of the Medi-Cal program.

A. It is mutually agreed that if the Budget Act of the current year or any subsequent years covered under this Contract does not appropriate sufficient funds for the program, DHCS shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Contract, and Contractor shall not be obligated to perform any provisions of this Contract in any year when insufficient funding may occur. Further, should funding for any Fiscal Year be reduced or deleted by the Budget Act for purposes of this program, DHCS must have the option to:

1) Cancel this Contract with no liability accruing to DHCS and no further obligation by Contractor to perform hereunder; or

2) Offer a Contract amendment to Contractor to reflect the reduced amount of available funding.

B. All payments are subject to the availability of federal appropriation of Medicaid funding.

1.1.2 Contractor Risk

Except as otherwise specified in this Contract, Contractor will assume the total risk of providing Covered Services to Members on the basis of periodic Capitation Payments paid to Contractor by DHCS for each Member. Subject to Exhibit B, Subsection 1.1.15 (*Medical Loss Ratio Remittance*), any funds not expended by Contractor after having fulfilled all obligations under this Contract may be retained by Contractor.

1.1.3 Capitation Payment Rates

A. DHCS must remit to Contractor a Capitation Payment no later than 45 calendar days after the first day of each month for each Member that appears on the approved list of Members supplied to Contractor by DHCS. Capitation Payments must be made in accordance with the schedule of Capitation Payment rates set forth below. For the list of aid codes included in each Rate Group below, please see the definition of Potential Member

set forth in Exhibit A, Attachment I, Section 1.0 (*Definitions*) of this Contract. Supplemental and Additional Payments listed below will be made in accordance to the requirements stated in Subsections 1.1.7 (*Supplemental Payments*) and 1.1.8 (*Additional Payments*) of this Exhibit.

For the period 01/01/2024 – 12/31/2024	**Orange**
Aid Group	**Rates**
Adult/Family/OTLIC Under 19 - SIS	$112.35
Adult/Family/OTLIC Under 19 - UIS	$35.99
Adult/Family/OTLIC 19 & Over - SIS	$286.34
Adult/Family/OTLIC 19 & Over - UIS	$205.92
SPD - SIS	$1,099.03
SPD - UIS	$597.57
BCCTP - SIS	$1,099.03
BCCTP - UIS	$597.57
SPD Dual - SIS	$516.03
SPD Dual - UIS	$88.27
LTC - SIS	$1,099.03
LTC - UIS	$597.57
LTC Dual - SIS	$516.03
LTC Dual - UIS	$88.27
Adult Expansion - SIS	$339.48
Adult Expansion - UIS	$269.46
WCM - SIS	$2,047.84
WCM - UIS	$503.16

For the period 01/01/2024 – 12/31/2024	**Orange**
Supplemental and Additional Payment Groups	**Rates**
Maternity - SIS	$8,584.73
Maternity - UIS	$8,584.73
Adult Expansion Maternity - SIS	$8,584.73
Adult Expansion Maternity - UIS	$8,584.73

B. If DHCS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral Contract Revenue effect for Contractor, then the split aid code will automatically be included in the same Rate Group as the original aid code covered under this Contract. Contractor agrees to accept the Capitation Payment rate specified for the original aid code as payment in full for Members in the new aid code. DHCS must confirm all aid code splits and the rates of payment for such new aid codes in writing to Contractor as soon as practicable after such aid code splits occur.

C. In accordance with 42 Code of Federal Regulations (CFR), part 438, section 438.7, the actuarial basis for the computation of Capitation Payment rates must be set forth in DHCS' rate certification(s) for the applicable Rating Period. Subject to approval by Centers for Medicare & Medicaid Services (CMS), said rate certification(s) are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto in full.

1.1.4 Capitation Payment Rates Constitute Payment in Full

Except as otherwise specified in this Contract, Capitation Payment rates for each Rating Period, as calculated by DHCS and approved by CMS, are prospective rates and constitute payment in full on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by Contractor in providing or arranging for such services under the terms of this Contract. Except as otherwise specified in this Contract, DHCS is not responsible for making payments associated with Contractor's losses.

1.1.5 Determination and Redetermination of Capitation Payment Rates

A. In accordance with Welfare and Institutions Code (W&I) section 14301.1, DHCS must establish Capitation Payment rates on an actuarial basis for each Rating Period, and reserves the right to redetermine and to amend such rates as necessary and appropriate.

1) DHCS must establish Capitation Payment rates in accordance with W&I section 14301.1, applicable federal and State laws and regulations, and generally accepted actuarial principles and practices.

2) DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider Contractor's performance on specified quality and equity benchmarks, as determined by DHCS and communicated to Contractors in advance of each applicable Rating Period, within the determination of Capitation Payment rates for that Rating Period.

3) If Contractor delegates financial risk for the provision of Covered Services in accordance with Exhibit A, Attachment III, Subsection 3.1.6 (*Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers*), DHCS reserves the right, subject to actuarial judgment and generally accepted actuarial principles and practices, to consider the actual payments received

by Providers for providing Covered Services to Members to inform the determination of Capitation Payment rates.

B. Capitation Payment rates must be effectuated through an amendment or change order to this Contract in accordance with Exhibit E, Subsection 1.1.6 (*Amendment and Change Order Process*) of this Contract, subject to the following provisions:

1) The amendment or change order shall be effective as of January 1 of each year covered by this Contract;

2) In the event there is any delay in a determination or redetermination of Capitation Payment rates so that an amendment or change order may not be processed in sufficient time to permit payment of new rates commencing January 1, payment to Contractor shall continue at the rates stated in an R Letter sent to Contractor by DHCS. The R Letter shall serve as notification from DHCS to Contractor of the Capitation Payment rates and the time period for which these rates will be applied. The R Letter must not be considered exempt from any requirement of this Contract. Those continued payments shall constitute interim payment only. Upon CMS final approval of the amendment/change order and rate certification providing for the rate change, DHCS must make retroactive adjustments for those months for which interim payment was made;

3) By accepting payment of new Capitation Payment rates prior to approval by CMS of the amendment/change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any and all amounts received in excess of the final approved rate. In the event that the final approved rate differs from the rates established by DHCS or agreed upon by Contractor and DHCS:

a) Any underpayment by DHCS must be paid to Contractor after final approval of the new rates. DHCS will provide Contractor a timeframe for payment of any underpayments;

b) Unless otherwise required by CMS, any overpayment to Contractor must be offset by DHCS' withholding from Contractor's future Contract Revenues of any amount due. DHCS may, at its sole discretion, withhold up to 100 percent of Contract Revenues for each month until any overpayment is fully recovered by the State; and

c) Contractor must review all Contract Revenues and notify DHCS of any payment errors in a form and manner specified by DHCS. If the error favors DHCS, DHCS may offset against future Contract Revenues as stated in Paragraph b) above. If the error favors Contractor, Contractor must notify DHCS within 365 calendar days of payment, otherwise Contractor forfeits the right to receive the corrected payment, except when Contractor demonstrates to DHCS' satisfaction, in a form and manner specified by DHCS, that Contractor could not reasonably have identified the error.

4) If mutual agreement between DHCS and Contractor cannot be attained on Capitation Payment rates in accordance with this Paragraph B, Contractor shall have the right to terminate this Contract. Contractor's notification of the intent to terminate this Contract must be in writing and provided to DHCS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with the terms set forth in Exhibit E, Subsection 1.1.16 (*Termination*) of this Contract. DHCS must pay Capitation Payment rates determined for the applicable Rating Periods until the Contract is terminated; and

5) DHCS must make reasonable efforts to notify and consult with Contractor regarding any proposed redetermination of Capitation Payment rates in accordance with this provision or Exhibit B, Subsection 1.1.6 (*Redetermination of Capitation Payment Rates Due to Obligation Changes*) below prior to implementation of any new rates.

1.1.6 Redetermination of Capitation Payment Rates Due to Obligation Changes

Final Capitation Payment rates may be adjusted during or subsequent to the applicable Rating Period to provide for changes in obligations that result in a material projected increase or decrease of cost as determined by the certifying actuaries, in accordance with W&I section 14301.1, to Contractor. Any adjustments must be effectuated through an amendment or change order to the Contract subject to the following:

A. The amendment or change order shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS;

B. In accordance with Subsection 1.1.5 *(Determination and Redetermination of Capitation Payment Rates*) of this Exhibit B, in the event DHCS is

unable to process the amendment or change order in sufficient time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor must continue at the rates then in effect. Upon final approval of the amendment or change order, DHCS must make adjustments for those months in which interim payments were made; and

C. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Subsection 1.1.16 (*Termination)* of this Contract, in the event a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or by a lawsuit that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the termination date provided by this Contract.

1.1.7 Supplemental Payments

A. Contractor shall be entitled to Supplemental Payments stated within this Section in accordance with the schedule of Supplemental Payment rates set forth in this Exhibit B, Subsection 1.1.3 (*Capitation Payment Rates*). Contractor must maintain evidence of payment for qualified services entitling Contractor to Supplemental Payments. Upon audit, Contractor's failure to have supporting records may result in recoupment by DHCS of Supplemental Payments paid to Contractor.

1) On a monthly basis, by no later than 20 calendar days following the end of each month, and in a format specified by DHCS, Contractor must submit a report for Supplemental Payments. This report must identify the Members receiving services qualifying for a Supplemental Payment and for whom Contractor is claiming payment.

2) To be eligible to receive a Supplemental Payment, Contractor must properly submit all required data to DHCS within 12 months of the month of the service entitling Contractor to a Supplemental Payment.

B. **Maternity Supplemental Payments**

1) Contractor shall be entitled to receive maternity Supplemental Payments for Members enrolled with Contractor on the date of the delivery of a Child, including retroactive Enrollments.

2) The maternity Supplemental Payment reimburses Contractor for the projected cost of delivery as determined by DHCS.

1.1.8 Additional Payments

A. Contractor shall be entitled to additional payments stated within this Section in accordance with the schedule of additional payment rates set forth below. Contractor must maintain evidence of payment for qualified services entitling Contractor to additional payments. Upon audit, Contractor's failure to have supporting records may result in recoupment by DHCS of additional payments paid to Contractor.

1) On a monthly basis, by no later than 20 calendar days following the end of each month and in a format specified by DHCS, Contractor must submit a report for additional payments. This report must identify the Members receiving services qualifying for any additional payment and for whom Contractor is claiming payment.

2) To be eligible to receive an additional payment, Contractor must properly submit all required data to DHCS within 14 months of the month of the service entitling Contractor to an additional payment.

B. Contractor shall be entitled to receive an Indian Health Care Provider (IHCP) payment for Members qualified to receive services in accordance with Exhibit A, Attachment III, Subsection 3.3.7 (*Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider)* of this Contract.

1) DHCS will annually publish the IHCP payment rates via an All Plan Letter (APL).

2) The IHCP payment reimburses Contractor for the amount paid to the IHCPs as required in Exhibit A, Attachment III, Subsection 3.3.7 *(Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider)* of this Contract. Payments must be based on Member utilization of qualifying services at IHCPs as reported by Contractor.

1.1.9 Recovery of Amounts Paid to Contractor

DHCS shall have the right to recover from Contractor amounts paid to Contractor in the following circumstances:

A. If DHCS determines that a Member has been improperly enrolled due to ineligibility of the Member to enroll in Contractor's Medi-Cal managed care health plan, a Member's residence is outside of Contractor's Service Area, or, pursuant to 22 California Code of Regulations (CCR) section 53891(a)(2), or a Member should have been disenrolled with an effective date in a prior month, DHCS may recover amounts paid to Contractor associated with the Member for the month(s) in question. To the extent permitted by law, Contractor may seek to recover any payments made to Providers for Covered Services rendered for the month(s) in question. Contractor must inform Providers that claims for services provided to Members during the month(s) in question may be paid by the DHCS fiscal intermediary if the Member is determined eligible for the Medi-Cal program;

B. Upon request by Contractor, DHCS may allow Contractor to retain amounts paid to Contractor associated with a Member who is eligible to enroll in Contractor's Medi-Cal managed care health plan, but should have been retroactively disenrolled in accordance with Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) of this Contract or under other circumstances as approved by DHCS. If Contractor retains Capitation Payments, Supplemental Payments, and any other additional payments, Contractor must provide or arrange and pay for all Medically Necessary Covered Services for the Member until such Member is disenrolled on a non-retroactive basis pursuant to the terms set forth in Exhibit A, Attachment III, Subsection 4.2.2 (*Disenrollment*) of this Contract;

C. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory federal Medicaid requirements, the United States Department of Health and Human Services (U.S. DHHS) may disallow Federal Financial Participation (FFP) for payments made by DHCS to Contractor. In this event, DHCS may recover the amounts disallowed by U.S. DHHS by imposing an offset to Contract Revenues. If recovery of the full amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months. DHCS, at its sole discretion, may grant or deny such a request; and

D. If DHCS determines that any other erroneous or improper payment(s) not mentioned above has been made to Contractor, DHCS may recover all such determined amounts by the imposition of an offset to Contract Revenues. At least 30 calendar days prior to seeking any such recovery, DHCS must notify Contractor of the improper or erroneous nature of the payment, and must describe the recovery process. If recovery of the full

amount at one time imposes a financial hardship on Contractor, Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six months. DHCS, at its sole discretion, may grant or deny such a request.

1.1.10 Reinsurance

In accordance with 22 CCR section 53252, Contractor may obtain reinsurance (i.e., stop loss coverage) to ensure maintenance of adequate capital by Contractor for the cost of providing Covered Services under this Contract, subject to the following conditions:

A. Reinsurance must not reduce Contractor's liability below $5,000 per Member for any one 12-month period.

B. Reinsurance may cover both of the following:

1) The total cost of services provided to Members under emergency circumstances by non-contracted Providers, including the cost of inpatient care in a non-contracted facility until such time as the Member may be safely transported to a Network facility; and

2) Up to 90 percent of all expenditures related to this Contract exceeding 115 percent of Contract Revenues and third-party recoveries during any Fiscal Year of Contractor.

C. At its sole discretion and determination, and following consultation with Contractor, DHCS may require Contractor to retain appropriate reinsurance coverage for high-cost Members or services.

1.1.11 Catastrophic Coverage Limitation

DHCS may limit Contractor's liability to provide or arrange and pay for health care services for illness of, or injury to Members, resulting from or greatly aggravated by a catastrophic occurrence or disaster which occurs subsequent to Enrollment. Following the Director's invocation of this catastrophic coverage limitation, Contractor will return a prorated amount of the total Capitation Payment received by Contractor for the month. The amount returned will be determined by dividing the total Capitation Payment made to Contractor for such month by the number of days in that month, whereupon Contractor will return the

amount to DHCS for each day in of the month after the Director's invocation of this catastrophic coverage limitation.

1.1.12 Financial Performance Guarantee

A. In accordance with 22 CCR section 53865, Contractor must annually provide satisfactory evidence of, and maintain, a Financial Performance Guarantee in the form specified by DHCS and in an amount of at least one million dollars ($1,000,000) or equal to at least one month's Contract Revenues for each of Contractor's Service Areas, based on Contractor's average monthly Contract Revenues calculated for the previous 12 months of Contractor's operation, except that if Contractor has been operating for less that 12 months average monthly Contract Revenues will be calculated for as many months as Contractor has been operating, whichever is higher, and subject to approval by DHCS. In its discretion, DHCS may increase the required amount of the Financial Performance Guarantee for Contractor up to an amount of two million dollars ($2,000,000) or equal to two months' Contract Revenues for each of Contractor's Service Areas, based on Contractor's average monthly Contract Revenues for the previous 12 months, except that if Contractor has been operating for less that 12 months average monthly Contract Revenues will be calculated for as many months as Contractor has been operating, whichever is higher, for any material breach of this Contract.

B. At Contractor's request, and with DHCS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment on a post payment basis, subject to DHCS approval.

C. DHCS shall take possession of the Financial Performance Guarantee in an amount sufficient to indemnify DHCS in the event that Contractor materially breaches or defaults on one or more terms in this Contract. Unless DHCS has a financial claim or offset against Contractor in which case DHCS may immediately enforce its rights under the Financial Performance Guarantee, the Financial Performance Guarantee shall remain in effect through the completion of the Phaseout Period in accordance with Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

1.1.13 Medicare Coordination

In accordance with 42 CFR section 438.3(t), Contractor must enter into a Coordination of Benefits Agreement with the Medicare program through CMS,

and must agree to participate in Medicare's automated claims crossover process for full benefit dual eligible Members.

1.1.14 Special Contract Provisions Related to Payment

A. Contractor must reimburse Network Providers pursuant to the terms of each of the following applicable Pass-Through Payments established pursuant to 42 CFR section 438.6(d), in accordance with the CMS-approved rate certification, and in a form and manner specified by DHCS through APLs or other technical guidance:

1) Hospital Quality Assurance Fee (HQAF) and District and Municipal Public Hospital (DMPH) Pass-Through Payments, which requires Contractor to make increased payments to private hospitals and DMPHs in accordance with DHCS guidance.

2) Martin Luther King Jr. (MLK) Community Hospital Pass-Through Payment, which requires Contractor to make increased payments to MLK Community Hospital in Los Angeles County in accordance with W&I section 14165.50 and DHCS guidance.

3) Benioff Children's Hospital Oakland (BCHO) Pass-Through Payment, which requires Contractor to make increased payments to BCHO in Alameda County in accordance with DHCS guidance.

4) Distinct Part Nursing Facilities Pass-Through Payment, which requires Contractor to make increased payments to select publicly owned hospitals in accordance with DHCS guidance.

B. Contractor must reimburse Providers pursuant to the terms of each applicable Directed Payment Initiative established in accordance with 42 CFR section 438.6(c), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each Directed Payment Initiative, including the Directed Payment Initiative preprint as applicable, available on the DHCS website at https://www.dhcs.ca.gov. Directed Payment Initiatives are subject to change in accordance with the requirements of 42 CFR section 438.6(c), and currently include:

1) Designated Public Hospital (DPH) Enhanced Payment Program, which requires Contractor to make uniform dollar or percentage increase payments to DPH systems for every qualifying service or assigned Member months in accordance with DHCS guidance,

including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(b).

2) Private Hospital Directed Payments Program (PHDP), which requires Contractor to make uniform dollar increase payments to eligible private hospitals for every qualifying service in accordance with the DHCS guidance, including but not limited to APL 21-018 and the Directed Payment Initiative preprint.

3) District Hospital Directed Payments Program (DHDP), which requires Contractor to make uniform dollar increase payments to eligible DMPHs for every qualifying service in accordance with the DHCS guidance, including but not limited to APL 21-018 and the Directed Payment Initiative preprint.

4) DPH Quality Incentive Pool (QIP), which requires Contractor to make performance-based quality incentive payments to DPH systems based on DHCS' evaluation of DPH systems' performance on specified quality measures in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(c).

5) DMPH QIP, which requires Contractor to make performance-based quality incentive payments to DMPH systems based on DHCS' evaluation of DMPH systems' performance on specified quality measures in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(c).

6) Directed Payments for Developmental Screening Services, which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every adjudicated claim for specified developmental screening services in accordance with DHCS guidance, including but not limited to APL 23-016, the Directed Payment Initiative preprint, and W&I section 14105.197(a)(3).

7) Proposition 56 Directed Payments for Physician Services, which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every adjudicated claim for specified physician services in accordance with DHCS guidance, including

but not limited to APL 23-019 and the Directed Payment Initiative preprint.

8) Directed Payments for Adverse Childhood Experiences, which requires Contractor to pay eligible Network Providers at no less than the California Medicaid State Plan approved rates for every adjudicated claim for specified adverse chidhood experiences screening services in accordance with DHCS guidance, including but not limited to APL 23-017, the Directed Payment Initiative preprint, and W&I section 14105.197(a)(4).

9) Proposition 56 Directed Payments for Family Planning Services, which requires Contractor to make uniform dollar increase payments to eligible Providers for every adjudicated claim for specified family planning services in accordance with DHCS guidance, including but not limited to APL 23-008 and the Directed Payment Initiative preprint.

10) Organ and Bone Marrow Transplants, which requires Contractor to pay eligible contracted and non-contracted Providers at exactly the California Medicaid State Plan approved rates for specified organ and bone marrow transplant services using the methodology developed and published by DHCS on an annual basis in accordance with DHCS guidance, including but not limited to APL 21-015, the Directed Payment Initiative preprint, and W&I section 14184.201(d).

11) LTC FFS-Equivalent Base Directed Payment, which requires Contractors to pay Network Providers, in specified counties where services were traditionally covered in the FFS delivery system, at exactly the California Medicaid State Plan approved case or service rates for Skilled Nursing Facility (SNF) services and Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), and ICF/DD-Nursing (ICF/DD-N) services and Subacute (adult and pediatric) services. In all other counties, it requires Contractors to pay Network Providers at no less than the California Medicaid State Plan approved case or service rates for SNF services and ICF/DD, ICF/DD-H, and ICF/DD-N services and Subacute (adult and pediatric) services at minimum. All payments must be made in accordance with DHCS guidance, including but

not limited to APL 23-004, the Directed Payment Initiative preprint, and W&I section 14184.201(b) – (c).

12) Workforce Quality Incentive Program (WQIP), which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every qualifying service adjusted based on DHCS' evaluation of their performance on specified quality and workforce measures in accordance with DHCS through APLs or other guidance, the Directed Payment Initiative preprint, and W&I section 14126.024.

13) In accordance with W&I section 5961.4(c), and for applicable dates of service, Contractor must reimburse Providers of Medically Necessary outpatient mental health or SUD treatment provided at a School Site to a Member who is a student 25 years of age or younger at least at the fee schedule rate or rates developed by the Department in accordance with W&I section 5961.4(a), as defined by DHCS in the California Medicaid State Plan, a Directed Payment Initiative, and other applicable guidance, but only to the extent Contractor is financially responsible for those School Site services under this Contract.

14) Equity and Practice Transformation Provider Directed Payment Program, which requires Contractor to pay performance-based quality incentive payments to Primary Care practices (that provide pediatric, family medicine, internal medicine, or obstetrics and gynecology (OB/GYN) services to Medi-Cal Members) in based on DHCS' evaluation of Provider performance on specified quality measures in accordance with the Directed Payment Initiative preprint and in a form and manner specified by DHCS through APLs or other guidance.

15) Targeted Rate Increases require Contractor to pay eligible Network Providers at no less than the California Medicaid State Plan approved rates for specified Primary Care services, including those provided by physician and non-physician professionals, obstetric services, including Doula services, and Non-Specialty Mental Health Services, in accordance with W&I section 14105.201, any applicable Directed Payment Initiative Preprint, and in a form and manner specified by DHCS through APLs or other guidance.

C. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APLs or other technical guidance. For

applicable Rating Periods, DHCS will make the terms of each approved Risk Sharing Mechanism available on the DHCS website at https://www.dhcs.ca.gov.

D. Contractor must comply with the terms of any applicable Incentive Arrangements approved by CMS under 42 CFR section 438.6(b)(2), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Incentive Arrangement available on the DHCS website at https://www.dhcs.ca.gov. Incentive Arrangement payments must not exceed 105 percent of the approved Capitation Payments attributable to the Enrollees or services covered by the Incentive Arrangement, as specified in 42 CFR section 438.6(b)(2) and as calculated by DHCS. DHCS may impose a cap on incentive payments and/or participation in applicable Incentive Arrangements if DHCS determines that the incentive payment(s) are likely to exceed 105 percent of the approved Capitation Payments. Contractor will be required to remit to DHCS any incentive payment amounts in excess of 105 percent of approved Capitation Payments. Incentive Arrangements are subject to change in accordance with the requirements of 42 CFR section 438.6(b)(2). Current Incentive Arrangements include:

1) California Advancing and Innovating Medi-Cal (CalAIM) Incentive Payment Program, through which Contractor may earn incentive payments for achievement of specified CalAIM Incentive Payment Program milestones and metrics associated with implementation of CalAIM initiatives as determined by DHCS and in accordance with DHCS guidance, including but not limited to the CalAIM Incentive Payment Program terms specified on the DHCS website https://www.dhcs.ca.gov, APL 23-003, and W&I section 14184.207.

2) Student Behavioral Health Incentive Program (SBHIP), through which Contractor may earn incentive payments for achievement of specified milestones and metrics associated with targeted interventions that increase access to preventive, early intervention, and Behavioral Health Services by school-affiliated Behavioral Health Providers as determined by DHCS and in accordance with the terms on the DHCS website https://www.dhcs.ca.gov, W&I section 5961.3, and in a form and manner specified by DHCS through APLs or other guidance.

1.1.15 Medical Loss Ratio Remittance

In accordance with W&I section 14197.2(c)(1), Contractor must provide a remittance to DHCS for a Medical Loss Ratio (MLR) reporting year if the MLR reported in accordance with Exhibit A, Attachment III, Subsection 1.2.5 (*Medical Loss Ratio*) for that MLR reporting year does not meet the minimum MLR standard of 85 percent. DHCS must validate Contractor's reported remittance amount pursuant to Exhibit A, Attachment III, Subsection 1.2.5 (*Medical Loss Ratio*) and determine the final remittance amount owed by Contractor for each MLR reporting year and rating region. Starting January 1, 2025, Contractor must impose equivalent remittance requirements on its Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors.

1.1.16 State Program Receiving Federal Financial Participation

Should any part of the scope of work under this contract relate to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must cease its work on the part no longer authorized by law after the effective date of the loss of such program authority. DHCS must adjust Capitation Payments to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law to receive FFP. If Contractor works on a State program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized State program or activity receiving FFP and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHCS. However, if Contractor worked on a State program or activity receiving FFP prior to the date legal authority ended for that State program or activity receiving FFP, and DHCS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the State program or activity receiving FFP lost legal authority.

1.1.17 Community Reinvestment

A. Contractor must demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing a set percentage of its annual net income under this Contract to community reinvestment, in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community*

Reinvestment Plan and Report). This requirement is effective following Contractor's first year of operation as a Medi-Cal managed care health plan, as determined by DHCS. The percentage of Contractor's annual net income required to be contributed must be:

1) 5 percent of the portion of Contractor's annual net income that is less than or equal to 7.5 percent of Contract Revenues for the year; and

2) 7.5 percent of the portion of Contractor's annual net income that is greater than 7.5 percent of Contract Revenues for the year.

B. If Contractor has a Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor, Contractor must require all of its Fully Delegated Subcontractors or Downstream Fully Delegated Subcontractors to demonstrate a commitment to the local communities in which it operates through community reinvestment activities including contributing a set percentage of the Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's annual net income under the Fully Delegated Subcontractor's Subcontractor Agreement or Downstream Subcontractor's Downstream Subcontractor Agreement that is attributable to Members covered under this Contract to community reinvestment, in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*). This requirement is effective following Contractor's first year of operation as a Medi-Cal managed care health plan, as determined by DHCS. The percentage of the Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's annual net income required to be contributed must be:

1) 5 percent of the portion of the Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's annual net income that is less than or equal to 7.5 percent of the amount the Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor is paid under its Subcontractor Agreement or Downstream Subcontractor Agreement with Contractor for the year; and

2) 7.5 percent of the portion of the Fully Delegated Subcontractor's or Downstream Fully Delegated Subcontractor's annual net income that is greater than 7.5 percent of the amount the Fully Delegated Subcontractor or Downstream Fully Delegated Subcontractor is paid under its Subcontractor Agreement or Downstream Subcontractor Agreement with Contractor for the year.

1.1.18 Quality Achievement Requirement

If Contractor does not meet quality outcome metrics as defined through an APL or similar guidance, it must contribute an additional 7.5 percent of its annual net income under this Contract to community reinvestment in accordance with the plan developed pursuant to Exhibit A, Attachment III, Subsection 1.2.7 (*Community Reinvestment Plan and Report*).

1.1.19 Enhanced Care Management Risk Corridor

A Risk Sharing Mechanism will be in effect for each of the Rating Periods covering dates of services from January 1, 2022, through December 31, 2024.

A. The Risk Sharing Mechanism described in this provision may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

B. The Risk Sharing Mechanism will be symmetrical and based on the results of an Enhanced Care Management (ECM) risk corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal Managed Care contracts between Contractor and the State for those capitation increments, services, and populations associated with ECM, as determined by DHCS.

C. Contractor must provide and certify allowable medical expense data as necessary for the ECM risk corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

D. DHCS or its designee will initiate the ECM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

Exhibit C – General Terms and Conditions

The entire General Terms and Conditions (GTC 04/2017) developed by the California Department of General Services (DGS) (“Exhibit C”) is not included in this Contract. Instead, applicable terms and provisions from Exhibit C have been incorporated throughout this Contract.

In the event that DGS amends Exhibit C after the effective date of the Contract, Contractor agrees that DHCS, in its sole discretion, may incorporate future DGS amendments into this Contract through the issuance of an All Plan Letter (APL) or other similar instructions.

Exhibit D(f) – Special Terms and Conditions

This is version (Rev. 10/22)

Exhibit D(f)

Special Terms and Conditions

(For federally funded service contracts or agreements and grant agreements)

The use of headings or titles throughout this exhibit is for convenience only and not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" shall also mean, “agreement”, "grant", “grant agreement”, "Grantee" and "Subgrantee" respectively.

The terms “California Department of Health Care Services”, “California Department of Health Services”, ‘Department of Health Care Services”, “Department of Health Services”, “CDHCS”, “DHCS”, “CDHS”, and “DHS” shall all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.). The provisions herein apply to this Agreement unless the provisions are removed by reference on the face of this Agreement, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the applicable conditions do not exist.

Index of Special Terms and Conditions

1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

a. The Contractor 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. The Contractor 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 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. The Contractor agrees 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 state the Contractor's 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.

b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, 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.

c. The Contractor 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 the Contractor's commitments under the provisions herein and post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Contractor 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.

e. The Contractor 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 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.

f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor 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 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.

g. The Contractor will include the provisions of Paragraphs a through g 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 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. The Contractor 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 the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor 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. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for nonrepresented State employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to CalHR rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with State or federal funds provided under the Agreement.)

a. Equipment/Property definitions

Wherever the term equipment and/or property is used, the following definitions shall apply:

(1) **Major equipment/property**: A tangible or intangible item having a base unit cost of **$5,000 or more** with a life expectancy of one (1)

year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.

(2) **Minor equipment/property:** A tangible item having a base unit cost of less than $5,000 with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.

b. **Government and public entities (including State colleges/universities and auxiliary organizations),** whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3

c. Paragraph c of Provision 3 also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.

d. **Nonprofit organizations and commercial businesses,** whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

(1) Equipment/property purchases not exceed $50,000 annually.

To secure equipment/property above the annual maximum limit of $50,000, the Contractor make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS be deducted from the funds available in this Agreement. Contractor submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

(2) All equipment/property purchases are subject to Paragraphs d

through h of Provision 3. Paragraph b of Provision 3 also apply, if equipment/property purchases are delegated to Subcontractors that are either a government or public entity.

(3) Nonprofit organizations and commercial businesses use a procurement system that meets the following standards:

(a) Maintain a code or standard of conduct that govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.

(b) Procurements be conducted in a manner that provides, to the maximum extent practical, open, and free competition.

(c) Procurements be conducted in a manner that provides for all of the following:

[1] Avoid purchasing unnecessary or duplicate items.

[2] Equipment/property solicitations be based upon a clear and accurate description of the technical requirements of the goods to be procured.

[3] Take positive steps to utilize small and veteran owned businesses.

e. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of $5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.

f. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either

deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.

g. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.

h. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) also be maintained on file by the Contractor and/or subcontractor for inspection or audit.

i. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment/Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with State or federal funds provided under the Agreement.)

a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement be considered State equipment and the property of DHCS.

(1) **Reporting of Equipment/Property Receipt**

DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor report the receipt to the DHCS Program Contract Manager. To report the

receipt of said items and to receive property tags, Contractor use a form or format designated by DHCS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor request a copy from the DHCS Program Contract Manager.

(2) **Annual Equipment/Property Inventory**

If the Contractor enters into an agreement with a term of more than twelve months, the Contractor submit an annual inventory of State equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor request a copy from the DHCS Program Contract Manager. Contractor:

(a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).

(b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.

(c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.

b. Title to State equipment and/or property not be affected by its incorporation or attachment to any property not owned by the State.

c. Unless otherwise stipulated, DHCS be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any State equipment and/or property.

d. The Contractor and/or Subcontractor maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of State equipment and/or property.

(1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost or stolen State equipment and/or property. In the event of State equipment and/or miscellaneous property theft, Contractor and/or Subcontractor immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor promptly submit one copy of the theft report to the DHCS Program Contract Manager.

e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, only be used for performance of this Agreement or another DHCS agreement.

Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and, at that time, query DHCS as to the requirements, including the manner and method, of returning State equipment and/or property to DHCS. Final disposition of equipment and/or property be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of State equipment and/or property for performance of work under a different DHCS agreement.

f. **Motor Vehicles**

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

(1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor return such vehicles to DHCS and deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.

(2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California be the legal owner of said motor vehicles and the Contractor be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.

(3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator also hold a State of California Class B driver's license.

(4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

(a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of $1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.

(b) The Contractor and/or Subcontractor, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance identify the DHCS contract or agreement number for which the insurance applies.

(c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is returned to DHCS.

(d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.

(e) The Contractor and/or Subcontractor, if not a self-insured

government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

[1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).

[2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.

[3] The insurance carrier notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices contain a reference to each agreement number for which the insurance was obtained.

(f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.

(g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more. Except as indicated in Paragraph a(3) herein, when securing

subcontracts for services exceeding $5,000, the Contractor obtain at least three bids or justify a sole source award.

(1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.

(2) DHCS may identify the information needed to fulfill this requirement.

(3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:

(a) A local governmental entity or the federal government,

(b) A State college or State university from any State,

(c) A Joint Powers Authority,

(d) An auxiliary organization of a California State University or a California community college,

(e) A foundation organized to support the Board of Governors of the California Community Colleges,

(f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,

(g) Firms or individuals proposed for use and approved by DHCS' funding Program via acceptance of an application or proposal for funding or pre/post contract award negotiations,

(h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Chapter 5 Section 5.80 Subsection B.2.

b. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

(1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor take

steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.

c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of $5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers be confirmed in writing by DHCS.

d. Contractor maintain a copy of each subcontract entered into in support of this Agreement and, upon request by DHCS, make copies available for approval, inspection, or audit.

e. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.

f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

g. The Contractor ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.

h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(Subcontractor Name) agrees to maintain and preserve, until three years after termination of (Agreement Number) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."

i. Unless otherwise stipulated in writing by DHCS, the Contractor be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.

j. Contractor, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, 32 and/or other numbered

provisions herein that are deemed applicable.

6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement 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 Agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of $10,000.)

a. The Contractor and/or Subcontractor maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.

b. The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records be subject at all reasonable times to inspection, audit, and reproduction.

c. Contractor agrees that DHCS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (Government Code Section 8546.7, Public Contract Code (PCC) Sections 10115 et seq., Code of California Regulations Title 2, Section 1896.77.) The Contractor comply with the above and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in PCC Section10115.10.

d. The Contractor and/or Subcontractor preserve and make available his/her records (1) for a period of six years for all records related to Disabled Veteran Business Enterprise (DVBE) participation (Military and Veterans

Code 999.55), if this Agreement involves DVBE participation, and three years for all other contract records from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.

(1) If this Agreement is completely or partially terminated, the records relating to the work terminated be preserved and made available for a period of three years from the date of any resulting final settlement.

(2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.

e. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.

f. The Contractor, if applicable, comply with the Single Audit Act and the audit requirements set forth in 2 C.F.R. § 200.501 (2014).

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to 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 inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor provide and 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 inspections and evaluations be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

a. It is mutually understood between the parties that this Agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.

b. This agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.

c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement be amended to reflect any reduction in funds.

d. DHCS has the option to invalidate or cancel the Agreement with 30-days advance written notice or to amend the Agreement to reflect any reduction in funds.

10. Termination

a. **For Cause**

The State may terminate this Agreement, in whole or in part, and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. All costs to the State be deducted from any sum due the Contractor under this Agreement and the balance, if any, be paid to the Contractor upon demand. If this Agreement is terminated, in whole or in part, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials, related to the terminated portion of the Contract, including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The State pay contract price for completed deliverables delivered

and accepted and items the State requires the Contractor to transfer as described in this paragraph above.

b. **For Convenience**

The State retains the option to terminate this Agreement, in whole or in part, without cause, at the State's convenience, without penalty, provided that written notice has been delivered to the Contractor at least ninety (90) calendar days prior to such termination date. In the event of termination, in whole or in part, under this paragraph, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials related to the terminated portion of the contract including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The Contractor will be entitled to compensation upon submission of an invoice and proper proof of claim for the services and products satisfactorily rendered, subject to all payment provisions of the Agreement. Payment is limited to expenses necessarily incurred pursuant to this Agreement up to the date of termination.

11. Intellectual Property Rights

a. **Ownership**

(1) Except where DHCS has agreed in a signed writing to accept a license, DHCS be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that are made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) For the purposes of this Agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal

rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.

(a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.

(3) In the performance of this Agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this Agreement. In addition, under this Agreement, Contractor may access and utilize certain of DHCS' Intellectual Property in existence prior to the effective date of this Agreement. Except as otherwise set forth herein, Contractor not use any of DHCS' Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHCS. Except as otherwise set forth herein, neither the Contractor nor DHCS give any ownership interest in or rights to its Intellectual Property to the other Party. If during the term of this Agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHCS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHCS in the third-party's license agreement.

(4) Contractor agrees to cooperate with DHCS in establishing or maintaining DHCS' exclusive rights in the Intellectual Property, and in assuring DHCS' sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must

include, but are not limited to, the subcontractor assigning and agreeing to assign to DHCS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHCS and which result directly or indirectly from this Agreement or any subcontract.

(5) Contractor further agrees to assist and cooperate with DHCS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHCS' Intellectual Property rights and interests.

b. **Retained Rights / License Rights**

(1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, Contractor retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this Agreement. Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this Agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.

(2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this Agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other Intellectual Property rights of DHCS or third party, or result in a breach or default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

c. **Copyright**

(1) Contractor agrees that for purposes of copyright law, all works [as defined in Paragraph a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with

Contractor's performance of this Agreement be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this Agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor enter into a written agreement with any such person that: (i) all work performed for Contractor be deemed a "work made for hire" under the Copyright Act and (ii) that person assign all right, title, and interest to DHCS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) All materials, including, but not limited to, visual works or text, reproduced or distributed pursuant to this Agreement that include Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, include DHCS' notice of copyright, which read in 3mm or larger typeface: "© [Enter Current Year e.g., 2010, etc.], California Department of Health Care Services. This material may not be reproduced or disseminated without prior written permission from the California Department of Health Care Services." This notice should be placed prominently on the materials and set apart from other matter on the page where it appears. Audio productions contain a similar audio notice of copyright.

d. **Patent Rights**

With respect to inventions made by Contractor in the performance of this Agreement, which did not result from research and development specifically included in the Agreement's scope of work, Contractor hereby grants to DHCS a license as described under Section b of this provision for devices or material incorporating, or made through the use of such inventions. If such inventions result from research and development work specifically included within the Agreement's scope of work, then Contractor agrees to assign to DHCS, without additional compensation, all its right, title and interest in and to such inventions and to assist DHCS in securing United States and foreign patents with respect thereto.

e. **Third-Party Intellectual Property**

Except as provided herein, Contractor agrees that its performance of this Agreement not be dependent upon or include any Intellectual Property of

Contractor or third party without first: (i) obtaining DHCS' prior written approval; and (ii) granting to or obtaining for DHCS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or third-party's Intellectual Property in existence prior to the effective date of this Agreement. If such a license upon the these terms is unattainable, and DHCS determines that the Intellectual Property should be included in or is required for Contractor's performance of this Agreement, Contractor obtain a license under terms acceptable to DHCS.

f. **Warranties**

(1) Contractor represents and warrants that:

(a) It is free to enter into and fully perform this Agreement.

(b) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.

(c) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such thirdparty based on an alleged violation of any such right by Contractor.

(d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.

(e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate,

sites, locations, property or props that may be used or shown.

(f) It has not granted and not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHCS in this Agreement.

(g) It has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

(h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.

(2) DHCS makes no warranty that the intellectual property resulting from this agreement does not infringe upon any patent, trademark, copyright or the like, now existing or subsequently issued.

g. **Intellectual Property Indemnity**

(1) Contractor indemnify, defend and hold harmless DHCS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of DHCS' use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or

DHCS and which result directly or indirectly from this Agreement. This indemnity obligation apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. DHCS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHCS.

(2) Should any Intellectual Property licensed by the Contractor to DHCS under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve DHCS' right to use the licensed Intellectual Property in accordance with this Agreement at no expense to DHCS. DHCS have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHCS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHCS be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in equity.

(3) Contractor agrees that damages alone would be inadequate to compensate DHCS for breach of any term of this Intellectual Property Exhibit by Contractor. Contractor acknowledges DHCS would suffer irreparable harm in the event of such breach and agrees DHCS be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

h. **Federal Funding**

In any agreement funded in whole or in part by the federal government, DHCS may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the Agreement; except as provided in 37 Code of Federal Regulations part 401.14; however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner

for governmental purposes and to have and permit others to do so.

i. **Survival**

The provisions set forth herein shall survive any termination or expiration of this Agreement or any project schedule.

12. 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 law.

a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act (42 USC 7606) section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations.

b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Clean Water Act (33 U.S.C. 1251 et seq.), as amended.

13. Prior Approval of Training Seminars, Workshops or Conferences

Contractor obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

14. Confidentiality of Information

a. The Contractor and its employees, agents, or subcontractors protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.

b. The Contractor and its employees, agents, or subcontractors not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.

c. The Contractor and its employees, agents, or subcontractors promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.

d. The Contractor not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or federal law.

e. For purposes of this provision, identity include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

f. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Agreement or incorporated into this Agreement by reference.

15. Documents, Publications and Written Reports

(Applicable to agreements over $5,000 under which publications, written reports and documents are developed or produced. Government Code Section 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds $5,000.

16. Dispute Resolution Process

a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.

(1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief render a decision within ten (10) working days after receipt of the written grievance from the Contractor. The Branch Chief respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.

(2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal be addressed to the Deputy Director of the division in which the branch is organized within ten (10) working days from receipt of the Branch Chief's decision. The Deputy Director of the division in which the branch is organized or his/her designee meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal.

b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor follow the procedures set forth in Health and Safety Code Section 100171.

c. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence be directed to the DHCS Program Contract Manager.

d. There are organizational differences within DHCS' funding programs and the management levels identified in this dispute resolution provision may not apply in every contractual situation. When a grievance is received and organizational differences exist, the Contractor be notified in writing by the DHCS Program Contract Manager of the level, name, and/or title of the appropriate management official that is responsible for issuing a decision at a given level.

17. Financial and Compliance Audit Requirements

a. The definitions used in this provision are contained in Section 38040 of the Health and Safety Code, which by this reference is made a part hereof.

b. Direct service contract means a contract or agreement for services contained in local assistance or subvention programs or both (see Health and Safety [H&S] Code Section 38020). Direct service contracts not include contracts, agreements, grants, or subventions to other governmental agencies or units of government nor contracts or agreements with regional centers or area agencies on aging (H&S Code Section 38030).

c. The Contractor, as indicated below, agrees to obtain one of the following audits:

(1) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **$25,000 or more** from any State agency under a direct service contract or agreement; the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit. Said audit be conducted according to Generally Accepted Auditing Standards. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(2) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **less than $25,000** per year from any State agency under a direct service contract or agreement, the Contractor agrees to obtain a biennial single, organization wide financial and compliance audit, unless there is evidence of fraud or other violation of State law in connection with this Agreement. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(3) ***If the Contractor is a State or Local Government entity or Nonprofit organization*** and expends $750,000 or more in federal awards, the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in 2 C.F.R. 200.501 entitled "Audit Requirements". An audit conducted pursuant to this provision will

fulfill the audit requirements outlined in Paragraphs c(1) and c(2) above. The audit be completed by the end of the ninth month following the end of the audit period. The requirements of this provision apply if:

(a) The Contractor is a recipient expending federal awards received directly from federal awarding agencies, or

(b) The Contractor is a subrecipient expending federal awards received from a pass-through entity such as the State, County or community based organization.

(4) If the Contractor submits to DHCS a report of an audit other than a 2 C.F.R. 200.501audit, the Contractor must also submit a certification indicating the Contractor has not expended $750,000 or more in federal funds for the year covered by the audit report.

d. Two copies of the audit report be delivered to the DHCS program funding this Agreement. The audit report must identify the Contractor's legal name and the number assigned to this Agreement. The audit report be due within 30 days after the completion of the audit. Upon receipt of said audit report, the DHCS Program Contract Manager forward the audit report to DHCS' Audits and Investigations Unit if the audit report was submitted under Section 16.c(3), unless the audit report is from a City, County, or Special District within the State of California whereby the report will be retained by the funding program.

e. The cost of the audits described herein may be included in the funding for this Agreement up to the proportionate amount this Agreement represents of the Contractor's total revenue. The DHCS program funding this Agreement must provide advance written approval of the specific amount allowed for said audit expenses.

f. The State or its authorized designee, including the Bureau of State Audits, is responsible for conducting agreement performance audits which are not financial and compliance audits. Performance audits are defined by Generally Accepted Government Auditing Standards.

g. Nothing in this Agreement limits the State's responsibility or authority to enforce State law or regulations, procedures, or reporting requirements arising thereto.

h. Nothing in this provision limits the authority of the State to make audits of this Agreement, provided however, that if independent audits arranged for

by the Contractor meet Generally Accepted Governmental Auditing Standards, the State rely on those audits and any additional audit work and build upon the work already done.

i. The State may, at its option, direct its own auditors to perform either of the audits described above. The Contractor will be given advance written notification, if the State chooses to exercise its option to perform said audits.

j. The Contractor include a clause in any agreement the Contractor enters into with the audit firm doing the single organization wide audit to provide access by the State or Federal Government to the working papers of the independent auditor who prepares the single organization wide audit for the Contractor.

k. Federal or State auditors have "expanded scope auditing" authority to conduct specific program audits during the same period in which a single organization wide audit is being performed, but the audit report has not been issued. The federal or State auditors review and have access to the current audit work being conducted and will not apply any testing or review procedures which have not been satisfied by previous audit work that has been completed.

The term "expanded scope auditing" is applied and defined in the U.S. General Accounting Office (GAO) issued Standards for *Audit of Government Organizations, Programs, Activities and Functions*, better known as the "yellow book".

18. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

By signing this Agreement, Contractor agrees that if any performance under this Agreement or any subcontract or subagreement 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 meet the requirements of 42 U.S.C. Section 263a (CLIA) and the regulations thereunder.

19. Novation Requirements

If the Contractor proposes any novation agreement, DHCS act upon the proposal within 60 days after receipt of the written proposal. DHCS may review and consider the proposal, consult and negotiate with the Contractor, and accept or reject all or part of the proposal. Acceptance or rejection of the proposal may be made orally within the 60-day period and confirmed in writing within five days of said decision. Upon written acceptance of the proposal, DHCS will initiate an amendment to this Agreement to formally implement the approved proposal.

20. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 2 CFR Part 180, 2 CFR Part 376

b. By signing this Agreement, the Contractor certifies to the best of its knowledge and belief, that it and its principals:

(1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

(2) Have not within a three-year period preceding this application/proposal/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) violation of federal or State antitrust statutes; or 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;

(3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and

(4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (federal, State or local) terminated for cause or default.

(5) Have not, within a three-year period preceding this application/proposal/agreement, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

(6) 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.

(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.

c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor submit an explanation to the DHCS Program Contract Manager.

d. The terms and definitions herein have the meanings set out in 2 CFR Part 180 as supplemented by 2 CFR Part 376.

e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Agreement for cause or default.

21. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

a. 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.

b. 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.

c. By signing this Agreement, Contractor or Grantee 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.

d. Contractor or Grantee further agrees that it will insert this certification into any subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

22. Drug Free Workplace Act of 1988

The Federal government implemented the Drug Free Workplace Act of 1988 in an attempt to address the problems of drug abuse on the job. It is a fact that employees who use drugs have less productivity, a lower quality of work, and a higher absenteeism, and are more likely to misappropriate funds or services. From this perspective, the drug abuser may endanger other employees, the public at large, or themselves. Damage to property, whether owned by this entity or not, could result from drug abuse on the job. All these actions might undermine public confidence in the services this entity provides. Therefore, in order to remain a responsible source for government contracts, the following guidelines have been adopted:

a. The unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the work place.

b. Violators may be terminated or requested to seek counseling from an approved rehabilitation service.

c. Employees must notify their employer of any conviction of a criminal drug statue no later than five days after such conviction.

d. Although alcohol is not a controlled substance, it is nonetheless a drug. It is the policy that abuse of this drug will also not be tolerated in the workplace.

e. Contractors of federal agencies are required to certify that they will provide drug-free workplaces for their employees.

23. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS have the right to annul this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

24. Payment Withholds

(Applicable only if a final report is required by this Agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this Agreement, DHCS may, at its discretion, withhold 10 percent (10%) of the face amount of the Agreement, 50 percent (50%) of the final invoice, or $3,000 whichever is greater, until DHCS receives a final report that meets the terms, conditions and/or scope of work requirements of this Agreement.

25. Performance Evaluation

(Not applicable to grant agreements.)

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Agreement. If performance is evaluated, the evaluation not be a public record and remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

26. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This provision shall not be construed to extend to this Agreement if made with a corporation for its general benefits.

27. Four-Digit Date Compliance

(Applicable to agreements in which Information Technology (IT) services are provided to DHCS or if IT equipment is procured.)

Contractor warrants that it will provide only Four-Digit Date Compliant (as defined below) Deliverables and/or services to the State. "Four Digit Date compliant" Deliverables and services can accurately process, calculate, compare, and sequence date data, including without limitation date data arising out of or relating to leap years and changes in centuries. This warranty and representation is subject to the warranty terms and conditions of this Contract and does not limit the generality of warranty obligations set forth elsewhere herein.

28. Prohibited Use of State Funds for Software

(Applicable to agreements in which computer software is used in performance of the work.)

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 Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

29. Use of Disabled Veteran's Business Enterprises (DVBE)

(Applicable to agreements over $10,000 in which the Contractor committed to achieve DVBE participation. Not applicable to agreements and amendments specifically exempted from DVBE requirements by DHCS.)

a. The State Legislature has declared that a fair portion of the total purchases and contracts or subcontracts for property and services for the State be placed with disabled veteran business enterprises.

b. All DVBE participation attachments, however labeled, completed as a condition of bidding, contracting, or amending a subject agreement, are incorporated herein and made a part of this Agreement by this reference.

c. Contractor agrees to use the proposed DVBEs, as identified in previously submitted DVBE participation attachments. Contractor understands and agrees to comply with the requirements set forth in Military and Veterans Code Section 999 et seq. in that should award of this contract be based on part on its commitment to use the DVBE subcontractor(s) identified in its bid or offer, per Military and Veterans Code section 999.5(g), a DVBE

subcontractor may only be replaced by another DVBE subcontractor and must be approved by both DHCS and the Department of General Services (DGS) prior to the commencement of any work by the proposed subcontractor. Changes to the scope of work that impact the DVBE subcontractor(s) identified in the bid or offer and approved DVBE substitutions will be documented by contract amendment.

d. Requests for DVBE subcontractor substitution must include:

(1) A written explanation of the reason for the DVBE substitution.

(2) A written description of the business enterprise that will be substituted, including its DVBE certification status.

(3) A written description of the work to be performed by the substituted DVBE subcontractor and an identification of the percentage share/dollar amount of the overall contract that the substituted subcontractor will perform.

e. Failure of the Contractor to seek substitution and adhere to the DVBE participation level identified in the bid or offer may be cause for contract termination, recovery of damages under rights and remedies due to the State, and penalties as outlined in Military and Veterans Code § 999.9; Public Contract Code (PCC) §10115.10, or PCC §4110 (applies to public works only).

f. Upon completion of this Contract, DHCS requires the Contractor to certify using the Prime Contractor's Certification – DVBE Subcontracting Report (STD 817), al of the following:

(1) The total amount the prime contractor received under the agreement;

(2) The name, address, Contract number and certification ID Number of the DVBE(s) that participated in the performance of this Contract;

(3) The amount and percentage of work the prime Contractor committed to provide to one or more DVBE(s) under the requirements of the Contract and the total payment each DVBE received from the prime Contractor;;

(4) That all payments under the Contract have been made to the DVBE(s); and

(5) The actual percentage of DVBE participation that was achieved. Upon request, the prime Contractor must provide proof of payment for the work.

g. If for this Contract the Contractor made a commitment to achieve the DVBE participation goal, the Department will withhold $10,000 from the final payment, or the full payment if less than $10,000, until the Contractor complies with the certification requirements above. A Contractor that fails to comply with the certification requirement must, after written notice, be allowed to cure the defect. Notwithstanding any other law, if, after at least 15 calendar days but not more than 30 calendar days from the date of written notice, the prime Contractor refuses to comply with the certification requirements, DHCS will permanently deduct $10,000 from the final payment, or the full payment if less than $10,000. (Mil. & Vet. Code § 999.7.)

h. A person or entity that knowingly provides false information will be subject to a civil penalty for each violation. (Mil. & Vet. Code § 999.5(d); Govt. Code § 14841.)

i. Contractor agrees to comply with the rules, regulations, ordinances, and statutes that apply to the DVBE program as defined in Section 999 of the Military & Veterans Code, including, but not limited to, the requirements of Section 999.5(d). (PCC§ 10230.)

30. Use of Small, Minority Owned and Women's Businesses

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors take all of the following steps to further this goal.

a. Ensure that small businesses, minority-owned firms, and women's business enterprises are used to the fullest extent practicable.

b. Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.

c. Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.

d. Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.

e. Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

31. Alien Ineligibility Certification

(Applicable to sole proprietors entering federally funded agreements.)

By signing this Agreement, the Contractor certifies that he/she is not an alien that is ineligible for State and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 U.S.C. 1601, et seq.)

32. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Government Code Sections 16645 through 16649 to this Agreement. Furthermore, Grantee, by signing this Agreement, hereby certifies that:

a. No State funds disbursed by this grant will be used to assist, promote or deter union organizing.

b. Grantee account for State funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.

c. Grantee , where State funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.

d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no State funds were used for those expenditures, and that Grantee provide those records to the Attorney General upon request.

33. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with Section 100525) of Chapter 3 of Part 1 of Division 101 of the Health and Safety Code, DHCS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.

b. As used herein, fringe benefits do not include:

(1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.

(2) Director's and executive committee member's fees.

(3) Incentive awards and/or bonus incentive pay.

(4) Allowances for off-site pay.

(5) Location allowances.

(6) Hardship pay.

(7) Cost-of-living differentials

c. Specific allowable fringe benefits include:

(1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.

d. To be an allowable fringe benefit, the cost must meet the following criteria:

(1) Be necessary and reasonable for the performance of the Agreement.

(2) Be determined in accordance with generally accepted accounting principles.

(3) Be consistent with policies that apply uniformly to all activities of the Contractor.

e. Contractor agrees that all fringe benefits be at actual cost.

f. Earned/Accrued Compensation

(1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.

(2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.

(3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

(a) **Example No. 1:**

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a one year agreement. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of an agreement, the Contractor during a one-year budget period may only claim up to three weeks of vacation and twelve days of sick leave as actually used by the employee.

Amounts earned/accrued in periods prior to the beginning of the Agreement are not an allowable cost.

(b) **Example No. 2:**

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

(c) **Example No. 3:**

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHCS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

34. Suspension or Stop Work Notification

a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.

b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided within 30 working days of the verbal notification. The suspension or stop work notification remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS' discretion and upon receipt of written confirmation.

(1) Upon receipt of a suspension or stop work notification, the Contractor immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.

(2) Within 90 days of the issuance of a suspension or stop work notification, DHCS either:

(a) Cancel, extend, or modify the suspension or stop work notification; or

(b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.

c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.

d. If the suspension or stop work notification is cancelled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification shall require an amendment to the Agreement.

e. If a suspension or stop work notification is not canceled and the Agreement is cancelled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.

f. DHCS shall not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

35. Public Communications

"Electronic and printed documents developed and produced, for public communications follow the following requirements to comply with Section 508 of the Rehabilitation Act and the American with Disabilities Act:

a. Ensure visual-impaired, hearing-impaired and other special needs audiences are provided material information in formats that provide the most assistance in making informed choices."

36. Compliance with Statutes and Regulations

a. The Contractor comply with all California and federal law, regulations, and published guidelines, to the extent that these authorities contain requirements applicable to Contractor's performance under the Agreement.

b. These authorities include, but are not limited to, Title 2, Code of Federal Regulations (CFR) Part 200, subpart F, Appendix II; Title 42 CFR Part

431, subpart F; Title 42 CFR Part 433, subpart D; Title 42 CFR Part 434; Title 45 CFR Part 75, subpart D; and Title 45 CFR Part 95, subpart F. To the extent applicable under federal law, this Agreement incorporate the contractual provisions in these federal regulations and they supersede any conflicting provisions in this Agreement.

37. Lobbying Restrictions and Disclosure Certification

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

a. Certification and Disclosure Requirements

(1) Each person (or recipient) who requests or receives a contract or agreement, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, file a certification (in the form set forth in Attachment 1, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.

(2) Each recipient file a disclosure (in the form set forth in Attachment 2, entitled “Standard Form-LLL ‘disclosure of Lobbying Activities’”) if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract, or grant or any extension or amendment of that contract, or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

(3) Each recipient 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 a(2) herein. An event that materially affects the accuracy of the information reported includes:

(a) 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;

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

(c) 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.

(4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract or agreement, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or agreement, or grant file a certification, and a disclosure form, if required, to the next tier above.

(5) All disclosure forms (but not certifications) be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person forward all disclosure forms to DHCS Program Contract Manager.

b. 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 or agreement, 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 or agreement, 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 or agreement, grant, loan, or cooperative agreement.

Attachment 1
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 complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

3. The undersigned 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 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:

California Department of Health Care Services

DHCS reserves the right to notifiy the contractor in writing of an alternate submission address.

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:
_ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	_ a. bid/offer/application b. initial award c. post-award	_ a. initial filing b. material change For Material Change Only: Year ___ quarter 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:
☐Prime ☐Subawardee Tier __, if known: Congressional District, If known:	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 Registrant *(If individual, last name, first name, MI)*:	b. Individuals Performing Services *(including address if different from 10a. (Last name, First name, MI):*

11. 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 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than $100,000 for each such failure.	
Signature:	
Print Name:	
Title:	
Telephone Number:	
Date:	
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)

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

This disclosure form be completed by the reporting entity, whether subawardee or prime federal recipient, 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. 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 followup 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 itis, 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 (CFDA) 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-90-001".

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 registrant under the Lobbying Disclosure Act of 1995 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. The certifying official sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing 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 E – Program Terms and Conditions

1.0 Program Terms and Conditions

1.1 Program Terms and Conditions

1.1.1 Governing Law
1.1.2 DHCS Guidance
1.1.3 Contract Interpretation
1.1.4 Assignments, Mergers, Acquisitions
1.1.5 Independent Contractor
1.1.6 Amendment and Change Order Process
1.1.7 Delegation of Authority
1.1.8 Authority of the State
1.1.9 Fulfillment of Obligations
1.1.10 Obtaining DHCS Approval
1.1.11 Certifications
1.1.12 Notices
1.1.13 Term
1.1.14 Service Area
1.1.15 Contract Extension
1.1.16 Termination
1.1.17 Phaseout Requirements
1.1.18 Indemnification
1.1.19 Sanctions
1.1.20 Liquidated Damages
1.1.21 Contractor's Dispute Resolution Requirements
1.1.22 Inspection and Audit of Records and Facilities
1.1.23 Confidentiality of Information
1.1.24 Pilot Projects
1.1.25 Cost Avoidance and Post-Payment Recovery of Other Health Coverage
1.1.26 Third-Party Tort and Workers' Compensation Liability
1.1.27 Litigation Support
1.1.28 Equal Opportunity Employer
1.1.29 Federal and State Nondiscrimination Requirements
1.1.30 Discrimination Prohibitions
1.1.31 Small Business Participation and Disabled Veteran Business Enterprises Reporting Requirements
1.1.32 Conflict of Interest Avoidance Requirements
1.1.33 Guaranty Provision
1.1.34 Priority of Provisions
1.1.35 Additional Incorporated Provisions – Narrative Proposals
1.1.36 Miscellaneous Provisions

Exhibit E – Program Terms and Conditions

1.1 Program Terms and Conditions

1.1.1 Governing Law

A. Contractor must comply with all applicable federal and State law.

B. All Contract disputes and determinations must be decided under California law.

C. The venue and forum for any action involving a Contract dispute will be in Sacramento County State court.

D. Applicability of the Knox-Keene Act

1) A Contractor who is licensed as a health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (KKA) and its implementing regulations 22 California Code of Regulations (CCR) section 1000, *et seq*. must comply with all applicable provisions of the KKA.

2) A Contractor who is not licensed to operate as a health care service plan pursuant to the KKA must perform all acts and satisfy all requirements under the KKA to the same extent as Contractors who are licensed pursuant to the KKA, except as otherwise expressly provided in this Contract. A Contractor who is not licensed to operate as a health care service plan under the KKA is not required by this Contract to perform or satisfy the following:

a) Any provision of the KKA which requires the submission of a report of any kind to the Department of Managed Health Care (DMHC) or obliges a health care service plan to seek approval from DMHC, including, but not limited to, the Independent Medical Review processes set out in section 1370.4 and Article 5.55 of the KKA;

b) Any provision under Article 3 of the KKA related to licensure; and

c) The provisions set forth in Exhibit K of this Contract. Exhibit K is not an exhaustive or exclusive list, and other provisions of the KKA may also be excluded from the Contract pursuant

to this Exhibit E, Subsection 1.1.1 (*Governing Law*) or other provisions of this Contract.

3) Both KKA-licensed Contractors and non-KKA-licensed Contractors are subject to the following provisions:

a) Nothing in this Exhibit E, Subsection 1.1.1 (*Governing Law*) is intended to relieve Contractor of any other duties or requirements that would otherwise apply; and

b) In the event that a provision of this Contract sets a standard or requirement that is higher, or affords a greater benefit or right to a Member than that which the KKA provides, the Contract provisions prevail.

1.1.2 DHCS Guidance

Contractor must comply with all DHCS guidance, including but not limited to All Plan Letters (APLs), Policy Letters (PLs), the California Medicaid State Plan, and the Medi-Cal Provider Manual.

A. APLs and PLs

Contractor must comply with all existing and future APLs and PLs as follows:

1) APLs and PLs existing on the effective date of the Contract will be considered part of the Contract as if fully set forth herein;

2) APLs and PLs issued or revised subsequent to the effective date of the Contract can provide clarification of existing contractual obligations;

3) APLs and PLs issued or revised subsequent to the effective date of the Contract can provide instructions regarding implementation of mandated obligations, including but not limited to implementation of changes in State or federal statutes or regulations, or pursuant to judicial interpretation; and

4) APLs and PLs issued by DHCS pursuant to statutory authority to issue guidance in lieu of regulations will have the same force and effect as regulations and may set forth new obligations.
APLs and PLs cited and incorporated by reference into the Contract also include any subsequent revisions to the APL or PL.

B. California Medicaid State Plan

Unless otherwise specified in this Contract, Contractor will comply with all applicable provisions of the California Medicaid State Plan, as amended. In the event there is a conflict between the California Medicaid State Plan and this Contract, the California Medicaid State Plan will control. The California Medicaid State Plan and any amendments thereto, can be viewed at the California's Medicaid State Plan (Title XIX) web page.

C. Medi-Cal Provider Manual

Unless otherwise specified in this Contract, Contractor must comply with all current and applicable provisions of the Medi-Cal Provider Manual. In the event that the Medi-Cal Provider Manual conflicts with this Contract, APLs and PLs, and/or any applicable federal or State laws, the Contract, the APL or PL, or the applicable law will control. The Medi-Cal Provider Manual can be viewed online.

1.1.3 Contract Interpretation

A. Conflict with Law

Any provision of this Contract that is in conflict with current or future applicable federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract will be effective on the effective date of the statutes or regulations necessitating it and will be binding on Contractor even though such amendment may not yet have been put in writing, formally agreed upon, and executed by Contractor and DHCS.

If changes in federal or State law result in a material change to the Contract, the amendment may constitute grounds for termination of this Contract in accordance with Exhibit E, Subsection 1.1.16 (*Termination*). The parties will be bound by the terms of the amendment until the effective date of the termination.

B. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers will each be deemed to include the other; (b) the masculine, feminine, and neuter genders will each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory,

and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

C. Ambiguities

If it is necessary to interpret the text of this Contract to address potential ambiguities, all applicable laws may be used as aids in interpreting the Contract. However, DHCS and Contractor agree that any such applicable laws will not be interpreted to create additional contractual obligations upon either DHCS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this Section. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties will be deemed authors of this Contract.

D. Unenforceable Provisions

In the event that any provision of this Contract is unenforceable or held to be unenforceable, then DHCS and Contractor agree that all other provisions of this Contract have force and effect and will not be affected thereby.

E. Timeliness

Time is of the essence in this Contract.

F. Entire Agreement

This written Contract, any amendments thereto, and DHCS guidance as identified in Exhibit E, Subsection 1.1.2 (*DHCS Guidance*), will constitute the entire agreement between the parties. No oral representations will be binding on either party unless such representations are put in writing and made an amendment to this Contract.

1.1.4 Assignments, Mergers, Acquisitions

Contractor is prohibited from assigning this Contract, either in whole or in part, without the express written consent of DHCS in the form of a formal written amendment signed by DHCS, Contractor, and the third-party assignee (See also, Exhibit A, Attachment III, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements).* Contractor must also obtain the express written consent of DHCS prior to entering into a merger or acquisition, whether or not Contractor is the merging party or the acquiring party.

1.1.5 Independent Contractor

Contractor and their employees and agents, in the performance of this Contract, will act in an independent capacity and not as officers or employees or agents of DHCS.

1.1.6 Amendment and Change Order Process

A. General Provisions

The parties recognize that during the term of this Contract, the Medi-Cal managed care program is a dynamic program requiring ongoing changes to its operations and that the scope and complexity of changes will vary widely over the term of this Contract. Contractor must develop a system which has the capability to implement such changes in an orderly and timely manner. This is an essential contract performance obligation.

B. Proposal of Contract Changes

Except for required amendments pursuant to Exhibit E, Subsection 1.1.3 (*Contract Interpretation*) should either party, during the life of this Contract, desire a change in this Contract, that change must be proposed in writing to the other party. The other party must acknowledge receipt of the proposal within ten calendar days of receipt of the proposal. The party proposing any such change will have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal must set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract.

1) Regardless of the party desiring the change, DHCS will be responsible for drafting the proposed amendment and providing it to Contractor for review and comment prior to the language being finalized and submitted to Centers for Medicare & Medicaid Services (CMS) for approval.

2) DHCS will determine Contractor's Capitation Payment rates for each Rating Period and, as necessary, subsequent revised rates for the same Rating Period, as stated in Exhibit B, Subsection 1.1.5 (*Determination and Redetermination of Capitation Payment Rates*).

C. Implementation of Contract Changes

DHCS may, at any time within the general scope of this Contract and by written notice, implement amendments or issue change orders to the Contract upon approval from CMS, as follows:

1) Capitation Payment rates may be implemented through a change order if the rates are the only changes proposed by DHCS for a Rating Period.

2) Capitation Payment rates that are also tied to proposed changes to the terms or requirements of the Contract effective within the Rating Period will be included in an amendment to the Contract.

D. Contractor's Obligation to Implement

Notwithstanding approval by CMS of proposed changes to this Contract, Contractor will comply with changes mandated by DHCS. In the case of changes mandated by regulations, statutes, federal guidelines, or judicial interpretation, Contractor must immediately begin implementation of any change proposed in an amendment to this Contract or through an APL. If DHCS implements an amendment, or issues a change order or APL, Contractor must implement the required changes and accept current Capitation Payments as stated in Exhibit B, Section 1.5 (*Determination and Redetermination of Capitation Payment Rates*) while discussions relevant to any Capitation Payment rate adjustment, if applicable, are taking place.

1.1.7 Delegation of Authority

DHCS intends to implement this Contract through a single administrator, called the "DHCS Contracting Officer." The Director will appoint its DHCS Contracting Officer. The DHCS Contracting Officer, under the direction of the Director and on behalf of DHCS, will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable federal and State laws and regulations. The DHCS Contracting Officer may delegate their authority to act to as an authorized representative through written notice to Contractor.

Contractor will designate a single administrator (Contractor's Representative) to implement this Contract. Contractor's Representative, on behalf of Contractor, will make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, federal and State laws and regulations. Contractor's Representative may delegate their authority to act to an authorized representative through written notice to the DHCS Contracting

Officer. Contractor's Representative will be empowered to legally bind Contractor to all agreements reached with DHCS.

Contractor will designate Contractor's Representative in writing and must notify the DHCS Contracting Officer in accordance with Exhibit E, Subsection 1.1.12 (*Notices*).

1.1.8 Authority of the State

A. Subject to federal and State laws and regulations, DHCS has sole authority to establish, define, and determine the reasonableness, necessity, level, and scope of Covered Services available under the Medi-Cal managed care program administered through this Contract or coverage for such benefits, or the eligibility of Members or Providers to participate in the Medi-Cal managed care program.

B. DHCS has sole authority to establish or interpret policy and its application related to administration of the Medi-Cal program.

C. Contractor must not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits; or eligibility of Members or Providers to participate in the program, without the express, written direction or approval of the DHCS Contracting Officer.

1.1.9 Fulfillment of Obligations

Contractor must not waive any covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract except by written agreement of the parties. Forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply. Until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this Contract, or under law, notwithstanding such forbearance or indulgence.

1.1.10 Obtaining DHCS Approval

A. DHCS Approval of Deliverables Prior to Commencement of Operations

Prior to commencement of operations, Contractor must obtain written approval from DHCS for all deliverables, including but not limited to

protocols, policies, and procedures, set forth in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*).

B. DHCS Approval of Protocols, Policies, and Procedures

In addition to the deliverables identified in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and* Requirements) of this Contract, DHCS reserves the right to review and approve or disapprove Contractor's protocols, policies, and procedures. DHCS may, from time to time, request changes to Contractor's existing protocols, policies, and procedures. DHCS will issue such requests through APLs or other similar instructions. The deliverables, protocols, policies, and procedures referenced in this Exhibit E, Subsections 1.1.10.A and B (*Obtaining DHCS Approval*), will be subject to the DHCS approval process set forth in Exhibit E, Subsection 1.1.10.C (*Obtaining DHCS Approval*), below.

C. DHCS Approval Process

Within 60 calendar days of receipt, DHCS will make all reasonable efforts to approve in writing Contractor's deliverables, protocols, policies, and procedures; provide Contractor with a written explanation of disapproval; or provide a written estimated date of completion of DHCS' review process.

If DHCS does not complete its review of submitted materials within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, Contractor may elect to implement or use the materials at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Exhibit E, Subsection 1.1.10.C (*Obtaining DHCS Approval*) will not be construed to imply DHCS approval of any materials that have not received written DHCS approval. This Section will not apply to Subcontractor Agreements, Downstream Subcontractor Agreements, or Network Provider Agreements subject to DHCS approval in accordance with Exhibit A, Attachment III, Subsection 3.1.2 (*DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements*).

1.1.11 Certifications

A. For each data submission required by 42 Code of Federal Regulations (CFR) section 438.604, Contractor must comply with the requirements of 42 CFR section 438.606 and APL 17-005. Contractor must submit its certification of compliance concurrently with the submission of its data, documentation or information pursuant to 42 CFR section 438.606(c).

Contractor's certification(s) must be certified by Contractor's Chief Executive Officer (CEO); Chief Financial Officer (CFO); or an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO. Contractor's CEO or CFO is solely responsible for the truth, accuracy, and completeness of Contractor's certification.

1) Contractor's data submissions must be in a form and manner specified by DHCS:

   a) Encounter Data as set forth in 42 CFR section 438.604(a)(1); and

   b) Data used by the State to certify actuarial soundness of Capitation Payment rates as set forth in 42 CFR section 438.604(a)(2).

2) Medical Loss Ratio (MLR) data as set forth in 42 CFR section 438.604(a)(3);

3) Financial data regarding provisions against risk of insolvency as set forth in 42 CFR section 438.604(a)(4);

4) Documentation described in 42 CFR section 438.207(b) used to certify compliance with this Contract's requirements for accessibility and availability of services, including Network adequacy;

5) Contractor's information on ownership and control, including its Subcontractors, Downstream Subcontractors, and Network Providers, as set forth in 42 CFR sections 438.608(c)(2), 438.602(c), and 455.104;

6) The annual report of overpayment recoveries as required in 42 CFR section 438.608(d)(3);

7) Network Data as required in Exhibit A, Attachment III, Subsection 2.1.4 (*Network Provider Data Reporting*);

8) Documentation confirming compliance with this Contract's interoperability requirements and APL 22-026 that is certified by Contractor's CEO or CFO and in accordance with submission requirements in APL 17-005; and

9) Any other data, documentation, or information requested by DHCS relating to the performance of Contractor's obligations under this Contract.

B. The Contractor Certification Clauses (CCC) contained in the Department of General Services form document CCC 04/2017 are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto.

1.1.12 Notices

All notices to be given under this Contract must be in writing and are deemed given when sent certified mailed or electronic mail (email) to DHCS or Contractor. DHCS and Contractor will designate email addresses for notices sent via email. Notices sent certified mail must be addressed to the following DHCS and Contractor addresses:

California Department of Health Care Services
Managed Care Operations Division

Attn: DHCS Contract Manager
MS 4407
P.O. Box 997413
Sacramento, CA 95899-7413

Orange County Health Authority, A Public Agency
dba: CalOptima Health
Attn: Contractor Representative
505 City Parkway West
Orange, CA 92868

1.1.13 Term

A. The Contract will be effective January 1, 2024, and will continue in full force and effect through December 31, 2024, subject to Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*), CMS waiver approval, and Exhibit D(f), Section 9 (*Federal Contract Funds*).

B. If Contractor has not already commenced operations, the term of this Contract consists of the following three periods:

1) The Implementation Period;

2) The Operations Period; and

3) The Phaseout Period.

C. The Operations Period will commence at the conclusion of the Implementation Period, subject to DHCS acceptance of Contractor's readiness to begin the Operations Period. The term of the Operations

Period is subject to the termination requirements of Exhibit E, Subsections 1.1.16 (*Termination*) and 1.1.19, (*Sanctions*), and subject to the limitation provisions of Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*).

D. The Phaseout Period will commence on the date the Operations Period or Contract extension ends. The Phaseout Period will extend until all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

E. If Contractor has commenced operations as of the effective date of this Contract, the term of the Contract consists of the Operations Period and the Phaseout Period. The term of the Operations Period is subject to the termination requirements of Exhibit E, Subsections 1.1.16 (*Termination*) and 1.1.19 (*Sanctions*) below and subject to the limitation requirements of Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*).

1.1.14 Service Area

The Service Area covered under this Contract includes:

Orange County/ies

Unless otherwise specified in this Contract, all Contract provisions apply separately to each Service Area. This Contract may expire for some Service Areas and remain in effect for others with each Service Area having its own Operations and Phaseout Periods.

1.1.15 Contract Extension

DHCS has the exclusive option to extend the term of the Contract for any Service Area during the last 12 months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. Contractor will be given at least nine months prior written notice of DHCS' decision on whether it will exercise this option to extend the Contract for each Service Area.

Contractor will provide written notification to DHCS of its intent to accept or reject the Contract extension within five Working Days of the receipt of the notice from DHCS.

1.1.16 Termination

A. DHCS-Initiated Terminations

1) Mandatory Termination

a) DHCS must terminate this Contract in the event of any of the following:

i. The Secretary of the U.S. Department of Health & Human Services (U.S. DHHS) determines that Contractor does not meet the requirements for participation in the Medicaid program (42 United States Code (USC) section 1396);

ii. DMHC finds that Contractor no longer qualifies for licensure under the KKA (Health and Safety Code (H&S) section 1340 *et seq.*), if licensure is required; or

iii. The Director determines the health and welfare of Members is jeopardized by continuation of the Contract.

b) Termination pursuant to Exhibit E, Subsection 1.1.16 (*Termination*) will be effective immediately. Termination under this Exhibit E, Subsection 1.1.16 (*Termination*) does not relieve Contractor of its obligations under Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

2) Termination for Cause

a) DHCS may terminate this Contract and be relieved of any payments should Contractor fail to perform the requirements of this Contract. In the event of such termination, DHCS may proceed with providing the services required under this Contract in any manner deemed proper by DHCS. All costs to the State will be deducted from any sum due Contractor under this Contract and the balance, if any, will be paid to Contractor upon demand.

b) DHCS will provide Contractor with at least 60 calendar days' notice prior to the effective date of termination, unless Potential Member harm requires a shorter notice period. Contractor agrees that this notice provision is reasonable. Termination under this Subsection does not relieve Contractor of its obligations under Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

c) DHCS will terminate this Contract under this Subsection, pursuant to the provisions of W&I section 14197.7 and 22 CCR section 53873.

d) Contractor may dispute termination decisions under this Exhibit E, Subsection 1.1.16 (*Termination*), through the dispute resolution process pursuant to Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*).

3) Permissive Termination

Following a merger or acquisition involving Contractor in which Contractor did not obtain DHCS' express written consent pursuant to Exhibit E, Subsection 1.1.4 (*Assignments, Mergers, Acquisitions*), whether Contractor is the merging party or the acquiring party, DHCS, in its sole discretion, retains the right to terminate this Contract.

a) DHCS will provide written notice of termination to Contractor at least 60 calendar days prior to the effective date of termination.

b) Contractor must fully perform all Contract obligations prior to the effective date of termination. Contractor will not be entitled to additional reimbursement for the services provided following notice of termination until the termination effective date.

c) Termination under this Subsection does not relieve Contractor of its Phaseout Requirement obligations as stated in Exhibit E, Subsection 1.1.17 (*Phaseout Requirements*).

4) Termination Without Cause

a) DHCS may terminate this Contract and award a new contract for one or more of the Service Areas to another Medi-Cal managed care plan during one of the amendment periods as described in Exhibit E, Subsection 1.1.15 (*Contract Extension*).

b) Notwithstanding any other provision in this Contract, DHCS may terminate this Contract in whole or in part at any time at DHCS' sole discretion.

c) DHCS will notify Contractor of termination under this Exhibit E, Subsection 1.1.16 (*Termination*) at least six months prior to the effective date of termination to allow for all Phaseout Requirements to be completed.

B. Contractor-Initiated Terminations

Contractor may only terminate this Contract under one or more of the following circumstances:

1) For Rating Periods subsequent to Calendar Year 2024, if Contractor does not accept the Capitation Payment rates determined by DHCS, or if DHCS decides to negotiate the Capitation Payment rates and the parties do not agree on the rates; or

2) When a change in contractual obligations is created by a State or federal change in the Medi-Cal program or a lawsuit that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent through the term of the Contract, the following will apply:

a) Contractor will submit a detailed written financial analysis to DHCS supporting its conclusions that it cannot remain financially solvent. At DHCS' request, Contractor will submit or otherwise make available to DHCS all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information requested by DHCS to evaluate Contractor's financial analysis;

b) DHCS and Contractor may negotiate an earlier termination date than the termination date set forth in this Exhibit E, Subsection 1.1.16 (*Termination*), if Contractor can demonstrate to the satisfaction of DHCS that it cannot remain financially solvent until the termination date that would otherwise be established under this Subsection;

c) Contractor must provide at least a six-month written notice of termination under this Exhibit E, Subsection 1.1.16 (*Termination*). The effective date of termination will be

December 31 of the year in which Contractor gives notice, unless the date of notice is less than six months before December 31. In that event, termination under this Exhibit E, Subsection 1.1.16 (*Termination*) will be effective no earlier than December 31 of the following year.

d) Termination under these circumstances does not relieve Contractor of its obligations as stated in Exhibit E, Subsection 1.1.17 (*Phaseout Requirements).*

C. Termination of Obligations

Contractor's obligations to provide Covered Services under this Contract or under any Contract extension terminate on the date the Operations Period ends.

D. Notice to Members of Transfer of Care

Following notice of termination by either DHCS or Contractor, notice to the Member will be directed by DHCS. Contractor will not send any notices to its Members regarding the termination unless it receives prior approval from DHCS.

1.1.17 Phaseout Requirements

A. DHCS will retain Capitation Payment for each Service Area from Contractor's Capitation Payment for the last four months of the Operations Period for each Service Area, or Contractor must provide a performance bond to DHCS of an equal amount, until all Directive Payment Initiatives and Supplemental Payments have been calculated and processed by DHCS and all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

Upon DHCS' processing of all Directive Payment Initiatives and Supplemental Payments and the completion of all Phaseout Period activities for each Service Area, the withhold will be paid to Contractor or the performance bond will be released. If Contractor fails to meet any requirements of the Phaseout Period for each Service Area, DHCS will deduct the costs of the remaining activities from the withhold amount and continue to withhold payment until all activities are completed.

B. The objective of the Phaseout Period is to ensure that, in connection with the expiration or termination of this Contract, Contractor ensures an

orderly transfer of necessary data and history records to DHCS or to a successor Medi-Cal managed care plan. Contractor will not provide services to Members during the Phaseout Period.

Within no later than 90 calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area, Contractor must assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, Contractor will make available to DHCS, without additional compensation, copies of each Member's Medical Records and files, and any other pertinent information, including information maintained by any Subcontractor, Downstream Subcontractor, or Network Provider, necessary to provide effected Members with case management and continuity of care. In no circumstances will a Medi-Cal Member be billed for this activity.

C. Phaseout for this Contract includes processing, payment, and monetary and data reconciliations necessary regarding Provider claims for Covered Services.

1) Phaseout for this Contract includes the completion of all financial and reporting obligations of Contractor. Contractor will remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members prior to the expiration or termination of this Contract. Contractor must timely submit to DHCS all reports required in Exhibit A, Attachment III, Article 7.0 (*Operations Deliverables and Requirements*) for the period from the last submitted report through the expiration or termination date, and Contractor will be obligated to cooperate with DHCS with regard to the reconciliation of Contractor's Encounter Data Reporting and Network Provider Data Reporting for up to two years following the expiration or termination of this Contract.

2) All data and information provided by Contractor will be accompanied by a letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials provided.

D. The Phaseout Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phaseout related activities are non-payable obligations and services.

1.1.18 Indemnification

A. As a condition of entering into this Contract, Contractor agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses accruing or resulting from any and all Network Providers, Subcontractors, Downstream Subcontractors, suppliers, laborers, and any other person, firm, or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this Contract.

B. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents, and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, and any Administrative Costs incurred by DHCS or a Member from any and all litigation, arbitration or mediation resulting directly, indirectly, or arising out of Contractor's denial, delay, or modification of requested Covered Services.

C. Contractor further agrees to indemnify, defend, and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, including DHCS' defense costs, judgments, damages, any Administrative Costs incurred from claims that Contractor violated the Telephone Consumer Protection Act of 1991, 47 USC section 227 *et seq*., and/or related Federal Communications Commission regulations in the performance of this Contract.

D. Contractor further agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any Administrative Costs incurred to the extent DHCS is required to provide notice to affected Members and Potential Members, and any other costs associated with any actual or alleged breach, by Contractor and any vendor, Subcontractor, Downstream Subcontractor, or Network Provider Contractor contracts with in the performance of this Contract, of the following statutes and regulations: the of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 USC section 17921 *et seq*., and their implementing privacy and security regulations at

45 CFR parts 160 and 164 and the Information Practices Act, and Civil Code (CC) section 1798 *et seq.* by Contractor.

E. DHCS is authorized to withhold any and all attorneys' fees and costs, judgments, damages, any Administrative Costs incurred pursuant to this indemnification agreement, from Contractor's next Capitation Payment or any other method to recoup DHCS' costs from Contractor.

1.1.19 Sanctions

A. Contractor is subject to sanctions and civil penalties for the specific conduct set forth in 42 CFR sections 438.700, 438.702, 438.704, 438.706, and 438.708. DHCS is also authorized to impose additional sanctions on Contractor pursuant to 42 CFR section 438.702(b) as set forth in W&I section 14197.7, APL 23-012, and any other applicable law.

B. Monetary sanctions imposed pursuant to W&I section 14197.7 may be separately and independently assessed and may also be assessed for each day Contractor fails to correct an identified deficiency. For deficiencies that impact Members and Potential Members, each impacted Member or Potential Member constitutes a separate violation for the purposes of imposing a monetary sanction.

C. Good cause for imposing monetary sanctions includes but is not limited to a breach of this Contract, a violation of a legal obligation (including, but not limited to, obligations imposed by statute, regulation, APL, PL, or other DHCS Guidance), a finding of deficiency that results in an improper denial or delay in the delivery of health care services, potential endangerment of a Member's care, disruption in Contractor's Network, failure to approve continuity of care for a Member, failure to timely and correctly reimburse claims, or a delay in required reporting to DHCS. Further grounds for imposing sanctions include, but are not limited to, those set forth in 42 CFR section 438.700 et seq., W&I section 14197.7, and APL 23-012.

D. DHCS may identify findings of noncompliance or good cause through any means, including, but not limited to, findings in audits; investigations; contract compliance reviews; Quality Improvement System monitoring; routine monitoring; facility site surveys; Encounter Data submissions; Grievances and Appeals; Network adequacy reviews; assessments of timely access requirements; reviews of utilization data; health plan rating systems; State Hearing decisions; Independent Medical Review (IMR) decisions; complaints from Members, Providers, Network Providers, Subcontractors, Downstream Subcontractors, other stakeholders, or whistleblowers;, and Contractor's self-disclosures.

E. Sanctions in the form of denial of payments provided for under this Contract for new Members will be taken, when and for as long as, payment for those Members is denied by CMS under 42 CFR section 438.730.

F. DHCS may also impose nonmonetary sanctions as set forth in 42 CFR section 438.700 et seq., W&I section 14197.7, APL 23-012, and any other applicable law.

G. DHCS is not required to impose a Corrective Action plan on Contractor before imposing any of the sanctions set forth in this Section or in State and federal law.

H. DHCS may impose sanctions in addition to any monetary damages recovered pursuant to Exhibit E, Subsection 1.1.20 (*Liquidated Damages*).

1.1.20 Liquidated Damages

A. If Contractor breaches this Contract, DHCS will be entitled to all legal and equitable remedies available under the law, including monetary damages in the form of actual, consequential, direct, indirect, special, and/or liquidated damages.

B. Contractor agrees that any breach of this Contract, including but not limited to a breach due to Contractor's delay in implementing new program requirements or plan readiness requirements or Contractor's failure to meet its Quality or Network Adequacy obligations, may result in damage to the State or DHCS that is difficult to quantify. In the event of such a breach, Contractor agrees that the Director is authorized to impose liquidated damages on Contractor in the amount of $25,000 for each separate and distinct breach in addition to liquidated damages in the amount of $25,000 for each day Contractor fails to remedy the breach, which the Parties agree bears a reasonable relationship to the range of actual damages the Parties anticipate would flow from such a breach.

C. Contractor acknowledges that DHCS' authority to impose monetary sanctions and other intermediate sanctions pursuant to 42 CFR section 438.700 *et seq*. and W&I section 14197.7, as set forth in Exhibit E, Subsection 1.1.19 (*Sanctions*), is separate and distinct, and that DHCS may recover damages for Contractor's breach, including liquidated damages, in addition to any sanctions imposed under Exhibit E, Subsection 1.1.19 *(Sanctions).*

1.1.21 Contractor's Dispute Resolution Requirements

Contractor must comply with and exhaust the requirements of this Section when it initiates a contract dispute with DHCS. This Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*) does not apply to challenges to sanctions as described in Exhibit E, Subsection 1.1.19 *(Sanctions)* liquidated damages as described in Exhibit E, Subsection 1.1.20 *(Liquidated Damages)*, or any other contract compliance action initiated by DHCS. Contractor's filing of a Notice of Dispute, as defined in Paragraph B of this Section, does not preclude DHCS from withholding or recouping the value of the amount in dispute from Contractor, or from offsetting the amount in dispute from subsequent Capitation Payment(s).

A. Resolution of Dispute by Negotiation

Contractor agrees to make best efforts to resolve all alleged contractual issues by negotiation and mutual agreement at the DHCS Contracting Officer level before appealing to the DHCS Office of Administrative Hearings and Appeals (OAHA). Contractor must exhaust OAHA's appeal process before filing a writ in Sacramento County Superior Court. During the negotiations to resolve Contractor's issues, DHCS and Contractor may agree, in writing, to an extension of time for continuing negotiations to resolve Contractor's dispute before the decision of the DHCS Contracting Officer is issued.

B. Notice of Dispute

Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to Contractor, Contractor must serve a written notice of dispute to the DHCS Contract Manager. Contractor's failure to serve its notice of dispute within 30 calendar days from the date the alleged dispute arises or otherwise becomes known to Contractor constitutes a waiver of all issues raised in Contractor's notice of dispute.

Contractor's notice of dispute must include, based on the most accurate information and substantiating documentation available to Contractor, the following:

1) That the dispute is subject to the procedures in this Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*);

2) The date, nature, and circumstances of the alleged conduct that is subject of the dispute;

3) The names, phone numbers, functions, and conduct of every Subcontractor, Downstream Subcontractor, Network Provider, DHCS/State official or employee involved in or knowledgeable of the alleged issue(s) that is the subject of the dispute;

4) The identification of any substantiating documents and the substance of any oral communications that are relevant to the alleged conduct;

5) Copies of all substantiating documentation and any other evidence attached to its notice of dispute;

6) The factual and legal bases supporting Contractor's notice of dispute;

7) The cost impact to Contractor directly attributable to the alleged conduct, if any; and

8) Contractor's desired remedy.

After Contractor submits its notice of dispute with all accurate available substantiating documentation, Contractor must comply with 22 CCR section 53851(d) and diligently continue performance of its obligations under this Contract, including compliance with contract requirements that are the subject of, or related to, Contractor's notice of dispute.

If Contractor requests and DHCS agrees, Contractor's notice of dispute may be decided by an Alternate Dispute Officer (ADO). DHCS will designate an ADO who was not directly involved in the alleged conduct that prompted Contractor's notice of dispute.

Any appeal of the DHCS Contracting Officer's decision to OAHA or a writ seeking review of OAHA's decision in Sacramento County Superior Court is limited to the issues and arguments set forth and properly documented in Contractor's notice of dispute, that were not waived or resolved.

C. Timeframes

1) The DHCS Contracting Officer or ADO will have 90 calendar days to review Contractor's initial notice of dispute and available substantiating documentation and issue a decision unless there is a written agreement between DHCS and Contractor to extend that

time. If the DHCS Contracting Officer or ADO determines that additional substantiating documentation is required, they will provide Contractor with a written request identifying the issue(s) requiring additional supporting documentation. Contractor must provide that additional substantiating documentation no later than 30 calendar days from receipt of the request.

2) Unless Contractor and the DHCS Contracting Officer or ADO agree to an extension of time, in writing, Contractor's failure to provide additional substantiating documentation, or otherwise notify the DHCS Contracting Officer or ADO that no additional documents exist, within 30 calendar days from the request, constitutes Contractor's waiver of all issues raised in Contractor's notice of dispute.

3) Issues raised by Contractor in the notice of dispute will be decided by the DHCS Contracting Officer or the ADO within 90 calendar days from receipt of Contractor's substantiating documentation or within 60 calendar days from receipt of all additionally requested substantiating documentation from Contractor, whichever is later.

D. The DHCS Contracting Officer's or ADO's Decision

1) If the DHCS Contracting Officer or the ADO finds in favor of Contractor, they may:

a) Correct the conduct which prompted Contractor's notice of dispute; or

b) Require performance of the disputed conduct and, if there is a cost impact sufficient to constitute a material change in obligations pursuant to the payment provisions under Exhibit B, Subsection 1.1.1 (*Budget Contingency Clause*), direct DHCS to comply with that Exhibit. In the event of such a finding DHCS will not owe interest on any underpayment found due and owing pursuant to the notice of dispute.

2) If DHCS' Contracting Officer or the ADO denies Contractor's notice of dispute, they are authorized to direct the manner of Contractor's future contractual performance.

E. Appeal of the DHCS Contracting Officer's or ADO's Decision

1) Contractor will have 30 calendar days following the receipt of DHCS Contracting Officer's or ADO's decision to appeal the decision to the Director, through OAHA. All of Contractor's appeals will be governed by H&S section 100171, except California Government Code (GC) section 11511 relating to depositions will not apply. The venue of OAHA appeals will be in Sacramento.

2) All of Contractor's appeals must be in writing and must be filed with OAHA and a copy sent to the Chief Counsel of DHCS and DHCS Contract Manager. Contractor's appeal will be deemed filed on the date it is received by OAHA. Contractor's appeal must specifically set forth the unresolved issues that remain in dispute and issues that have not been waived because of Contractor's failure to provide all substantiating documentation to DHCS, as specified in Exhibit E, Subsection 1.1.21 (*Contractor's Dispute Resolution Requirements*). Additionally, Contractor's appeal is solely limited to the issues raised in its notice of dispute that have not been resolved or waived.

3) Contractor has the burden of proof of demonstrating that its position is correct and must show by a preponderance of evidence that:

   a) DHCS acted improperly such that it breached this Contract; and

   b) Contractor sustained a cost impact directly related to DHCS' breach.

4) OAHA's jurisdiction is limited to issues and arguments raised in the notice of dispute that were not waived either by the untimely filing of the notice of dispute or statement of disputed issues, or by Contractor's failure to provide all requested substantiating documentation requested by DHCS Contracting Officer or ADO or otherwise resolved by Contractor and DHCS.

5) Contractor's failure to timely appeal the decision to OAHA constitutes a waiver by Contractor of all issues raised in Contractor's notice of dispute. This waiver of claims also precludes the filing of a writ in Sacramento Superior Court, or any other court.

F. No Obligation to Pay Interest

If Contractor prevails on its notice of dispute pursuant to a DHCS Contracting Officer's or ADO's decision, an OAHA decision, or an order or

decision issued by the Sacramento County Superior Court or any California court of appeal, DHCS will not be required to pay interest on any amounts found to be due or owing to Contractor arising out of the notice of dispute.

G. Contractor's Duty to Perform

Contractor must comply with all requirements of 22 CCR section 53851(d) and all obligations under this Contract, including continuing Contract requirements that are the subject of, or related to, Contractor's notice of dispute until there is a final decision from the DHCS Contracting Officer, the ADO or a decision on an appeal in Sacramento County Superior Court.

H. Waiver of Claims

Contractor waives all claims or issues if it fails to timely submit a notice of dispute with all substantiating documents within the timeframes noted in Subsection 1.1.21.C, above. Contractor also waives all claims or issues set forth in its notice of dispute if it fails to timely submit all additional substantiating documentation within 30 calendar days of the DHCS Contracting Officer's or ADO's request, or if it fails to timely appeal the DHCS Contracting Officer's or ADO's decision in the manner and within the time specified in this Subsection 1.1.21. Contractor's waiver includes all damages whether direct or consequential in nature.

1.1.22 Inspection and Audit of Records and Facilities

A. Recordkeeping Requirements

1) Records to be Maintained

Contractor must maintain all records and documents necessary to disclose how Contractor discharges its obligations under this Contract. These records and documents will disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which Contractor administered its daily business, and the cost thereof.

Contractor must maintain all working papers, reports submitted to (DHCS, DMHC, Division of Medi-Cal Fraud & Elder Abuse (DMFEA), United States Department of Health & Human Services

(U.S. DHHS), and United States Department of Justice (US DOJ), financial records, books of account, Medical Records, prescription files, laboratory results, Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members.

In addition, and in accordance with 42 CFR section 438.3(u), Contractor must retain the following information for no less than ten years and allow auditing entities to inspect and audit:

a) Member Grievance and Appeal records as required in 42 CFR section 438.416;

b) Base data as defined in 42 CFR section 438.5(c);

c) MLR reports as required in 42 CFR section 438.8(k); and

d) Data, information, and documentation specified in 42 CFR sections 438.604, 438.606, 438.608, and 438.610.

2) Records Retention Period

Notwithstanding any other records retention time period set forth in this Contract, Contractor must maintain all records and documents described in this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*) for a minimum of ten years from the final date of the Phaseout Period or from the date of completion of any audit, whichever is later, in accordance with 42 CFR sections 438.3(h) and (u) and 438.230(c).

B. Right to Audit and Inspect Records and Facilities

1) Authorized Agencies

Contractor agrees that the following agencies, including but not limited to, DHCS, CMS, U.S. DHHS, U.S. DHHS Office of the Inspector General, the Comptroller General of the United States, US DOJ, DMFEA, DMHC, the External Quality Review Organization (EQRO) contractor, and all other agencies authorized under State and federal law (authorized agencies), and their duly authorized representatives or designees, will have the right to audit and inspect the records, documents, and facilities of Contractor,

and its Subcontractors, Downstream Subcontractors, and Network Providers.

2) Right to Audit and Inspect at Any Time

DHCS, and its designees, and other authorized agencies and their designees, may, at any time, inspect and audit any and all records, documents, contracts, computers, or other electronic systems maintained by Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers, and may, at any time, inspect the premises, facilities, and equipment pertaining directly or indirectly to the delivery of Medi-Cal services pursuant to 42 CFR sections 438.3(h) and (u) and 438.230(c), and other applicable State and federal law.

3) Scope of Inspection

DHCS and other authorized agencies may, at any time, audit, inspect, and monitor, Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers, to assure compliance with any provision of this Contract; evaluate the quality, appropriateness, and timeliness of services performed under this Contract; and for any other reasonable purpose.

Upon request, and through the end of the records retention period specified in Exhibit E, Subsection 1.1.22.A.2 (*Inspection and Audit of Records and Facilities*), Contractor must furnish any record, or copy of it, to DHCS or any other auditing entity listed in this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*), at Contractor's sole expense.

4) Right to Audit and Inspect Exists for Ten Years

The right to audit and inspect under this Exhibit E, Subsection 1.1.22 (*Inspection and Audit of Records and Facilities*) exists for ten years from the final date of the Contract Phaseout Period or from the date of completion of any audit, whichever is later, in accordance with 42 CFR sections 438.3(h) and (u) and 438.230(c).

5) Additional Facility Inspection Rights

In addition to Exhibit D(f), Section 8 (*Site Inspection*) in order to ensure compliance with this Contract, and for any other reasonable purpose, Contractor agrees to the following:

a) DHCS, and its authorized representatives and designees, and authorized agencies, and their authorized representatives and designees, will have the right to access the premises and facilities of Contractor, and the premises and facilities of its Subcontractors, Downstream Subcontractors, and Network Providers, with or without notice, including, but not limited to, the Management Information Systems (MIS) operations site or such other places where duties and obligations under the Contract are performed.

b) Staff designated by DHCS, and the designated staff of other authorized agencies, must be provided access to security areas of all Contractor, and its Subcontractors, Downstream Subcontractors,' and Network Providers. Contractor must provide, and must require any and all of its Subcontractors, Downstream Subcontractors, and Network Providers to provide, reasonable cooperation and assistance to auditing representatives in the performance of their duties.

c) DHCS may conduct unannounced inspections and audits of the premises and facilities of Contractor, and its Subcontractors, Downstream Subcontractors, and Network Providers, selected at DHCS' sole discretion, to verify compliance of these sites with DHCS requirements.

1.1.23 Confidentiality of Information

In addition to Exhibit D(f), Section 14 (*Confidentiality of Information*), Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. 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 42 CFR section 431.300 *et seq.*, W&I section 14100.2, 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 will be protected by Contractor.

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 to DHCS requests for Medical Records made in accordance with applicable law, unless the law requires such reporting.

B. With respect to any identifiable information obtained by Contractor, or its Subcontractors, Downstream Subcontractors, or Network Providers, concerning a Member under this Contract, Contractor will ensure the following:

1) Any such information will not be used for any purpose other than carrying out the express terms of this Contract;

2) All requests for disclosure of such information will be promptly transmitted to DHCS, except requests for Medical Records in accordance with applicable law;

3) Any such information will not be disclosed, except as otherwise specifically permitted by this Contract, to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR section 431.300 *et seq.*, W&I section 14100.2, and regulations adopted thereunder; and

4) At the termination of this Contract, the return all such information to DHCS or maintain such information as directed by DHCS.

C. Contractor will have provisions in its Subcontractor Agreements and Network Provider Agreements requiring Subcontractors, Downstream Subcontractors, and Network Providers to comply with this Exhibit E, Subsection 1.1.23 (*Confidentiality of Information*).

1.1.24 Pilot Projects

DHCS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect Contractor's obligations under this Contract. Any changes in the obligations of Contractor that are necessary for the operation of a pilot project in Contractor's Service Area will be implemented through a contract amendment.

1.1.25 Cost Avoidance and Post-Payment Recovery of Other Health Coverage

A. Contractor must Cost Avoid or make a Post-Payment Recovery (PPR) for the reasonable value of services paid by Contractor and rendered to a Member whenever a Member's Other Health Coverage (OHC) covers the same services, fully or partially. However, in no event may Contractor Cost Avoid or seek PPR for the reasonable value of services from a Third Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

B. Contractor must, at a minimum, utilize the Medi-Cal eligibility record for Cost Avoidance and PPR purposes.

C. Contractor retains all monies for PPR when Contractor initiates and completes recovery within 12 months from the date of payment of a service. Any monies for PPR obtained after the 12 months following the date of payment of a service are considered Medi-Cal recoveries and must be remitted to DHCS.

D. If Contractor initiates an active repayment plan with Network Providers or third-party insurance carriers that is agreed upon prior to, and extends beyond 12 months from, the date of payment of a service, Contractor will be allowed to retain the recovered monies.

E. Contractor must coordinate benefits with other coverage programs and entitlements, recognizing the OHC as primary and the Medi-Cal program as the payer of last resort, except for services in which Medi-Cal is required to be the primary payer.

F. If Contractor does not perform PPR for a Member with OHC, Contractor must demonstrate to DHCS, upon request, that the cost of PPR exceeds the total Contract Revenues Contractor projects it would receive from such activity.

G. Cost Avoidance

1) Contractor must not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third-party coverage, designated by an OHC code or Medicare coverage, without proof that the Provider has first exhausted all sources of other payments. Acceptable forms of proof that all sources of payment have been exhausted or do not apply include a denial letter from the OHC for the service, an explanation of benefits indicating that the service is not covered by the OHC, or documentation demonstrating that Provider has billed the OHC and received no response for at least 90 calendar days.

2) Contractor must ensure that Providers do not refuse to provide Covered Services to Members, when OHC is indicated on a Member's Medi-Cal eligibility record.

3) Contractor must allow Providers to direct bill services that meet DHCS' requirements for direct billing without attempting to Cost Avoid those services. Cost Avoidance is not required prior to payment for services provided to Members with OHC codes A or N. More information on services that qualify for direct billing can be found in the Medi-Cal Provider Manual, Part 2 – General Medicine, section "Other Health Coverage (OHC): CPT-4 and HCPCS Codes (oth hlth cpt)".

4) Prior to delivering services, Contractor must ensure that Providers review the Member's Medi-Cal eligibility record for third-party coverage, designated by OHC or Medicare coverage code. If the Member's Medi-Cal eligibility record indicates OHC and the requested service is covered by OHC, Contractor must ensure that Providers notify the Member to seek the service from OHC.

5) When Contractor denies a claim due to OHC, Contractor must include OHC information in its notice of claim denial to Provider. OHC information includes, but is not limited to, the name of the OHC or Medicare carrier, and contact or billing information of the OHC.

H. Reporting Requirements for Cost Avoidance

Contractor must report new OHC information not found on the Medi-Cal eligibility record or that is different from what is reflected on the Medi-Cal eligibility record to DHCS within ten calendar days of discovery. Contractor must report discrepancies in the Medi-Cal record by either completing and submitting an OHC removal or addition form found online at https://www.dhcs.ca.gov or reporting OHC information to DHCS in batch updates. Batch updates regarding OHC information are processed by DHCS on a weekly basis. Contractor may contact its DHCS Contract Manager for more information regarding this process.

I. Post-Payment Recovery

1) Contractor must pay Provider's claim and then seek to recover the cost of the claim by billing the liable third parties in either of the following circumstances:

a) The Member had OHC code A on their Medi-Cal eligibility record at the time of service; or

b) For services defined by DHCS as preventive pediatric services.

2) When Contractor discovers that a service was provided to a Member with OHC designated in the Medi-Cal eligibility record, and Contractor did not properly Cost Avoid the service, then Contractor must bill the OHC for the cost of actual services rendered. If OHC is discovered retroactively, Contractor must also bill the OHC for the cost of actual services rendered.

3) Contractor must bill the liable OHC for the cost of services provided to Members. Billing and recoupment must be completed within 12 months from the date of payment of a service.

4) Monies recovered by DHCS or DHCS' contracted recovery agent starting on the first day of the 13th month after the date of payment of a service will be retained by DHCS.

J. Reporting Requirements

Contractor must submit a monthly PPR Report to DHCS via Secure File Transfer Protocol (SFTP) by the 15th day of each month in a format specified by DHCS in APLs. This report must contain claims and recovery information and any other information specified by DHCS in APLs.

K. Contractor must have written policies and procedures implementing all of the requirements of this Exhibit E, Subsection 1.1.25 (*Cost Avoidance and Post-Payment Recovery of Other Health Coverage*).

1.1.26 Third-Party Tort and Workers' Compensation Liability

Contractor must not make a claim for recovery of the value of Covered Services rendered to a Member in cases or instances involving casualty insurance, tort, Workers' Compensation, or class action claims. Contractor's failure to comply with this provision is non-delegable. In the event that Contractor's failure to comply with this provision negatively impacts DHCS' ability to recover its full statutory lien, DHCS reserves the right to deduct any losses from Contractor's Capitation Payments. To assist DHCS in exercising DHCS' exclusive responsibility for recovering casualty insurance, tort, Workers' Compensation, or class action claims, Contractor must meet the following requirements:

A. Within 30 calendar days of DHCS' request, submit all requested service and utilization information and, when requested, copies of paid invoices/claims for its Members, including information from Network Providers, out-of-Network Providers, Subcontractors, and Downstream Subcontractors. Service and utilization information and copies of paid invoices/claims must set out any services provided by Contractor, including, but not limited to, physical, mental, and dental health services. Records must include services provided on a Fee-For-Service, capitated basis, and any other payment arrangements, regardless of whether a payment was made or denied. The reasonable value of the services must be calculated as the usual, customary, and reasonable charge made to the general public for similar services, or the amount paid to Network Providers or out-of-Network Providers for similar services. No additional payment will be made to Contractor for compliance with this provision.

B. Submit the requested service and utilization information and paid invoices/claims in a form and manner specified by DHCS through DHCS designated SFTP, in compliance with the electronic format and process, as set forth in APLs. Contractor must include the attestation in a form and manner specified by DHCS signed by the custodian of records or a designee with knowledge of the Member Information provided to DHCS, as set forth in APLs.

C. Notify DHCS using the appropriate online notification form at the Third Party Liability and Recovery Division Online Forms page, https://dhcs.ca.gov/PIForms, within ten calendar days of receiving a request from attorneys, insurers, or Members for a lien, pursuant to DHCS' recovery rights. These requirements do not relieve Contractor of other legal duties to Contractor's Members or other entities, including, without limitation, the duty to respond to Members' requests for their own Protected Health Information pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

D. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding Contractor's service and utilization information and copies of paid invoices/claims file submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the SFTP folders.

E. Have written policies and procedures implementing all of the requirements of this Exhibit E, Subsection 1.1.26 (*Third-Party Tort and Workers' Compensation Liability*).

1.1.27 Litigation Support

A. Records

Upon request by DHCS, Contractor must timely gather, preserve, and provide, in the form and manner specified by DHCS, any information, subject to any lawful privileges, in the possession of Contractor or its Subcontractors, Downstream Subcontractors, or Network Providers , relating to threatened or pending litigation by or against DHCS. If Contractor asserts that any requested documents are covered by a lawful privilege, Contractor must:

1) Sufficiently identify the claimed privileged documents to reasonably identify the documents; and

2) State the privilege being claimed that supports withholding production of the document.

Contractor agrees to promptly provide DHCS with a copy of any documents provided to any party in any litigation by or against DHCS. Contractor acknowledges that time is of the essence in responding to such a request. Contractor will use its best efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records received by Contractor or its Subcontractors, Downstream Subcontractors, or Network Providers related to this Contract or the Subcontractor Agreements, Downstream Subcontractor Agreements, and Network Provider Agreements entered into under this Contract.

B. Document Authentication and Testimony

Contractor will make its personnel and employees available to DHCS to authenticate documents, provide testimony as a witness, act as a “person most knowledgeable,” and assist in other ways as requested by DHCS, in connection with litigation, Public Record Acts requests, subpoenas, inquiries, and/or audits by federal and State agencies and departments, and inquiries by third-parties, as requested by DHCS. No additional payments will be paid to Contractor for the activities described in this Exhibit E, Subsection 1.1.27 (*Litigation Support*).

1.1.28 Equal Opportunity Employer

Contractor must comply with all applicable federal and State employment discrimination laws. Contractor, must:

A. In all solicitations or advertisements for employees placed by or on behalf of Contractor, state that it is an equal opportunity employer;

B. Send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a DHCS-approved notice, advising the labor union or workers' representative of its commitment as an equal opportunity employer and post copies of the notice in conspicuous places available to employees and applicants for employment;

C. Not unlawfully discriminate against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status;

D. Ensure that the evaluation and treatment of its employees and applicants for employment are free of such discrimination and comply with the provisions of the Fair Employment and Housing Act (GC §12900 *et seq*.), and the applicable regulations promulgated thereunder (2 CCR § 11000 *et seq.*). The applicable regulations of the Fair Employment and Housing Council implementing GC section 12990, set forth in Subchapter 5 of Division 4.1 of Title 2 of the California Code of Regulations are incorporated into this Contract by reference and made a part hereof as if set forth in full;

E. Give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement; and

F. Include the nondiscrimination and compliance provisions of this clause in all contracts to perform work under the Contract, in accordance with 2 CCR section 11105.

1.1.29 Federal and State Nondiscrimination Requirements

Contractor must:

A. 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; and

B. Comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I section 14029.91, and State implementing regulations.

1.1.30 Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor must not unlawfully 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 section 422.56, in accordance with the statutes identified in Exhibit E, Subsection 1.1.29 (*Federal and State Nondiscrimination Requirements*) above, rules and regulations promulgated pursuant thereto, or as otherwise provided by law. For the purpose of this Contract, discrimination includes, but is not limited to, unlawfully:

1) Denying any Member Covered Services or availability of a Facility;

2) Providing a Member with any Covered Service that is different, or is provided in a different manner or at a different time from that which is provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation, separate treatment, or harassment in any manner related to the receipt of any Covered Service;

4) Restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; 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;

5) 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 section 422.56, to the Members to be served;

6) Utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination;

7) 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

8) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and Potential Members.

B. Member Affirmative Action

Contractor must take affirmative action to ensure that Members are provided Covered Services without regard to 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 section 422.56, except as needed to provide equal access to LEP Members or Members with disabilities, or where medically indicated. For the purposes of this Section, genetic information 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 genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

C. Discrimination Related To Health Status

Contractor must not discriminate against Members or Potential Members on the basis of their health status or requirements for health care services during Enrollment, re-Enrollment or disenrollment. Contractor must not terminate the Enrollment of a Member based on an adverse change in the Member’s health.

1.1.31 Small Business Participation and Disabled Veteran Business Enterprises Reporting Requirements

A. Contractor must comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Public Contract (PC) Code section 10230.

B. If for this Contract, Contractor made a commitment to achieve small business participation, then Contractor must annually and within 60 calendar days of receiving final payment under this Contract report to DHCS the actual percentage of small business participation that was achieved (GC § 14841).

C. If for this Contract, Contractor made a commitment to achieve DVBE participation, then Contractor must annually and within 60 calendar days of receiving final payment under this Contract certify in a report to DHCS:

1) The total amount Contractor received under the Contract;

2) The name and address of the DVBE(s) that participated in the performance of the Contract;

3) The amount each DVBE received from Contractor;

4) That all payments under the Contract have been made to the DVBE; and

5) The actual percentage of DVBE participation that was achieved. (Military and Veterans Code § 999.5(d); GC § 14841).

1.1.32 Conflict of Interest Avoidance Requirements

Contractor will comply with all requirements relating to Contractor's obligations to avoid conflicts of interest as described in Exhibit H (*Conflict of Interest Avoidance Requirements*).

1.1.33 Guaranty Provision

If Contractor is a subsidiary of another entity, Contractor must submit a guaranty from any entity in Contractor's chain of ownership that is publicly traded. If no such parent entity is publicly traded, the guaranty must be submitted by a parent entity at a level in the chain of ownership that is acceptable to DHCS. The guaranty must meet all requirements set forth in Exhibit I (*Contractor's Parent Guaranty Requirements*) of this Contract and be

in a form satisfactory to DHCS, and provide for the full and prompt performance of all covenants, terms and conditions, and agreements throughout the term of the Contract.

1.1.34 Priority of Provisions

In the event of a conflict between the provisions of Exhibit D(f) (*Special Terms and Conditions*) and any other Exhibits of this Contract, the provisions in the other Exhibits will prevail over the provisions in Exhibit D(f). Additionally, where Exhibit D(f) contains provisions on the same subject matter as a provision in another Exhibit of this Contract, the language in the other Exhibit preempt and prevail over the language in Exhibit D(f).

In the event of a conflict between any Article summary (Articles 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0) and a more specific term in this Contract, the more specific term will prevail over the Article summary.

1.1.35 Additional Incorporated Provisions – Proposals

Any and all final Proposals, including Exhibits and Attachments (collectively referred to as “Proposal”), submitted by Contractor in response to the Request for Proposal 20-10029 (RFP), or any subsequent Requests for Proposal in connection with any managed care contract, are hereby incorporated by reference into this Contract. DHCS is relying on Contractor’s representations in Contractor’s Proposal in awarding contracts, and, accordingly, DHCS may enforce such representations against Contractor, including, but not limited to, representations that it will perform in a certain manner, provide enhanced services, and/or meet more stringent requirements than those required in the Contract. Contractor is required to obtain written approval from DHCS before implementing any such enhanced services or requirements reflected in Contractor’s Proposal. In the event the Proposal(s) does not address Contract requirements, the Contract will govern.

1.1.36 Miscellaneous Provisions

A. Antitrust Claims

By signing this Contract, Contractor hereby certifies that if these services or goods are obtained by means of a competitive bid, Contractor must comply with the Antitrust Claims requirements of the GC sections 4550 *et seq.*.

B. Child Support Compliance Act

Contractor recognizes the importance of Child and family support obligations and must fully comply with all applicable State and federal laws relating to Child and family support enforcement (Chapter 8 (commencing with section 5200) of Part 5 of Division 9 of the Family Code).

C. Priority Hiring Considerations

Contractor must give priority consideration in filling vacancies in positions funded by the Contract to qualified recipients of aid under W&I section 11200 in accordance with PC section 10353.

D. Interoperability

1) Contractor must comply with the CMS Interoperability and Patient Access Final Rule, as set forth in 42 CFR sections 406, 407, 422, 423, 431, 438, 457, 482 and 485, and 45 CFR section 156.

2) Contractor must ensure that its contracted hospitals comply with the electronic notification requirements as set forth in 42 CFR section 482.24(d).

3) Contractor must participate in the California Health and Human Services Data Exchange Framework to exchange health information or provide access to health information to and from various entities in real time as set forth in H&S section 130290.

E. Electronic Visit Verification

All Network Providers who are eligible must comply with Electronic Visit Verification (EVV) requirements.

1) Contractor must collaborate with DHCS, and take action as required by DHCS, to comply with and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers comply with federal requirements for Electronic Visit Verification (EVV) set forth in 42 USC section 1396b(l) and with State requirements for EVV set forth in W&I section 14043.51, Section 12006(a) of the Federal Cures Act, and APL 22-014.

2) Contractor must implement and ensure that its applicable Subcontractors, Downstream Subcontractors, and Network Providers implement a State-approved EVV solution, as required, for personal care services and home health care services provided in a Member's home.

3) Contractor must verify that all Network Providers capture and transmit the following six mandatory data components when providing Personal Care Services and Home Health Care Services in a Member's home:

   a) The type of service performed;

   b) The individual receiving the service;

   c) The date of the service;

   d) The location of service delivery;

   e) The individual providing the service; and

   f) The time the service begins and ends.

4) Contractor must monitor and ensure all Network Providers comply with the EVV requirements when rendering personal care services and home health care services, subject to federal EVV requirements in accordance with APL 22-014 and the established guidelines below:

   a) Monitor providers for compliance with the EVV requirements and Information Notice(s), and alert DHCS to any compliance issues.

   b) Supply Providers with technical assistance and training on EVV compliance.

   c) Require Providers to comply with an approved Corrective Action plan.

   d) Deny payment if the Provider is not complying with EVV requirements and arrange for Members to receive services from a Provider who does comply.

Exhibit F – Contractor's Release

Contractor's Release

Instructions to Contractor:

With final invoice(s), submit one (1) original and one (1) copy. The original must bear the original signature of a person authorized to bind Contractor. The additional copy may bear photocopied signatures.

Submission of Final Invoice

Pursuant to **contract number** ___entered into between the Department of Health Care Services (DHCS) and Contractor (identified below), Contractor does acknowledge that final payment has been requested via **invoice number(s)** ___, in the **amount(s) of $** and **dated** ___. If necessary, enter "See Attached" in the appropriate blocks and attach a list of invoice numbers, dollar amounts and invoice dates.

Release of all Obligations

By signing this form, and upon receipt of the amount specified in the invoice number(s) referenced above, Contractor does hereby release and discharge the State, its officers, agents and employees of and from any and all liabilities, obligations, claims, and demands whatsoever arising from the above referenced contract.

Repayments Due to Audit Exceptions / Record Retention

By signing this form, Contractor acknowledges that expenses authorized for reimbursement do not guarantee final allowability of said expenses. Contractor agrees that the amount of any sustained audit exceptions resulting from any subsequent audit made after final payment will be refunded to the State.

All expense and accounting records related to the above referenced contract must be maintained for audit purposes for no less than three years beyond the date of final payment, unless a longer term is stated in said contract.

Recycled Product Use Certification

By signing this form, Contractor certifies under penalty of perjury that a minimum of 0% unless otherwise specified in writing of postconsumer material, as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether it meets the requirements of Public Contract Code Section 12209. Contractor specifies that printer or duplication cartridges offered or sold to the State comply with the requirements of Public Contract Code Section 12156(e).

Reminder to Return State Equipment/Property (If Applicable)

(Applies only if equipment was provided by DHCS or purchased with or reimbursed by contract funds)

Unless DHCS has approved the continued use and possession of State equipment (as defined in the above referenced contract) for use in connection with another DHCS agreement, Contractor agrees to promptly initiate arrangements to account for and return said equipment to DHCS, at DHCS' expense, if said equipment has not passed its useful life expectancy as defined in the above referenced contract.

Patents / Other Issues

By signing this form, Contractor further agrees, in connection with patent matters and with any claims that are not specifically released as set forth above, that it will comply with all of the provisions contained in the above referenced contract, including, but not limited to, those provisions relating to notification to the State and related to the defense or prosecution of litigation.

ONLY SIGN AND DATE THIS DOCUMENT WHEN ATTACHING IT TO THE FINAL INVOICE

Contractor's Legal Name (as on contract):
Signature of Contractor or Official Designee:
Date:

Printed Name/Title of Person Signing:

Distribution: Accounting (Original) Program

Exhibit G – Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations parts 160 and 164 (collectively, and as used in this Agreement)

2. The term "Agreement" as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term "Business Associate" shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by federal and/or State laws.

4.1 As used in this Agreement and unless otherwise stated, the term "PHI" refers to and includes both "PHI" as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act (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 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, W&I section 5328, and Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply

with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure. Business Associate 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 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 be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate, 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 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; updates will be available online at the NIST Computer Security Resource Centerhttps://csrc.nist.gov/publications/sp800.

9.2.3 Business Associate 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 at the NIST Cryptographic Module Validation Program page, with information about the Cryptographic Module Validation Program under FIPS 140-2 available online. In addition, Business Associate maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate 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 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 be renewed annually.

9.2.6 Business Associate 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 ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or Confidential Information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate 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 make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate 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 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 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 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 notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business

Associate determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate 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 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 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 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 provide notice by telephone to DHCS.

18.1.2 Business Associate 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 be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, “DHCS Contacts”) using the DHCS Contact Information at Section 18.6. below.

Notice 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 include all information known at the time the incident is reported. The Privacy Incident Reporting Form is available online.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate 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 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" include any applicable additional information not included in the Initial Form. The Final PIR Form 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 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 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 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 notify individuals accordingly and pay all costs of such notifications, as well as all costs associated with the breach. The notifications comply with

applicable federal and State law. DHCS approve the time, manner and content of any such notifications and their review and approval 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 initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	**DHCS Privacy Office**	**DHCS Information Security Office**
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or State law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business

Associate promptly remedy any violation of this Agreement and 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 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 make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Exhibit H – Conflict of Interest Avoidance Requirements

1.0 The Department of Health Care Services (DHCS) requires Contractor to avoid conflicts of interest or the appearance of conflicts of interest. DHCS reserves the right to determine, in DHCS' sole discretion, whether any information received from any source indicates the existence of a potential, suspected, and/or actual conflict of interest.

Exhibit H

1.1 Conflict of Interest Avoidance Requirements

1.0 Conflict of Interest Avoidance Requirements

1.1.1 Introduction

Contractor must ensure that it complies with the conflict of intererst avoidance requirements set forth in this Exhibit H and must also ensure the compliance of its employees, officers, and directors throughout the entire term of the Contract, and any extensions thereto. Contractor must also ensure that its Subcontractors and Downstream Subcontractors (as those terms are defined in the Contract), and the employees, officers and directors of Subcontractors and Downstream Subcontractors, comply with the requirements set forth in this Exhibit H throughout the entire term of the Contract, and any extension thereto.

1.1.2 Identification of Ownership, Contractual, and Financial Interests

Contractor will disclose the following to DHCS, in a form and manner directed by DHCS through All Plan Letter (APL) or other similar instructions:

A. Any form of ownership interest, affiliation, financial interest, contractual relationship, and/or control Contractor has in any corporation or other entity that operates as a Medi-Cal managed care health plan, Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM), pharmaceutical company or any other health care provider, fiscal intermediary, billing agent, or any other controlling agent for Medi-Cal services (“Medi-Cal Program Participant”); and

B. Any form of ownership interest, affiliation, financial interest, contractual relationship, and/or control Contractor has in any corporation, partnership, limited partnership, limited liability company, sole proprietorship, or any other legal entity that is not a Medi-Cal Program Participant.

To the extent any interest identified by Contractor in Section 1.2 results in a potential, suspected, and/or actual conflict of interest, Contractor will be subject to all requirements of this Exhibit H.

1.1.3 Conflicts of Interest

If Contractor has a potential, suspected, and/or actual conflict of interest, Contractor must provide a description of the relationship and a conflict avoidance plan to ensure that such a relationship will not adversely affect DHCS, other Medi-Cal managed care plans, and/or Medi-Cal Members. In the conflict avoidance plan, Contractor must also establish procedures to avoid, neutralize, and/or mitigate a potential, suspected, and/or actual conflict of interest.

Any of the following instances would be considered a potential, suspected, and/or actual conflict of interest, including but not limited to any of these instances in the past, present, or future:

A. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the Contract would allow for private or personal benefit or for any purpose that is inconsistent with the goals and objectives of the Contract;

B. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, improperly uses their positions for purposes that are, or give the appearance of being, for private gain for themselves or others, such as those with whom they have family, business, or other ties that are determined by DHCS to be a conflict of interest;

C. An instance where Contractor or any of its Subcontractors and Downstream Subcontractors, or any employee, officer, or director of Contractor or any of its Subcontractors and Downstream Subcontractors, gains an unfair competitive advantage due to its unequal access to information, such as where non-public information gained on one contract by Contractor may be leveraged in bidding for another government contract;

    1) Where pursuant to the Political Reform Act (Govt. Code (GC) §§ 87100–87500), a DHCS official has an economic Interest in Contractor and the official makes, participates in the making of, or uses his or her official position to influence the making of a decision involving Contractor where it is reasonably foreseeable that the decision could materially affect the official's economic interest;

    2) Where pursuant to GC section 1090 *et seq*., a DHCS official participates in the making of a Contract with Contractor and the official is financially interested in the Contract;

    3) Where in contravention of Welfare and Institutions Code (W&I) section 14479, a DHCS officer or employee is employed in a management or consultant position by Contractor, Subcontractor,

or Downstream Subcontractor one year after the DHCS officer or employee terminates their State employment; and

4) For Two-Plan managed care models, an instance where Contractor will be contracted, affiliated, or otherwise entered into a partnership arrangement to serve as a Local Initiative in the same Two-Plan county where Contractor is operarting as the commercial plan, or has indicated an intent to do so.

D. Conflict Avoidance Plan Framework

The requirements of a conflict avoidance plan will vary depending on the nature of the conflict, but must include, at a minimum, the following elements:

1) Clear definitions;

2) Statement of organizational commitment to develop and follow the conflict avoidance plan;

3) Description of the type of conflict of interest (*e.g.*, unequal access to information, impaired objectivity, and/or biased ground rules implicated by a contract);

4) Description of the factors that may or do place Contractor in a potential, suspected, and/or actual conflict of interest situation;

5) If applicable, identification of Subcontractors and Downstream Subcontractors with potential, suspected, and/or actual conflict of interest;

6) Detailed plans for avoiding, neutralizing, and/or mitigating conflicts of interest, or, if not feasible, an explanation and justification for accepting conflicts of interest;

7) Administrative, technical, physical, and management controls, as required in the context of the specific conflict of interest;

8) Provision for third-party monitoring and a requirement that the third-party monitor certify Contractor's compliance with the conflict avoidance plan, if required by DHCS;

9) Contractor's certification of compliance with the conflict avoidance plan; and

10) Provisions requiring periodic review and amendment by Contractor of the conflict avoidance plan to address material changes impacting the conflict of interest.

1.1.4 DHCS Approval of Conflict Avoidance Plan

DHCS, in its sole discretion, will determine whether the specific provisions of the conflict avoidance plan satisfactorily address the actual, suspected, or potential conflicts of interest. DHCS, in its sole discretion, may impose additional requirements or require modification to the conflict avoidance plan, which may include, but are not limited to, the following:

A. Termination of contractual obligations that in DHCS' determination create actual or potential conflicts of interest;

B .Removal of Contractor's management or staff who DHCS determines were involved in the relationship creating the conflict of interest; and/or

C .Creation of an "ethical firewall," with measures to ensure that no information passes between individuals/entities within Contractor's organization that were involved in the conflict and those individuals/entities not involved in the conflict.

These requirements will vary, depending on the nature of the potential, suspected, and/or actual conflicts of interest, the manner in which those potential, suspected, and/or actual conflicts of interest impact the Contract, and DHCS' determination of the best method for addressing those conflicts of interest.

1.1.5 Third-Party Monitor Oversight

DHCS may, in its sole discretion, appoint a third-party monitor to assist in overseeing Contractor's compliance with the conflict avoidance plan. The third-party monitor's responsibilities will include monitoring, reporting, consulting, and, where necessary, investigation of compliance concerns. Appropriate provisions regarding the third-party monitor's duties and Contractor's obligations in connection with the third-party monitor will be included in the conflict avoidance plan.

1.1.6 DHCS' Right of Termination

If DHCS is aware or becomes aware of a potential, suspected, and/or actual conflict of interest, Contractor will be given an opportunity to submit additional

information to resolve the conflict of interest. If Contractor has a potential, suspected, and/or actual conflict of interest, Contractor will have five Working Days from the date of notification by DHCS of the potential, suspected, and/or actual conflict of interest to provide complete information regarding the conflict of interest. If DHCS determines that an actual conflict of interest exists and the conflict cannot be resolved or mitigated to the satisfaction of DHCS, the conflict of interest will be grounds for termination of the Contract by DHCS for cause.

1.1.7 Notice of Conflict of Interest to DHCS

Contractor, and each of its Subcontractors and Downstream Subcontractors, must notify their DHCS Contract Manager within ten Working Days of when they become aware of any potential, suspected, or actual conflict of interest, or when any change occurs to the information provided to DHCS previously, whether provided previously through the Request for Procurement or previous notice given during the term of the Contract. This notice will be in a form and manner as directed by DHCS through APLs or other similar instructions.

Exhibit I – Contractor's Parent Guaranty Requirements

1.0 Contractor's Parent Guaranty Requirements

If Contractor is a subsidiary of a corporation or other legal entity, the full and prompt performance of all covenants, provisions, and agreements resulting from this Contract for the life of the Contract must be guaranteed by that entity in Contractor's chain of ownership, which is publicly traded (the "Guaranty"). This entity will be known as Contractor's "parent corporation" for purposes of the Contract (the "Guarantor").

1.1 Contractor's Parent Guaranty Requirements

1.1.1 Minimum Requirements
1.1.2 Provisions
1.1.3 Terms

1.0 Contractor's Parent Guaranty Requirements

1.1.1 Minimum Requirements

The Guaranty must, at a minimum, meet the following requirements. It must:

A. Be made to DHCS, in writing, by the Contract effective date;

B. Be signed by an official authorized to bind the Guarantor organization;

C. Accept unconditional responsibility for all performance and financial requirements and obligations of the Contract including, but not limited to, maintenance of Tangible Net Equity (TNE) and payment of liquidated damages;

D. Recite that "for good and valuable consideration, receipt of which is hereby acknowledged," Guarantor is making the Guaranty;

E. State that Guarantor stipulates that if the Contract is ultimately awarded to the subsidiary, that DHCS will so award in reliance upon the Guaranty;

F. State that the undersigned corporate officer warrants that they have personally reviewed all pertinent corporate documents, including but not limited to, articles of incorporation, bylaws, and agreements between the parent and subsidiary; and

G. State that the undersigned corporate officer warrants that nothing in these documents in any way limits the capacity of the parent to enter into this Guaranty.

1.1.2 Provisions

The Guaranty must include the following provisions:

A. DHCS need not take any action against Contractor, any other guarantor, or any other person, firm or corporation, or resort to any security held by Contractor at any time before proceeding against Guarantor;

B. Guarantor hereby waives any and all notices and demands which may be required to be given by any other statute or rule of law and agrees that its liability hereunder will be in no way affected, diminished, or released by any extension of time, forbearance, or waiver, which may be granted to Contractor, its successor or assignee;

C. This Guaranty will extend to and include all future amendments, modifications, and extensions of the Contract and all future supplemental and other agreements with respect to matters covered by the Contract that DHCS and Contractor may enter into, with or without notice to or knowledge of Guarantor, but Guarantor will have the benefit of any such extension, forbearance, waiver, amendment, modification, or supplemental or other agreement. It is the purpose and intent of the parties hereto that the obligations of Guarantor hereunder will be co-extensive with, but not in excess of, the obligations of Contractor, its successor or assignee, under the Contract; and

D. Guarantor agrees that the Guaranty will continue in full force and effect despite any change in the legal or corporate status of the subsidiary, including, but not limited to, its sale, reorganization, dissolution or bankruptcy.

1.1.3 Terms

The Guaranty must be presented in terms, which DHCS in its sole discretion, determines, as a whole, adequately establish Contractor's financial responsibility.

Exhibit J: Delegation Reporting and Compliance Plan

This Exhibit contains instructions and templates for Contractor to make submissions to DHCS per the requirements set forth in Exhibit A, Attachment III, Subsection 3.1.3 *(Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan)*. As with all Exhibits to the Contract, Exhibit J is a part of this Contract and the reporting requirements in this Exhibit J and the use of the prescribed template are binding and enforceable contractual obligations under this Contract. Contractor must complete Exhibit J for each county in which they operate.

Template A: Delegation Function Matrix

Instructions: Complete *Table A1: Delegation Function Matrix – For Subcontractor* for all functions that are delegated through applicable Subcontractor Agreements. Contractor may not delegate contractual duties and obligations where delegation is legally or contractually prohibited. Use additional pages of Table A1 as needed – additional pages will not be counted in the total page count for the Delegation Justification and Plan.

Contractor Name:

Applicable County:

Compliance Officer:

Compliance Contact Information:

1. **Subcontractor Name:** Name of the Subcontractor with whom Contractor has a Subcontractor Agreement

2. **Type of Subcontractor:** Fully Delegated Subcontractor, Partially Delegated Subcontractor, Administrative Subcontractor

3. **Delegated Function(s):** The function(s) Contractor is delegating to Subcontractor. In the case of a Fully Delegated Subcontractor, this may be "all delegable functions."

4. **Address:** The address for location of the performance of Subcontractor's functions

5. **Contact Info:** Name and contact information for each of Subcontractor's key personnel who is responsible for ensuring compliance.

6. **Medi-Cal Managed Care Member:** Percentage of the total Medi-Cal Members assigned to the Subcontractor if applicable.

7. **Proportion of Capitated Rates At Risk:** Proportion of total capitated rates for which the Subcontractor is at risk, if applicable.

Table A1: Delegation Function Matrix—For Subcontractors

Subcontractor Name (1)	Type of Subcontractor (2)	Delegated Function(s) (3)	Address (4)	Contact Info (5)	Percentage of Total Members (6)	Proportion of Total Capitated Rate (7)

Subcontractor Name	Type of Subcontractor	Delegated Function(s)	Address	Contact Info	Percentage of Total Members	Proportion of Total Capitated Rate

Instructions: Complete *Table A2 Delegation Function Matrix—Downstream Subcontractors* for all functions that are delegated through applicable Downstream Subcontractor Agreements. Use additional pages of Table A2 as needed. Subcontractor or Downstream Subcontractor may not delegate contractual duties and obligations where delegation is legally or contractually prohibited. Complete one for each Subcontractor that delegates functions downstream and, as applicable, for each Downstream Subcontractor, if they further delegate functions downstream. Use additional pages of Table A2 as needed – additional pages will not be counted in the total page count for the Delegation Justification and Plan.

Subcontractor or Downstream Subcontractors Name:

Applicable County(ies):

Compliance Officer:

Compliance Contact Information:

1. **Downstream Subcontractor Name:** Name of the Downstream Subcontractor with whom the Subcontractor has a Downstream Subcontractor Agreement; or the name of the Downstream Subcontractor with whom the Subcontractor's Downstream Subcontractor further delegates functions downstream

2. **Type of Downstream Subcontractor:** Downstream Fully Delegated Subcontractor, Downstream Partially Delegated Subcontractor, Downstream Administrative Subcontractor

3. **Delegated Function(s):** The function(s) Subcontractor is delegating to Downstream Subcontractor; in the case of a Downstream Fully Delegated Subcontractor, this may be "all delegable functions."

4. **Address:** The address of the location of the performance of the Downstream Subcontractor's functions.

5. **Contact Info:** Name and contact information for each of the Downstream Subcontractor's key personnel who is responsible for ensuring compliance.

6. **Medi-Cal Managed Care Member:** Percentage of the total Medi-Cal Members assigned to the Downstream Subcontractor, if applicable.

7. **Proportion of Capitated Rates At Risk:** Proportion of total capitated rates for which the Downstream Subcontractor, is at risk, if applicable.

Table A2: Delegation Function Matrix—For Downstream Subcontractors

Downstream Subcontractor Name (1)	Type (2)	Delegated Function(s) (3)	Address (4)	Contact Info (5)	Percentage of Total Members (6)	Proportion of Total Capitated Rate (7)

Template B: Delegation Justification and Plan

Instructions: Complete this template for each Subcontractor or Downstream Subcontractor. Contractor may not delegate for those contractual duties and obligations where delegation is legally or contractually prohibited. Responses must be limited to no more than ten pages.

Subcontractor or Downstream Subcontractor Name:

Applicable County(ies):

Subcontractor or Downstream Key Personnel:

Subcontractor Key Personnel Contact Information:

Type of Subcontractor or Downstream Subcontractor: Fully delegated, Partially delegated, Administrative, Downstream Fully delegated, Downstream Partially delegated, Downstream Administrative:

a) **Justification of Subcontractor Agreement or Downstream Subcontractor Agreement:** Describe the purpose and the justification of the Subcontractor Agreement or Downstream Subcontractor Agreement.

b) **Pre-Existing Relationships:** Describe any pre-existing relationship, including any affiliation, parent entity, or prior existing contract between Contractor and Subcontractor, or Subcontractor and Downstream Subcontractor including the duration of such pre-existing relationship.

c) **Sub-Delegation**: Indicate if Subcontractor or Downstream Subcontractor is permitted to sub-delegate any functions. If so, describe how Contractor will maintain oversight over delegated functions to Subcontractors and Downstream Subcontractors. Provide citations to provisions in the Subcontractor Agreement and Downstream Subcontractor Agreement to support Contractor's assertions.

d) **Impact on Contractor:** Describe the impact and benefit, if any, the Subcontractor Agreement or Downstream Subcontractor Agreement will have on Contractor's operations, administrative capacity, and financial viability.

e) **Contractor's Administrative Capacity to Oversee and Monitor Subcontractor and Downstream Subcontractor:** Describe Contractor's administrative capacity to oversee and monitor Subcontractor and Downstream Subcontractor as applicable

f) **Subcontractor's and Downstream Subcontractor's Administrative Capacity:** Describe Subcontractor's and Downstream Subcontractor's administrative capacity to perform each delegated function, including but not limited to Subcontractor's and Downstream Subcontractor's capacity to perform quality monitoring and community engagement, if applicable.

g) **Subcontractor's and Downstream Subcontractors' Compliance with Applicable Contractual Provisions:** Detail how the Subcontractor Agreement and Downstream Subcontractor Agreement complies with, and ensures compliance, with all provisions of the Contract applicable to the delegated functions, including appropriate citations to the provisions in the Subcontractor Agreement and Downstream Subcontractor Agreement. Please complete Template C (Contract Requirements Grid) in Exhibit J to indicate which provisions are included in the Subcontractor Agreements and Downstream Subcontractor Agreements, as applicable for each Agreement.

h) **Contractor's Oversight Policy and Procedures:** Describe how Contractor will inform Subcontractor and Downstream Subcontractors of Contractor's oversight policies and procedures.

i) **Financial Arrangement:** Contractor must include description of any financial arrangements it has with Subcontractor and Downstream Subcontractor.

j) **Other Information:** Include any other information that would assist DHCS in its review of Contractor's delegated structure.

k) **Previously Approved Documents: (Applicable to annual submissions only)** If Contractor has previously submitted documentation to DHCS in connection with the Subcontractor Agreement or Downstream Subcontractor Agreement, either through the Request for Proposal (RFP) process or during the term of this Contract, Contractor must provide any such documentation.

Template C: Contract Requirements Grid

Instructions: If you delegate any functions, complete this template for those contractual duties. One Template C should be submitted showing all delegated functions to accompany Templates A and B.

Contractors must complete this table to indicate all the contract requirements that are applicable to their Subcontractors or Downstream Subcontractor, depending on the functions that are delegated to the respective entities.

This table also references obligations of Contractor where delegation must be contractually prohibited. While Contractor must not delegate contractual duties and obligations where delegation is contractually prohibited, Contractor or Subcontractor or Downstream Subcontractor may include related contractual requirements in their Agreements. For example, while Contractor may not delegate the functions of a Compliance Program, they may require Subcontractor and Downstream Subcontractors to maintain their own compliance programs. Regardless of a Contractor's system of delegation, Contractor remains obligated to ensure performance of all duties and obligations under the Contract.

Fully Delegated Subcontractors must comply with all contractual requirements. Partially Delegated Subcontractors and Downstream Partially Delegated Subcontractors, and Administrative Subcontractors and Downstream Administrative Subcontractors must at minimum comply with requirements outlined in Exhibit A, Attachment III, Subsection 3.1.5.B *(Subcontractor and Downstream Subcontractor Agreement Requirements)*.

Additional requirements may apply depending on the nature of the function or functions delegated. For example, if a Subcontractor delegates claims processing to an Administrative Downstream Subcontractor for this function, the Administrative Downstream Subcontractor must comply with Exhibit A, Attachment III, Subsection 3.3.5 *(Claims Processing)* for all requirements related to timely processing of claims.

Delegating functions or including contractual provisions in Subcontractor Agreements or Downstream Subcontractor Agreements does not absolve Contractor of ensuring compliance of the Subcontractors or Downstream Subcontractors.

Note:

(1) Must not be delegated: These rows reference contractual requirements associated with functions for which delegation is contractually prohibited. While Contractor must not delegate contractual duties and obligations where delegation is legally or contractually prohibited, Contractor may include related contractual requirements in the Subcontractor Agreements. For example, while Contractor may not delegate the functions of a Compliance Program, they may require Subcontractor and Downstream Subcontractors to maintain their own compliance programs.

Contractor Name:

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.0 Organization	
1.1 Plan Organization and Administration	
1.1.1 Legal Capacity	☐
1.1.2 Key Personnel Disclosure Form	☐
1.1.3 Conflict of Interest – Current and Former State Employees	☐
1.1.4 Contract Performance	☐
1.1.5 Medical Decisions	☐
1.1.6 Medical Director	☐
1.1.7 Chief Health Equity Officer	*(1) Must not be delegated*
1.1.8 Key Personnel Changes	☐
1.1.9 Administrative Duties/Responsibilities	☐
1.1.10 Member Representation	☐
1.1.11 Diversity, Equity, and Inclusion Training	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.2 Financial Information	
1.2.1 Financial Viability and Standards Compliance	☐
1.2.2 Contractor's Financial Reporting Obligations	☐
1.2.3 Independent Financial Audit Reports	☐
1.2.4 Cooperation with DHCS' Financial Audits	☐
1.2.5 Medical Loss Ratio	*(1) Must not be delegated*
1.2.6 Contractor's Obligations	☐
1.2.7 Community Reinvestment Plan and Report	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
1.3 Program Integrity and Compliance Program	
1.3.1 Compliance Program	*(1) Must not be delegated*
1.3.2 Fraud Prevention Program	☐
1.3.3 Provider Screening, Enrolling, and Credentialing/Recredentialing	☐
1.3.4 Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers	☐
1.3.5 Disclosures	☐
1.3.6 Treatment of Overpayment Recoveries	☐
1.3.7 Federal False Claims Act Compliance and Support	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.0 Systems and Processes	
2.1 Management Information System	
2.1.1 Management Information System Capability	☐
2.1.2 Encounter Data Reporting	☐
2.1.3 Participation in the State Drug Rebate Program	☐
2.1.4 Network Provider Data Reporting	☐
2.1.5 Program Data Reporting	☐
2.1.6 Template Data Reporting	☐
2.1.7 Management Information System/Data Audits	☐
2.1.8 Management Information System/Data Correspondence	☐
2.1.9. Tracking and Submitting Alternative Format Selections	☐
2.1.10 Interoperability Application Programming Information System Requirements	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.2 Quality Improvement and Health Equity Transformation Program	
2.2.1 Quality Improvement and Health Equity Transformation Program Overview	☐
2.2.2 Governing Board	☐
2.2.3 Quality Improvement and Health Equity Committee	☐
2.2.4 Provider Participation	☐
2.2.5 Subcontractor and Downstream Subcontractor Quality Improvement Activities	☐
2.2.6 Quality Improvement and Health Equity Transformation Program Policies and Procedures	☐
2.2.7 Quality Improvement and Health Equity Annual Plan	☐
2.2.8 National Committee for Quality Assurance Accreditation	*(1) Must not be delegated*
2.2.9 External Quality Review Requirements	☐
2.2.10 Quality Care for Children	☐
2.2.11 Quality Monitoring for Skilled Nursing Facilities—Long-Term Care	☐
2.2.12 Disease Surveillance	☐
2.2.13 Credentialing and Recredentialing	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
2.3 Utilization Management Program	
2.3.1 Prior Authorizations and Review Procedures	☐
2.3.2 Timeframes for Medical Authorization	☐
2.3.3 Review of Utilization Data	☐
2.3.4 Delegating Utilization Management Activities	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
3.0	**Provider, Network Providers, Subcontractors, and Downstream Subcontractors**	
3.1	**Network Provider Agreements, Subcontractor Agreements, Downstream Subcontractor Agreements, and Contractor's Oversight Duties**	
3.1.1	Overview of Contractor's Duties and Obligations	☐
3.1.2	DHCS Approval of Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements	☐
3.1.3	Contractor's Duty to Disclose All Delegated Relationships and to Submit Delegation Reporting and Compliance Plan	☐
3.1.4	Contractor's Duty to Ensure Subcontractor, Downstream Subcontractor, and Network Provider Compliance	*(1) Must not be delegated*
3.1.5	Requirements for Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements	☐
3.1.6	Financial Viability of Subcontractors, Downstream Subcontractors, and Network Providers	☐
3.1.7	Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics	☐
3.1.8	Network Provider Agreements with Safety-Net Providers	☐
3.1.9	Network Provider Agreements, Subcontractor Agreements, and Downstream Subcontractor Agreements with Local Health Departments	☐
3.1.10	Nondiscrimination in Provider Contracts	☐
3.1.11	Public Records	☐
3.1.12	Requirement to Post	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
3.2 Provider Relations	
3.2.1 Exclusivity	☐
3.2.2 Provider Dispute Resolution Mechanism	☐
3.2.3 Out-of-Network Provider Relations	☐
3.2.4 Contractor's Provider Manual	☐
3.2.5 Network Provider Training	☐
3.2.6 Emergency Department Protocols	☐
3.2.7 Prohibited Punitive Action Against the Provider	☐
3.2.8 Submittal of Inpatient Days Information	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
3.3 Provider Compensation Arrangements	
3.3.1 Compensation and Value Based Arrangements	☐
3.3.2 Capitation Arrangements	☐
3.3.3 Provider Financial Incentive Program Payments	☐
3.3.4 Identification of Responsible Payor	☐
3.3.5 Claims Processing	☐
3.3.6 Prohibited Claims	☐
3.3.7 Federally Qualified Health Center, Rural Health Center, and Indian Health Care Provider	☐
3.3.8 Non-Contracting Certified Nurse Midwife, Nurse Practitioner, and Licensed Midwife Providers	☐
3.3.9 Non-Contracting Family Planning Providers	☐
3.3.10 Sexually Transmitted Disease	☐
3.3.11 Human Immunodeficiency Virus Testing and Counseling	☐
3.3.12 Immunizations	☐
3.3.13 Community Based Adult Services	☐
3.3.14 Organ and Bone Marrow Transplants	☐
3.3.15 Long-Term Care Services	☐
3.3.16 Emergency Services and Post-Stabilization Care Services	☐
3.3.17 Provider-Preventable Conditions	☐
3.3.18 Prohibition Against Payment to Excluded Providers	☐
3.3.19 Compliance with Directed Payment Initiatives and Related Reimbursement Requirements	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.0 Member	
4.1 Marketing	
4.1.1 Training and Certification of Marketing Representatives	☐
4.1.2 Marketing Plan	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.2 Enrollments and Disenrollments	
4.2.1 Enrollment	☐
4.2.2 Disenrollment	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.3 Population Health Management and Coordination of Care	
4.3.1 Population Health Management Program Requirements	☐
4.3.2 Population Needs Assessment	☐
4.3.3 Data Integration and Exchange	☐
4.3.4 Population Health Management Service	☐
4.3.5 Population Risk Stratification and Segmentation, and Risk Tiering	☐
4.3.6 Screening and Assessments	☐
4.3.7 Care Management Programs	☐
4.3.8 Basic Population Health Management	☐
4.3.9 Other Population Health Requirements for Children	☐
	☐
4.3.10 Transitional Care Services	☐
4.3.11 Targeted Case Management Services	☐
4.3.12 Mental Health Services	☐
4.3.13 Alcohol and Substance Use Disorder Treatment Services	☐
4.3.14 California Children's Services	☐
4.3.15 Services for Persons with Developmental Disabilities	☐
4.3.16 School-Based Services	☐
4.3.17 Dental	☐
4.3.18 Direct Observed Therapy for Treatment of Tuberculosis	☐
4.3.19 Women, Infants, and Children Supplemental Nutrition Program	☐
4.3.20 Home and Community-Based Services Programs	☐
4.3.21 In-Home Supportive Services	☐
4.3.22 Indian Health Care Providers	☐
4.3.23 Managed Care Liaisons	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.4 Enhanced Care Management	
4.4.1 Contractor's Responsibilities for Administration of Enhanced Care Management	☐
4.4.2 Populations of Focus for Enhanced Care Management	☐
4.4.3 Enhanced Care Management Providers	☐
4.4.4 Enhanced Care Management Provider Capacity	☐
4.4.5 Enhanced Care Management Model of Care	☐
4.4.6 Member Identification for Enhanced Care Management	☐
4.4.7 Authorizing Members for Enhanced Care Management	☐
4.4.8 Assignment to an Enhanced Care Management Provider	☐
4.4.9 Initiating Delivery of Enhanced Care Management	☐
4.4.10 Discontinuation of Enhanced Care Management	☐
4.4.11 Core Service Components of Enhanced Care Management	☐
4.4.12 Data System Requirements and Data Sharing to Support Enhanced Care Management	☐
4.4.13 Oversight of Enhanced Care Management Providers	☐
4.4.14 Payment of Enhanced Care Management Providers	☐
4.4.15 Enhanced Care Management Reporting Requirements	☐
4.4.16 Enhanced Care Management Quality and Performance Incentive Program	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.5 Community Supports	
4.5.1 Contractor's Responsibility for Administration of Community Supports	☐
4.5.2 DHCS Pre-Approved Community Supports	☐
4.5.3 Community Supports Providers	☐
4.5.4 Community Supports Provider Capacity	☐
4.5.5 Community Supports Model of Care	☐
4.5.6 Identifying Members for Community Supports	☐
4.5.7 Authorizing Members for Community Supports and Communication of Authorization Status	☐
4.5.8 Referring Members to Community Supports Providers for Community Supports	☐
4.5.9 Data System Requirements and Data Sharing to Support Community Supports	☐
4.5.10 Contractor's Oversight of Community Supports Providers	☐
4.5.11 Delegation of Community Supports Administration to Network Providers, Subcontractors, or Downstream Subcontractors	☐
4.5.12 Payment of Community Supports Providers	☐
4.5.13 Community Supports Reporting Requirements	☐
4.5.14 Community Supports Quality and Performance Incentive Program	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
4.6 Member Grievance and Appeal System	
4.6.1 Grievance and Appeal Program Requirements	☐
4.6.2 Grievance Process	☐
4.6.3 Discrimination Grievances	☐
4.6.4 Notice of Action	☐
4.6.5 Appeal Process	☐
4.6.6 Responsibilities in Expedited Appeals	☐
4.6.7 State Hearings and Independent Medical Reviews	☐
4.6.8 Continuation of Services Until Appeal and State Hearing Rights Are Exhausted	☐
4.6.9 Grievance and Appeal Reporting and Data	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.0 Services – Scope and Delivery	
5.1 Member Services	
5.1.1 Members Rights and Responsibilities	☐
5.1.2 Member Services Staff	☐
5.1.3 Member Information	☐
5.1.4 Primary Care Provider Selection	☐
5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.2 Network and Access to Care	
5.2.1 Access to Network Providers and Covered Services	☐
5.2.2 Network Capacity	☐
5.2.3 Network Composition	☐
5.2.4 Network Ratios	☐
5.2.5 Network Adequacy Standards	☐
5.2.6 Access to Emergency Service Providers and Emergency Services	☐
5.2.7 Out-of-Network Access	☐
5.2.8 Specific Requirements for Access to Programs and Covered Services	☐
5.2.9 Network and Access Changes to Covered Services	☐
5.2.10 Access Rights	☐
5.2.11 Cultural and Linguistic Programs and Committees	☐
5.2.12 Continuity of Care for Seniors and Persons with Disabilities	☐
5.2.13 Network Reports	☐
5.2.14 Site Review	☐
5.2.15 Street Medicine	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.3 Scope of Services	
5.3.1 Covered Services	☐
5.3.2 Medically Necessary Services	☐
5.3.3 Initial Health Appointment	☐
5.3.4 Services for Members Less Than 21 Years of Age	☐
5.3.5 Services for Adults	☐
5.3.6 Pregnant and Postpartum Members	☐
5.3.7 Services for All Members	☐
5.3.8 Investigational Services	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
5.4 Community Based Adult Services	
5.4.1 Covered Services	☐
5.4.2 Coordination of Care	☐
5.4.3 Required Reports for the Community Based Adult Services Program	☐
5.4.4 Community Participation	☐
5.4.5 Community Based Adult Services Program Integrity	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
5.5	**Mental Health and Substance Use Disorder Benefits**	
5.5.1	Mental Health Parity Requirements	☐
5.5.2	Non-Specialty Mental Health Services and Substance Use Disorder Services	☐
5.5.3	Non-Specialty Mental Health Services Providers	☐
5.5.4	Emergency Mental Health and Substance Use Disorder Services	☐
5.5.5	Mental Health and Substance Use Disorder Services Disputes	☐
5.5.6	No Wrong Door for Mental Health Services	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
5.6	**MOUs with Local Government Agencies, County Programs, and Third Parties**	
5.6.1	MOU Purpose	☐
5.6.2	MOU Requirements	☐
5.6.3	MOU Oversight and Compliance	☐

Contractual Requirements		Delegated to Subcontractor
Exhibit A, Attachment III		
6.0	**Emergency Preparedness and Response**	
6.1	General Guidance	☐
6.2	Business Continuity Emergency Plan	☐
6.3	Member Emergency Preparedness Plan	☐
6.4	California's Standardized Emergency Management System	☐
6.5	Reporting Requirements During an Emergency	☐
6.6	DHCS Emergency Directives	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit A, Attachment III	
7.0 Operations Deliverables and Requirements	☐

Contractual Requirements	Delegated to Subcontractor
Exhibit E	
1.0 Program Terms and Conditions	
1.1.1 Governing Law	☐
1.1.2 DHCS Guidance	☐
1.1.3 Contract Interpretation	☐
1.1.4 Assignments, Mergers, Acquisitions	☐
1.1.5 Independent Contractor	☐
1.1.6 Amendment and Change Order Process	☐
1.1.7 Delegation of Authority	*(1) Must not be delegated*
1.1.8 Authority of the State	☐
1.1.9 Fulfillment of Obligations	☐
1.1.10 Obtaining DHCS Approval	☐
1.1.11 Certifications	☐
1.1.12 Notices	☐
1.1.13 Term	☐
1.1.14 Service Area	☐
1.1.15 Contract Extension	☐
1.1.16 Termination	☐
1.1.17 Phaseout Requirements	☐
1.1.18 Indemnification	☐
1.1.19 Sanctions	☐
1.1.20 Liquidated Damages	☐
1.1.21 Contractor's Dispute Resolution Requirements	☐
1.1.22 Inspection and Audit of Records and Facilities	☐
1.1.23 Confidentiality of Information	☐
1.1.24 Pilot Projects	☐

Contractual Requirements	Delegated to Subcontractor
1.1.25 Cost Avoidance and Post-Payment Recovery (PPR) of Other Health Coverage (OHC)	☐
1.1.26 Third-Party Tort and Workers' Compensation Liability	☐
1.1.27 Litigation Support	☐
1.1.28 Equal Opportunity Employer	☐
1.1.29 Federal and State Nondiscrimination Requirements	☐
1.1.30 Discrimination Prohibitions	☐
1.1.31 Small Business Participation and Disabled Veteran Business Enterprises (DVBE) Reporting Requirements	☐
1.1.32 Conflict of Interest Avoidance Requirements	*(1) Must not be delegated*
1.1.33 Guaranty Provision	☐
1.1.34 Priority of Provisions	☐
1.1.35 Additional Incorporated Provisions – Narrative Proposals	☐
1.1.36 Miscellaneous Provisions	☐

Exhibit K – Excluded Provisions as to Contractors Not Licensed Pursuant to the Knox-Keene Health Care Service Plan Act of 1975

Unless otherwise specified in this Contract, the following provisions of the Knox-Keene Health Care Service Plan Act of 1975, (KKA) and its implementing regulations (22 California Code of Regulations (CCR) section 1000, *et seq*.) are excluded from this Contract if Contractor is not licensed to operate as a health care service plans pursuant to the KKA. This list is not exhaustive or exclusive since other provisions of the KKA may also be excluded from the Contract pursuant to Exhibit E, Subsection 1.1.1 (*Governing Law*) or other provisions of the Contract:

1. Health and Safety Code (H&S) sections 1341 – 1341.14.
2. H&S sections 1342.4 – 1342.73.
3. H&S sections 1346 – 1347.5.
4. H&S sections 1348.9 – 1348.96.
5. H&S, Article 3 of Chapter 2.2 of Division 2.
6. H&S, Article 3.1 of Chapter 2.2 of Division 2.
7. H&S, Article 3.15 of Chapter 2.2 of Division 2.
8. H&S, Article 3.16 of Chapter 2.2 of Division 2.
9. H&S, Article 3.17 of Chapter 2.2 of Division 2.
10. H&S, Article 3.5 of Chapter 2.2 of Division 2.
11. H&S sections 1359 – 1361.1.
12. H&S section 1363.01.
13. H&S section 1363.03.
14. H&S section 1363.05.
15. H&S, Article 4.5 of Chapter 2.2 of Division 2.
16. H&S sections 1367.002 – 1367.009.
17. H&S section 1367.010 – 1367.012.
18. H&S section 1367.02.
19. H&S section 1367.035.
20. H&S section 1367.042.
21. H&S section 1367.07 – 1367.1
22. H&S sections 1367.45 – 1367.46.
23. H&S section 1367.15.
24. H&S section 1367.23.
25. H&S section 1367.30.
26. H&S section 1368.2
27. H&S sections 1368.04 – 1368.05.
28. H&S section 1372.
29. H&S section 1373.5.
30. H&S sections 1373.621 – 1373.622.
31. H&S section 1373.7 – 1373.8.
32. H&S section 1373.95.

33. H&S section 1373.10.
34. H&S section 1373.14.
35. H&S section 1373.18.
36. H&S section 1374.
37. H&S sections 1374.5 – 1374.58.
38. H&S sections 1374.9 – 1374.10.
39. H&S, Article 5.5 of Chapter 2.2 of Division 2.
40. H&S, Article 5.55 of Chapter 2.2 of Division 2.
41. H&S sections 1374.65 – 1374.721.
42. H&S sections 1374.723 – 1374.76.
43. H&S sections 1375.1 – 1375.3.
44. H&S section 1376.
45. H&S section 1377.
46. H&S sections 1379.5 – 1380.
47. H&S section 1381.
48. H&S section 1383.
49. H&S section 1385.
50. H&S, Article 6.1 of Chapter 2.2 of Division 2.
51. H&S, Article 6.2 of Chapter 2.2 of Division 2.
52. H&S, Article 7 of Chapter 2.2 of Division 2.
53. H&S sections 1389.1 – 1389.7.
54. H&S, Article 8 of Chapter 2.2 of Division 2.
55. H&S, Article 8.5 of Chapter 2.2 of Division 2.
56. H&S sections 1395.6.H&S sections 1399.5.
57. H&S section 1399.57.
58. H&S, Article 10 of Chapter 2.2 of Division 2.
59. H&S, Article 10.2 of Chapter 2.2 of Division 2.
60. H&S, Article 11 of Chapter 2.2 of Division 2.
61. H&S, Article 11.1 of Chapter 2.2 of Division 2.
62. H&S, Article 11.5 of Chapter 2.2 of Division 2.
63. H&S, Article 11.8 of Chapter 2.2 of Division 2.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

1.0 Definitions

As used in this Exhibit L of this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms governs the construction of this Contract:

California Children Services (CCS) Provider 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 (H&S), 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.

Specialized Durable Medical Equipment means DME 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 beneficiary; 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.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

2.0 **EXHIBIT L** OPERATIONAL READINESS DELIVERABLES AND REQUIREMENTS

	Operational Readiness Requirement
Exhibit L 1	Submit a written transition plan detailing the transfer of case management, Care Coordination, Provider referral, and service authorization administrative functions of the California Children's Services (CCS) program to Contractor to be prepared by the designated county agency and Contractor. The transition plan must include the following: 1) Detailed process for completing all required risk assessments, including telephonic or in-person communications and, for CCS-eligible Members determined to be high risk, all required Individual Care Plans (ICPs) within one year for Whole-Child Model (WCM) transition Members. 2) Process for verifying that approved Subcontractors and Downstream Subcontractors that are delegated risk and are responsible for arranging for the provision of Covered Services are compliant. Refer to All Plan Letter (APL) 21-005 WCM Section: Risk Level and Needs Assessment Process for direction on required deliverable updates. 3) Detailed Dispute Resolutions Policy stating that disagreements between Contractor and the county CCS program regarding CCS medical eligibility determinations must be resolved by the county CCS program, in consultation with DHCS. Refer to APL 21-005 WCM Section: Dispute Resolution and Provider Grievances for direction on required deliverable update.
Exhibit L 2	Submit the executed WCM Memorandum of Understanding (MOU) or evidence indicating a reasonable effort to finalize the MOU with the county CCS program. Additionally, the MOU must address Contractor and CCS coordination with regards to Medical Therapy Unit services.
Exhibit L 3	Submit a Provider network that includes an appropriate number of CCS Providers adequate to serve the needs of CCS-eligible Members in the Service Area.
Exhibit L 4	Submit an updated Provider network via the Provider Network Readiness template. Contractor must complete and submit the provided template and include additional contracted CCS-paneled Providers, allied and medical

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

	supportive personnel, Durable Medical Equipment (DME) Providers, and approved Provider facilities, including: Specialists, Tertiary and Pediatric Community Hospitals, Neonatal Intensive Care Units, and Special Care Centers.
Exhibit L 5	Submit policies and procedures to ensure continuity of care for CCS-eligible Members with their CCS Providers, Specialized Durable Medical Equipment Providers, and Prescription Drugs.
Exhibit L 6	Submit updated policies and procedures that outline Continuity of Care (COC) for CCS-Medically Necessary services, including the following: 1) COC for CCS-eligible Members to receive services outside of Contractor's Subcontractor if there is a WCM network certification deficiency within Contractor's Subcontractor Network. 2) COC is allowed for CCS-eligible Members to continue to receive services from their previous DE, including their assigned PCP, for those who are required to select or be reassigned to a new DE. Contractor and its Subcontractors and Downstream Subcontractors must comply with COC requirements outlined in APL 22-032 and APL 21-005.
Exhibit L 7	Submit Provider network analysis to demonstrate the availability of an appropriate Provider network to serve the needs of CCS Members, including Primary Care Providers (PCP), pediatric Specialists and sub-Specialists, professional, allied, and medical supportive personnel, licensed acute care hospitals, special care centers, and DME Providers.
Exhibit L 8	Submit Contractor's standard, monthly 274 file(s) to the PACES production environment to confirm that the proposed Provider network supplied through the Provider Network Readiness template was realized via executed contracts, and the Provider network meets the needs of CCS Members.
Exhibit L 9	Submit an attestation that Contractor and its Subcontractors and Downstream Subcontractors will work to execute contracts with all Providers included on the updated Provider Network Readiness template submission.
Exhibit L 10	Submit updated policies and procedures for ensuring Subcontractors and Downstream Subcontractors fully comply with all the terms and conditions of this Contract with WCM network certification requirements including: 1) Policies and procedures for ensuring Subcontractors and Downstream Subcontractors meet WCM operational requirements included in the contract as well as APL 21-005.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

	2) Process for ensuring a Subcontractor and Downstream Subcontractor meets WCM network certification requirements. 3) Oversight and readiness activities for Subcontractors and Downstream Subcontractors for Phase 2 to demonstrate requirements are met for implementation including: a) Subcontractor and Downstream Subcontractor Correspondence/Bulletins b) Agendas and Meeting Notes regarding WCM c) Policies and Procedures of review process for Subcontractors and Downstream Subcontractors 4) Oversight and enhanced readiness activities for Subcontractors and Downstream Subcontractors for Phase 3 to demonstrate requirements are met for implementation including: a) Subcontractor and Downstream Subcontractor Correspondence/Bulletins b) Agendas and Meeting Notes regarding WCM c) Policies and Procedures review process for Subcontractors and Downstream Subcontractors.
Exhibit L 11	Submit updated policies and procedures to ensure that credentialing and re-credentialing includes and speaks to CCS Providers.
Exhibit L 12	Submit attestation that no CCS-eligible Members will be enrolled or assigned to a Subcontractor and Downstream Subcontractor that is excluded from participating in WCM and that Contractor will allow Members access to CCS-paneled providers within all of Contractor's Provider network for CCS services. Provide process for how Contractor will ensure that that no CCS-eligible Members will be enrolled or assigned to a DE that is excluded from participating in WCM.
Exhibit L 13	Submit updated policies and procedures to include details surrounding the processes by which a CCS-eligible Member may maintain access to a Provider or a Specialized DME Provider for up to 12 months. The policy and procedure must endure the following: 1) COC requirements for pharmaceutical services and the provision of prescribed drugs, as described in contract Exhibit A, Attachment III, Subsection 5.3.7.H (*Services for All Members*), are applied to CCS-eligible Members. 2) Contractor must send a written notice to the Member 60 days before the 12-month authorization expires. 3) Allow a CCS-eligible Member, or a family member or caregiver of a CCS beneficiary, to appeal the continuity of care 12-month limitation to the Director or their designee.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

Exhibit L 14	Submit updated policies and procedures to explain the approach and development of ICPs for CCS-eligible Members based on the results of the pediatric health risk assessment process. ICPs must be completed with a particular focus on CCS specialty care, consider behavioral health needs, and must coordinate those services. If needed, Contractor must facilitate a CCS-eligible Member's ability to access appropriate community resources and other agencies, including referrals for behavioral services such as Specialty Mental Health Services and Substance Use Disorder services. The policies and procedures must include access for families to know where to go for ongoing information, education, and support so that they understand the goals, treatment plan, and course of care for their Child and their role in the process, what it means to have primary or specialty care for their Child, when it is time to call a PCP, Specialist, urgent care, or emergency room, what an interdisciplinary care team is, and what the community resources are. Risk Level and Needs Assessment. Refer to APL 21-005 WCM Section: Risk Level and Needs Assessment Process, for direction on required deliverable updates.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

3.0 Whole Child Model Program

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

3.1 Whole Child Model Scope of Services

3.1.1 Whole Child Model Program Compliance

Contractor agrees to implement the Whole Child Model (WCM) program, as directed by DHCS and in accordance with Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) and All Plan Letter (APL) 21-005, in order to cover benefits that were previously covered by the California Children's Services (CCS) program. Contractor's implementation of and participation in the WCM program renders this Contract's requirements around CCS, as stated in Exhibit A, Attachment III, Subsection 4.3.14 (*California Children's Services*), and elsewhere in this Contract, inapplicable to Contractor.

A. Contractor must provide all Medically Necessary services previously covered by the CCS program as Covered Services for Members who are eligible for the CCS program at the time of the transition of benefits to Contractor, and for Members who are determined eligible for CCS after the transition of benefits.

B. To ensure consistency in the provision of covered CCS, Contractor must use all current and applicable CCS program guidelines, including CCS program regulations, CCS program information notices, and CCS numbered letters in developing criteria for use by Contractor's Medical Director or the equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, Contractor must 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

C. Contractor must be responsible for all available Medically Necessary Medi-Cal services. Any Medically Necessary CCS services not available as a Medi-Cal Covered Service must remain the responsibility of the State and the county.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

D. Contractor must submit its written transition plan to DHCS before commencing the transition to the Whole Child Model. The transition plan will detail how Contractor will transition CCS-eligible Members from the county CCS program to the Whole Child Model, and take over responsibility for case management, care coordination, Provider referrals, and service authorizations for Members who are enrolled in the CCS program at the time of the transition, in accordance with Health and Safety Code (H&S) section 123850(b)(1) and APL 21-005.

E. Contractor must provide DHCS with documentation confirming that a local stakeholder process has been established in accordance with Welfare and Institutions Code (W&I) section 14094.7(d)(3). Such documentation may include meeting minutes, a meeting schedule, or other forms of confirmation approved by DHCS.

F. Contractor must execute a MOU with the county CCS program as stipulated in Exhibit A, Attachment III, Subsection 5.6.1 (*MOU Purpose*), for the coordination of CCS services to Members. This MOU must include the following:

1) Agreements on the transition of Care Coordination and service authorization for CCS from the county CCS program to Contractor, and how Contractor will work with the county CCS program to ensure continuity and consistency;

2) Policy and procedures for referral to and coordination with the local CCS Medical Therapy Unit (MTU) to ensure appropriate access to MTU services, and other non-MTU services provided under this Contract;

3) A provision to allow a Member eligible for CCS to continue to receive care management and Care Coordination from their current CCS public health nurse, unless this requirement is waived by DHCS in accordance with W&I section 14094.13(h). The Member or the Member's parents, custodial parents, legal guardians, or other Authorized Representatives, must make the request to continue with their current CCS public health nurse within 90 days of their transition to the Whole Child Model, in accordance with W&I section 14094.13(e) and (f).

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

3.1.2 Annual Medical Eligibility Redeterminations

A. Contractor must provide all necessary documentation, dated within the last six months but no later than 12 months prior to the Member's CCS program eligibility end date to allow for an annual medical eligibility redetermination by the county CCS program. This includes but is not limited to:

1) The Member's current medical records that document the Member's medical history;

2) Results of physical examinations by a Physician;

3) Laboratory test results;

4) Radiologic findings; and

5) Other tests and examinations that support the diagnosis of the eligible condition(s), including any medical therapy unit diagnosis or high-risk infant follow-up reports.

B. Contractor must provide the documentation to the county CCS program no later than 60 calendar days before the Member's CCS program eligibility end date. If documentation is received after the 60-day timeframe, Contractor and the county CCS program should collaborate to determine the best approach for submitting documents.

C. If the county CCS program requires additional documentation, Contractor must, upon notification from the county CCS program, coordinate with the Member's Provider(s) to obtain any needed documentation, within the agreed upon timeframe, to support the county CCS program's medical redetermination efforts.

D. Contractor must proactively engage in a collaborative process with the county CCS program to remedy any issues or challenges related to timeliness or completeness of records for the medical eligibility redetermination process.

E. For disputes between Contractor and the county CCS program regarding CCS medical eligibility determinations where a resolution cannot be

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

reached, Contractor may refer the dispute directly to DHCS for review and a final determination.

3.1.3 CCS Advisory Committees

A. Contractor must create and maintain a CCS clinical advisory committee, separate and distinct from its Quality Improvement and Health Equity Committee described in Exhibit A, Attachment III, Section 2.3 (*Quality Improvement and Health Equity Committee*). The CCS clinical advisory committee must be composed of Contractor's Medical Director or the equivalent, the county CCS medical director, and at least four CCS-paneled Providers.

1) The CCS clinical advisory committee must advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and to serve as clinical advisers on other clinical issues relating to CCS conditions.

2) The CCS clinical advisory committee must meet at least quarterly, or more frequently if determined necessary.

B. Contractor must establish a CCS family advisory group that is separate and distinct from its Community Advisory Committee described in Exhibit A, Attachment III, Subsection 5.2.11.E (*Cultural and Linguistic Programs and Committees*), and is specifically for CCS families.

1) The CCS family advisory group must be comprised of CCS-eligible Members' parents, custodial parents, legal guardians, or other Authorized Representatives. Family representatives who serve may receive a reasonable per diem payment to enable in-person participation in the CCS family advisory group.

2) Contractor may conduct CCS family advisory group meetings at least quarterly and utilize teleconference or other similar electronic means to facilitate participation.

3) A representative of the CCS family advisory group must be invited to serve on the DHCS statewide stakeholder advisory group for CCS.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

3.1.4 CCS Provider Network

A. Contractor must include in their Network an adequate number of CCS Providers able to serve the needs of Members with CCS conditions and receive timely access. Contractor must utilize only paneled CCS Providers to treat CCS conditions when a CCS-eligible Member's condition requires treatment from the Provider types described in this Provision. DHCS remains responsible for paneling CCS Providers. Contractor may use an out-of-state Provider, in accordance with APL 19-004, if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition.

B. In addition to the Network requirements found in Exhibit A, Attachment III, Subsection 5.2.3 (*Network Composition*), Contractor must also include the following:

1) An adequate number of hospitals and/or facilities that include neonatal intensive care units, CCS-approved pediatric intensive care units, and CCS-approved inpatient facilities.

2) Licensed acute care hospitals and special care centers approved by the CCS program to treat a CCS-eligible condition.

3) That among the pediatric Network Providers are an adequate number of CCS-paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty.

C. In addition to the requirements in Exhibit A, Attachment III, Subsection 2.2.13 (*Credentialing and Recredentialing*), Contractor must credential CCS Providers in accordance with APL 21-005.

D. CCS Providers must be able to utilize Contractor's Provider Dispute Resolution Mechanism, as described in Exhibit A, Attachment III, Section 3.2.2 (*Provider Dispute Resolution Mechanism*).

3.1.5 Provider Compensation

In addition to the requirements found in Exhibit A, Attachment III, Section 3.3 (*Provider Compensation Arrangements*), Contractor must also reimburse Physicians and surgeons providing CCS to eligible Members at rates that are

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

equal to or exceed the applicable CCS Fee-For-Service (FFS) rates, unless the Physician and surgeon enters into an agreement on an alternative payment methodology mutually agreed to by the Physician and surgeon and Contractor.

3.1.6 Covered Services

In addition to the requirements found in Exhibit A, Attachment III, Section 5.3 (*Scope of Services*), Contractor must cover CCS 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, Contractor must refer the Member to the county CCS office for eligibility determination.

A. Contractor must ensure assessment and Care Coordination for the transition of Members who are eligible for CCS and receiving services through the CCS program at the time of the transition, as required below in Exhibit L, Subsection 3.1.9 (*Care Management and Coordination of Care*).

B. For the identification of a Member eligible for CCS, Contractor must ensure the following:

1) Network Providers must 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 medical condition.

2) Initial referrals of Member's with CCS-eligible conditions must be made to the county CCS program by telephone, same day mail, or fax or other secure electronic system, if available. The initial referral must be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS program.

3) Contractor must provide all Medically Necessary CCS Covered Services for the Member's CCS-eligible condition(s).

4) If the county CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary Covered Services to the Member, including Early Periodic

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

Screening, Diagnosis and Testing (EPSDT) as required in Exhibit A, Attachment III, Subsection 5.3.4.F (*Services for Members Less Than 21 Years of Age*).

3.1.7 Continuity of Care

Contractor must provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with W&I sections 14094.13, H&S section 1373.96, APL 21-005, and as follows:

A. In accordance with W&I section 14094.13(a)-(d), Contractor must ensure continuity of care between Members eligible for CCS 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.

B. For out-of-Network CCS Providers and Providers of Specialized Durable Medical Equipment, Contractor must provide continuity of care under the following conditions:

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 the WCM program.

2) The Member has previously received Specialized Durable Medical Equipment from the Provider.

3) The CCS Provider or Provider of Specialized Durable Medical Equipment accepts Contractor's rate for the service, or the applicable Medi-Cal or CCS FFS rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by Contractor and the CCS Provider.

4) Contractor confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

5) The CCS Provider makes treatment information available to Contractor, to the extent authorized by the State and federal patient privacy provisions.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

6) The Provider of Specialized Durable Medical Equipment makes information available as requested by Contractor, to the extent authorized by the State and federal patient privacy provisions.

7) At its discretion, Contractor may extend the continuity of care period beyond the 12 months specified in Paragraph C.1) above.

C. Ensure that the continuity of care requirements for Pharmaceutical Services and Provision of Prescribed Drugs described in Exhibit A, Attachment III, Subsection 5.3.7.H (*Services for All Members*), are applied to Members who are eligible for the CCS program at the time of the transition to the WCM program. Before the previously prescribed drug is discontinued, Contractor and the Member's prescribing CCS Provider must 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.

D. For CCS neonatal intensive care units, Contractor must pay the Provider either the equivalent of Medi-Cal FFS rates, such as the All Patient Refined Diagnosis Related Group (APR-DRG) rates or other established rates, or Contractor's negotiated rate, whichever is higher, for up to 12 months after the transition.

3.1.8 EPSDT Services

For CCS-eligible Members, Contractor must provide all Medically Necessary Covered Services, including EPSDT services, as described in Exhibit A, Attachment III, Subsection 5.3.4.E (*Services for Members Less Than 21 Years of Age*), when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, Contractor must apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

3.1.9 Care Management and Coordination of Care

In addition to the requirements in Exhibit A, Attachment III, Section 2.3 (*Utilization Management Program*), and Exhibit A, Attachment III, Section 4.3 (*Population Health Management and Coordination of Care*), Contractor must provide service authorization, case management, and Care Coordination for CCS by a primary point of contact with knowledge or adequate training on the CCS

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions. Once a Member's eligibility for the CCS program is established, Contractor must complete the following for risk stratification and assessment, and coordination of care in accordance with APL 21-005:

A. For Members identified as eligible for CCS, Contractor must conduct a Risk Stratification and Segmentation (RSS) in accordance with the requirements in Exhibit A, Attachment III, Subsection 4.3.5 (*Population Risk Stratification and Segmentation, and Risk Tiering*), and approved by DHCS to use for CCS-eligible Members. Based on the results of the health risk stratification, Contractor must then further assess CCS-eligible Members' risk levels and needs with an in-person or telephone communication, or an additional risk assessment approved by DHCS.

B. For the transition of Members who are eligible for CCS and receiving services through the CCS program at the time of the transition, Contractor must conduct a RSS in accordance with the requirements of this Contract.

C. As determined necessary by Contractor's RSS, Contractor must provide Complex Care Management Services as described in Exhibit A, Attachment III, Subsection 4.3.7 (*Care Management Programs*), to all Members eligible for CCS and coordinate care between the Primary Care Provider (PCP), CCS specialty services, and if applicable Non-Specialty Mental Health Services and Regional Center services across all settings. The provision of Complex Care Management must include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS, behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other Authorized Representatives.

D. Contractor must also arrange referral to Specialty Mental Health and Drug Medi-Cal services as appropriate through the county Substance Use Disorder (SUD) program if determined necessary through Contractor's RSS. To arrange services with a Regional Center, Contractor must:

    1) Coordinate with Members eligible for CCS and their parents, custodial parents, legal guardians, or other Authorized Representatives, in understanding and accessing services; and

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

2) Operate as a central point of contact for questions regarding access, care, and problem resolution.

E. Contractor must create a Care Management Plan (CMP) for CCS-eligible Members who have been determined high risk through the RSS process, incorporate the required elements stated in W&I section 14094.11I and APL 21-005, be specific to individual Member needs, and update the CMP at least annually.

F. Provide Person-Centered Planning, as described in Exhibit A, Attachment III, Subsection 5.2.12 (*Continuity of Care*), to Members eligible for CCS and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

G. Provide information to Members eligible for CCS on how to access local family resource centers or family empowerment centers.

H. Allow a Member eligible for CCS, 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 WCM program, in accordance with W&I 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, Contractor must 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.

I. If Contractor expands its CCS coverage area to other counties, Contractor must comply with CCS program standards including, but not limited to, referral standards as stated in W&I section 14093.06(a).

3.1.10 Rights for Members Eligible for CCS

A. Contractor must provide a mechanism for a Member eligible for CCS, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

B. For Members receiving continuity of care as stated in Provision 5, Paragraph C of this Attachment, Contractor must send a written notice 60 days prior to the end of the authorized continuity of care period. The notice must explain the right to petition Contractor for an extension of the continuity of care period, the criteria used to evaluate the petition, and the Appeals process if Contractor denies the petition.

C. In addition to the Member's right to file a Grievance or request an Appeal, State Hearing, or an Independent Medical Review if applicable, as stated in Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*), Contractor must also ensure that Members who are eligible for CCS, 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, as stated in this Exhibit L, Subsection 3.1.6 (*Covered Services*), to the DHCS Director in accordance with W&I section 14094.13(i)(1).

D. Contractor must also ensure that CCS-eligible Members retain the right to request an Appeal and State Hearing for CCS eligibility and CCS service authorization denials.

3.2 Required Reports for the Whole Child Model Program

In addition to the reporting requirements for Exhibit A, Attachment III, Section 4.6 (*Member Grievance and Appeal System*) stated in Exhibit A, Attachment III, Section 7.0.(*Operations Deliverables and Requirements*), Contractor must also identify which Grievances and requests for Appeal were submitted by CCS-eligible Members.

3.3 Data Sharing Links

Contractor must establish and maintain communication links to allow interfaces with Children's Medical Services (CMS) Net and outside entities designated by DHCS.

3.3.1 Contractor must establish and maintain an agreement with the Office of Technology Services (Otech) within the California Department of Technology for an appropriate link between Contractor and Otech for the purpose of computer access for records contained in CMS Net and other Medi-Cal eligibility files that may be made available to Contractor. Upon connectivity with the authorized

Exhibit L
REQUIREMENTS SPECIFIC TO CONTRACTOR

external entities, Contractor must retrieve information in a format to be determined by DHCS.

3.3.2 Contractor must comply with all data sharing requirements in Exhibit G of this Contract.

3.4 Whole Child Model Payments

Contractor must be paid a supplemental WCM monthly payment for each Member who is determined eligible for CCS. Payments for Members identified as CCS-eligible cannot exceed the rate as stated in Exhibit B, Section 1.3 (*Capitation Payment Rates*) and will be adjusted if DHCS has sent a separate rate payment for the Member for the same month of service. The payment period for the supplemental WCM payment must commence on the effective date of this Contract, January 1, 2024.

3.4.1 Contractor must receive the supplemental WCM payment in accordance with the conditions listed below.

A. The supplemental WCM payment must be in lieu of any other compensation for a CCS-eligible Member in any month.

B. Contractor must be eligible to receive a supplemental WCM payment in the month in which a Member is determined to be eligible to receive CCS by the county CCS program.

3.4.2 If DHCS determines that a Member for whom Contractor received a supplemental WCM payment was not determined eligible for CCS in the month(s) for which supplemental WCM payment was made, DHCS must recover any amount improperly paid, by an offset to Contractor's capitation payment, in accordance with Exhibit B, Section 1.9 (*Recovery of Amounts Paid to Contractor*). DHCS must give Contractor 30 calendar days prior written notice of any such offset.

EXHIBIT A
SCOPE OF WORK

1. Service Overview

This is a companion to Contractor's Medi-Cal Managed Care Health Plan Contract 23-30235, hereafter referred to as the "Primary Contract", to cover specific Medi-Cal State-Supported Services to Contractor's Members enrolled under Contractor's Primary Contract.

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

B. Private Services described in Exhibit A, Subsection 1.2.A (*All State-Supported Services to be Performed*), must be provided in the same manner as described in the Primary Contract under Exhibit A, Attachment 3, Section 5.2 (*Network and Access to Care*).

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

2. Service Location

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

3. Project Representatives

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

Department of Health Care Services	**Orange County Health Authority, A Public Agency**
Managed Care Operations Division Attention: Chief, Procurement and Contract Development Branch Telephone: (916) 449-5000 Fax: (916) 449-5090	**CalOptima Health** Attention: Michael Wood, Manager, Regulatory Affairs & Compliance Telephone: (714) 246-8415 Fax: (714) 246-6418

Back to Item

Back to Agenda

EXHIBIT A
SCOPE OF WORK

B. Direct all inquiries to:

Department of Health Care Services	**Orange County Health Authority, A Public Agency**
Managed Care Operations Division Attention: Contracting Officer	**CalOptima Health** Attention: Michael Wood, Manager, Regulatory Affairs & Compliance
1501 Capitol Avenue, Suite 71.4001 Mail Stop 4408 P.O. Box 997413 Sacramento, CA 95899-7413	505 City Parkway West Orange, CA 92868
Telephone: (916) 449-5000 Fax: (916) 449-5090	Telephone: (714) 246-8415 Fax: (714) 246-6418

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

4. Americans with Disabilities Act

Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement shall comply with the accessibility requirements of the Rehabilitation Act and the Americans with Disabilities Act of 1973 (The Act) section 508 as amended in 29 USC section 794(d), and regulations implementing The Act as set forth in Title 36 of the Federal Code of Regulations Part 1194. In 1998, Congress amended The Act to require federal agencies to make their electronic and information technology accessible to people with disabilities. California Government Code section 11135 codifies The Act section 508, requiring accessibility of electronic and information technology.

The provision of the State Supported Services is subject to the Provisions set forth in the Exhibits and Attachments appended hereto.

EXHIBIT A
SCOPE OF WORK

1.0 State-Supported Services

EXHIBIT A
SCOPE OF WORK

1.0 State-Supported Services

1.1. Definitions

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

Primary Contract means Contract Number 23-30235, including all applicable amendments, Exhibits, and/or Attachments to that Contract as of and subsequent to the effective date of this Contract. Termination of the Primary Contract shall be deemed a termination of this Contract.

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

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

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

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

B. Permanently Residing Under Color of Law (PRUCOL);

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

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

E. Trafficking and Crime Victim Assistance Program (TCVAP); and

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

EXHIBIT A
SCOPE OF WORK

1.2 All State-Supported Services to be Performed

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

A. Current Procedural Terminology Codes*: 59840 through 59857

B. CMS Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336

1.2.2 The codes identified above in Exhibit A, Subsection 1.2.A (*All State-Supported Services to be Performed*), are subject to change upon the Department of Health Care Services (DHCS) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.

1.2.3 Contractor agrees to provide, or arrange to provide, to UIS Members enrolled under this Contract all Covered Services specified in the Primary Contract, except as set forth in Exhibit A, Section 1.3 of this Contract.

1.3 Primary Contract Covered Services Excluded from This Contract

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

1.3.1 The provision of pregnancy-related services for UIS Members as described in Exhibit A, Attachment 3, Subsection 5.3.6 (*Pregnant and Postpartum Members*), of the Primary Contract.

1.3.2 The provision of Emergency Services for UIS Members as described in Exhibit A, Attachment 3, Subsection 3.3.16 (*Emergency Services and Post-Stabilization Care Services*), and defined in Exhibit A, Attachment 1, Section 1.0 (*Definitions*), of the Primary Contract.

EXHIBIT B
BUDGET DETAIL AND PAYMENT PROVISIONS

1.0 Budget Detail and Payment Provisions

Back to Item

Back to Agenda

EXHIBIT B
BUDGET DETAIL AND PAYMENT PROVISIONS

1.1 Overview

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

1.2 Capitation Rates

1.2.1 DHCS shall remit to Contractor a Capitation Payment for each month that a Member appears on the approved list of Members supplied to Contractor by DHCS. Subject to Exhibit B, Subsection 1.2.3 (*Capitation Rates*) of this Contract, Capitation Payments must be made in accordance with the schedule of Capitation Payment rates set forth below. Contractor and DHCS agree to update the table below upon the establishment of Capitation Payment rates in accordance with this Exhibit B, Subsection 1.2.3 (*Capitation Rates*) of this Contract.

For the period 01/01/2024 – 12/31/2024	**Orange**
Aid Group	**Rates**
Adult & Family/OTLIC (19 & Older) - PS	$0.18
Adult Expansion - PS	$0.18
Adult & Family/OTLIC (Under 19) - PS	$0.18
Adult/Family/OTLIC Under 19 - UIS	$61.82
Adult/Family/OTLIC 19 & Over - UIS	$162.02
SPD - UIS	$615.12
BCCTP - UIS	$615.12
SPD Dual - UIS	$320.45
LTC - UIS	$615.12
LTC Dual - UIS	$320.45
Adult Expansion - UIS	$234.36
WCM - UIS	$1,166.16

1.2.2 Aid Codes within each Aid Group for this time-period are set forth in the Primary Contract for Members enrolled under the Primary Contract. For the purposes of this

EXHIBIT B
BUDGET DETAIL AND PAYMENT PROVISIONS

Contract, UIS Members are defined in Exhibit A, Section 1.1 (*Definitions*) of this Contract.

1.2.3 UIS Member Capitation Payments and Private Services (PS) payments will be made monthly, in alignment with Capitation Payments in the Primary Contract.

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

1.2.5 DHCS shall establish Capitation Payment rates on an actuarial basis, and that basis shall be set forth in the DHCS rate certification(s), including any amendment(s) or revision(s), for the applicable Rating Period. Upon completion, said rate certification(s) are hereby incorporated by reference and made a part of this Contract by this reference as if attached hereto in full.

Back to Item

Back to Agenda

EXHIBIT E
ADDITIONAL PROVISIONS

1.0 Program Terms and Conditions

EXHIBIT E
ADDITIONAL PROVISIONS

1.1 Additional Incorporated Exhibits

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

A. Exhibit B, Section 1.3 (*Capitation Payment Rates*);

B. Exhibit B, Subsection 1.9.B (*Recovery of Amounts Paid to Contractor*), regarding disallowance of Federal Financial Participation (FFP);

C. Exhibit B, Section 1.7 (*Supplemental Payments*);

D. Exhibit B, Section 1.16 (*State Programs Receiving Federal Financial Participation*);

E. Exhibit D(F);

F. Exhibit E, Section 1.6 (*Amendment and Change Order Process*);

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

H. Any Primary Contract provision otherwise provided for in this Contract.

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

1.2 Governing Law

In addition to Exhibit E, Section 1.1 (*Governing Law*) of the Primary Contract, Contractor also agrees to the following:

1.2.1 If it is necessary to interpret this Contract, all applicable laws may be used as aids in interpreting the Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHCS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this provision, Governing Law. Except for Exhibit E, Section 1.19 (*Sanctions*) of the Primary Contract, the parties agree that any remedies for DHCS or Contractor's non-compliance with laws not expressly incorporated into this Contract, or any

Back to Item

Back to Agenda

covenants judicially implied to be part of this Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties shall be deemed authors of this Contract.

1.2.2 Any provision of this Contract that is in conflict with current or future applicable federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

1.2.3 Such amendment shall constitute grounds for termination of this Contract in accordance with the procedures and provisions of Exhibit B, Subsection 1.5.B.4 (*Determination and Redetermination of Capitation Payment Rates*) in the Primary Contract. The parties shall be bound by the terms of the amendment until the effective date of the termination.

1.3 Entire Agreement

This written Contract, and any amendments thereto, will constitute the entire agreement between the parties. No oral representations will be binding on either party unless such representations are put in writing and made an amendment to this Contract.

1.4 Amendment Process

1.4.1 Proposal of Contract Changes

Except for required amendments pursuant to Section 1.2 (*Governing Law*) above, and Exhibit E, Section 1.3.A (*Conflict with Law*) of the Primary Contract, should either party, during the life of this Contract, desire a change in this Contract, that change must be proposed in writing to the other party. The other party must acknowledge receipt of the proposal within ten calendar days of receipt of the proposal. The party proposing any such change will have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal must set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract.

A. Regardless of the party desiring the change, DHCS will be responsible for drafting the proposed amendment and providing it to Contractor for review and comment.

B. DHCS will determine Contractor's Capitation Payment rates for each Rating Period and, as necessary, subsequent revised rates for the same Rating Period, as stated in Exhibit B, Section 1.2 (*Capitation Rates*) of this Contract.

1.4.2 Implementation of Contract Changes

DHCS may, at any time within the general scope of this Contract and by written notice, implement amendments or issue change orders to the Contract, as follows:

A. Capitation Payment rates may be implemented through a change order if the rates are the only changes proposed by DHCS for a Rating Period.

B Capitation Payment rates that are also tied to proposed changes to the terms or requirements of the Contract effective within the Rating Period will be included in an amendment to the Contract.

1.5 Notices

All notices to be given under this Contract must be in writing and are deemed given when sent certified mail or electronic mail (email) to DHCS or Contractor. DHCS and Contractor will designate email addresses for notices sent via email. Notices sent certified mail must be addressed to the following DHCS and Contractor addresses:

California Department of Health Care Services Managed Care Operations Division Attn: DHCS Contract Manager MS 4407 P.O. Box 997413 Sacramento, CA 95899-7413	Orange County Health Authority, A Public Agency Attn: Michael Wood, Manager, Regulatory Affairs & Compliance 505 City Parkway West Orange, CA 92868

1.6 Term

The Contract will become effective January 1, 2024, and will continue in full force and effect through the term of the Primary Contract, subject to the provisions of Exhibit B, Section 1.1 (*Budget Contingency Clause*), of the Primary Contract.

1.7 Non-Cancellation

Except as set forth in Exhibit E, Section 1.8 below, this Contract will thereafter continue in full force and effect through the end date specified in the Primary Contract, subject to Exhibit B, Section 1.1 (*Budget Contingency Clause*), of the Primary Contract.

EXHIBIT E
ADDITIONAL PROVISIONS

1.8 Termination for Cause and Other Terminations

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

1.9 Administrative Duties/Responsibilities

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

Additional CY 2024 MCP Primary Agreement Detail

Category	Requirement	Sub-Regulatory Guidance
Directed Payment Initiatives and Related Reimbursement Requirements	-Reimburse eligible Providers in accordance with the terms of applicable Pass-Through Payments and Directed Payment Incentives as specified in the contract. -Provide Provider-level data to DHCS and Providers eligible for Directed Payment Initiatives in a form and manner specified by DHCS through APLs or other technical guidance.	-All – Plan Letter (APL) APL 23-008: Proposition 56 Directed Payments for Family Planning Services -APL 23-014: Proposition 56 Value-Based Payment Program Directed Payments -APL 23-015: Proposition 56 Directed Payments for Private Services -APL 23-016:Directed Payments for Developmental Screening Services -APL 23-017: Directed Payments for Adverse Childhood Experiences Screening Services -APL 23-019: Proposition 56 Directed Payments for Physician Services Prop 56 Directed Payments Expenditures File Technical Guidance
Plan Organization and Administration	-Maintain a full-time Chief Health Equity Officer who has the necessary qualifications or training at the time of hire or within one year of hire to meet the requirements of the position, including but not limited to those outlined in the contract.	APL 23-025: Diversity, Equity, and Inclusion Training Program Requirements

Back to Item

Back to Agenda

Emergency Preparedness	-By January 1, 2025, MCPs must maintain an Emergency Preparedness and Response Plan, including a Business Continuity Plan and Member Emergency Preparedness Plan. -Implement protocols during a federal, State, or county declared state of Emergency, that allow Members timely access to Covered Services. -Cooperate with local city and county Emergency Preparedness programs within the MCP's Service Area to ensure provision of health care services.	
Data Sharing	-Enter into a data sharing agreement with the County Department, which supports the timely and frequent exchange of member information and data, including, as applicable, Behavioral Health and physical health data, maintaining the confidentiality of exchanged information and data, and bi-directional monitoring of data exchange processes.	APL 23-013: Mandatory Signatories to the California Health and Human Services Agency Data Exchange Framework
Memorandum of Understanding (MOU)	-Coordinate and execute an MOU with the Local Government Agencies (LGAs), county program and third-party entities and county programs listed in Exhibit A, Attachment III, Subsection 5.6.1 to ensure Care Coordination, data sharing, and non-duplicative services for Members.	APL 23-029: Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities
Key Personnel Changes	-Report to DHCS (within 10 calendar days at the MCP-level and 20 calendar days at the Subcontractor-level) any changes in the status of executive-level personnel including, but not limited to the chief executive officer, chief financial officer, chief operations officer, the chief medical director, the chief Health Equity officer, the compliance officer, and government relations persons.	
Financial Information	-Establishment of Medical Loss Ratio (MLR) reporting requirements on Subcontractors and Downstream Subcontractors effective January 1, 2025. -Submit an annual Community Reinvestment Plan for DHCS's approval that details its anticipated community reinvestment activities for the MCP and its Subcontractors.	
Program Integrity and Compliance Program	-Ensure that compliance program and fraud prevention program include, at a minimum, the elements outlined in the contract.	

Management and Information System (MIS)	-Must have and maintain a MIS that supports all data requested under the contract. -Conduct MIS and data audits to the extent directed by DHCS in accordance with the contract, APLs, or similar instructions which will be no less frequently than once every three years.	APL 22-026: Interoperability and Patient Access Final Rule APL 22-002: Alternative Format Selection for Members with Visual Impairments APL 21-009: Collecting Social Determinants of Health Data APL 20-017: Requirements for Reporting Managed Care Program Data
Quality Improvement and Health Equity	-Implement a Quality Improvement and Health Equity Transformation Program (QIHETP) consistent with federal and state standards, and the DHCS Comprehensive Quality Strategy. -Implement and maintain a Quality Improvement and Health Equity Committee (QIHEC) led by the medical director or designee in collaboration with the Chief Health Equity Officer. -Must obtain full National Committee for Quality Assurance (NCQA) Health Equity Accreditation by January 1, 2026.	
Appeals	-Removal of 14-day extension language for appeals.	
Provider Relations and Compensation Arrangements	-Establish fast, fair, and cost – effective dispute resolution process. -Updated Network Provider training requirements. -Utilize value-based and alternative payment models to compensate Network Providers.	APL 23-005: Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21

Network and Access Changes to Covered Services	-Notify DHCS if unable to contract with a certified Community – Based Adult Services (CBAS) Provider or when a contract is terminated with a CBAS or Long – Term Care (LTC) Network Provider. -Notify DHCS of intent to terminate a contract with a Safety-Net Provider. -Note this reporting requirement is in addition to terminations reported in accordance with APL 21-003 requirements.	APL 21-003: Medi-Cal Network Provider and Subcontractor Terminations
Timeframes for Medical Authorizations	-Updated timeframe for processing medical authorization of Medically Necessary physician administered drugs.	
Reporting Requirements	-New and revised reporting requirements, including but not limited to the following: Community Reinvestment Plan and Report; Preliminary and Quarterly Fraud, Waste, Abuse Reports; MIS/Data Audits; NCQA Health Plan Accreditation and Health Equity Accreditation results; Delegation Reporting and Compliance Plan; Provider Dispute Resolutions Report; Population Health Management Strategy (PHMS); Population Needs Assessment; Community Advisory Committee (CAC) Report/Notes/Minutes; MOU Reports; Emergency Reports; and Financial Reports.	
Terminology Changes	-Update terms and definitions used in the agreement.	
Aid Code Categories	-Addition of new covered aid codes to the Primary Agreement.	
Operational Readiness Deliverables	-Updates to requirements in operational readiness deliverables.	

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contact

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

Recommended Actions

1. Authorize and direct the Chairman of the Board of Directors to execute an Amendment between the California Department of Health Care Services (DHCS) and CalOptima Health related to the 2023-B Contract Amendment for Calendar Year (CY) 2023.

Background

As a County Organized Health System (COHS), CalOptima Health contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In December 2016, CalOptima Health entered into a new four-(4) year agreement with the DHCS for the Primary Agreement for Medi-Cal services. Amendments to this agreement are summarized in the attached appendix, including Amendment 62, which extends the Primary Agreement to December 31, 2023. *See*, Attachment 1. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services.

Discussion

Calendar Year (CY) 2023-B Contract Amendment to the Primary Agreement (January 1, 2023 through December 31, 2023)

On August 2, 2023, DHCS provided managed care plans (MCPs), including CalOptima Health, with a draft version of the CY 2023-B Contract Amendment and notified MCPs that they will submit a finalized version of the amendment to the Centers for Medicare & Medicaid Services (CMS) in December 2023. This amendment will bring MCP agreements, including CalOptima Health, into alignment with requirements effective January 1, 2023. *See* Attachment 3 for further information regarding the changes contained within the draft amendment.

DHCS will provide the finalized amendment to CalOptima Health for signature in early December. The agreement amendment contains notable language changes, and it is worth noting that DHCS has generally already implemented the requirements of the CY 2023-B Contract Amendment by issuing sub-regulatory guidance such as All Plan Letters (APLs). Simultaneously, DHCS has been working with CMS to formalize the requirements in DHCS's agreements with MCPs, including CalOptima Health. DHCS's implementation of these requirements via sub-regulatory guidance prior to the formal inclusion of the requirements in MCP agreements is largely due to the lengthy CMS review process. While the contractual obligations are retroactive, CalOptima Health staff has implemented the required operational changes and other contractual requirements by following the DHCS APLs and sub-regulatory guidance.

Back to Agenda

The amendment does not contain any rate changes or otherwise set any rates. As such, staff is requesting that the Board provide authority and direction to the Chair to execute this agreement amendment.

Fiscal Impact
The recommended action to execute the CY 2023-B Contract Amendment to the DHCS Primary Agreement is expected to be budget neutral to CalOptima Health.

Rationale for Recommendation
CalOptima Health's execution of the CY 2023-B Contract Amendment to its Primary Agreement with DHCS is necessary for the continued operation of CalOptima Health's Medi-Cal program.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Attachment 1_Appendix Summary of Agreement Amendments with DHCS
2. Attachment 2_CY 2023-B MCPs Draft Amendment
3. Attachment 3_Additional CY 2023-B Contract Amendment Detail

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 6

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

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

Back to Item

Back to Agenda

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

Back to Item

Back to Agenda

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

Back to Item

Back to Agenda

A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-56 incorporates updated Bridge Period (July 1, 2019 – December 31, 2020) capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) members, and includes new corresponding rate tables that split each existing category into a SIS and UIS version.	October 1, 2020
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022
A-59 incorporates new Calendar Year (CY) 2022 capitation rates and benefit changes implemented in CY 2022	August 5, 2021 March 3, 2022 August 4, 2022
A-60 incorporates new benefits changes for Calendar Year (CY) 2022.	August 4, 2022
A-61 incorporates new benefit changes for Calendar Year (CY) 2022.	May 4, 2023
A-62 extends the Primary Agreement with DHCS to December 31, 2023.	May 5, 2022
A-63 incorporates new benefits changes for Calendar Year (CY) 2023.	February 2, 2023
A-64 incorporates updated Calendar Year (CY) 2021 capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members.	Not applicable due to non – substantive changes.
A-65 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-66 incorporates updated Calendar Year 2022 Capitation Payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members and includes new corresponding rate tables that split each existing category into a SIS version and UIS version.	Not applicable due to non – substantive changes.

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010

Back to Item

Back to Agenda

A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-09 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021
Agreement 22-20494 incorporates both Hyde services ("Private Services") and the new Unsatisfactory Immigration Status members from January 1, 2023 to December 31, 2023.	December 1, 2022
A-01 incorporates rates for CY 2023 for Hyde services (now referred to as "Private Services") and the new Unsatisfactory Immigration Status (UIS) members.	December 1, 2022

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018

Back to Item

Back to Agenda

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

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

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

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

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

Back to Item

Back to Agenda

IV. Exhibit A, Attachment 6, PROVIDER NETWORK, is amended to read:

12. Subcontractor Reports

B. Subcontractor Network Certification

3) Contractor must have a process in place to impose Corrective Action and sanctions and report to DHCS, as specified by DHCS, when a Subcontractor's Network that provides Medi-Cal Covered Services fail**s** to meet Network adequacy standards as set forth in APL ~~21-006~~**23-006**. Contractor must ensure all Members assigned to a Subcontractor's Network that is under a Corrective Action continue to receive access to Medically Necessary Covered Services within timely access standards and applicable time or distance standards as set forth in Exhibit A, Attachment 9, Access and Availability, Provision 4, Access Standards, by supplementing the Subcontractor's Network until the Corrective Action is resolved.

21. Electronic Visit Verification

All Network Providers who are eligible must comply with Electronic Visit Verification (EVV) requirements.

A. Contractor must collaborate with DHCS, and take action as required by DHCS, to ensure that all Network Providers subject to EVV are compliant with Section 12006(a) of the Federal Cures Act, W&I section 14043.51, and APL 22-014.

B. Contractor must verify that all Network Providers capture and transmit the following six mandatory data components when providing personal care services and home health care services in a Member's home:

1) The type of service performed;

2) The individual receiving the service;

3) The date of the service;

4) The location of service delivery;

5) The individual providing the service; and

6) The time the service begins and ends.

C. Contractor must monitor and ensure all Network Providers comply with the EVV requirements when rendering personal care services and home health care services, subject to Federal EVV requirements in accordance with APL 22-014 and the established guidelines below:

1) Monitor Providers for compliance with the EVV requirements and information notice(s), and alert DHCS to any compliance issues.

2) Supply Providers with technical assistance and training on EVV compliance.

3) Require Providers to comply with an approved corrective action plan.

4) Deny payment if the Provider is not complying with EVV requirements and arrange for Members to receive services from a Provider who does comply.

V. Exhibit A, Attachment 8, Provider COMPENSATION ARRANGMENTS, Provision 7, is amended to read:

7. Federally Qualified Health Centers ~~(FQHC)~~, Rural Health Clinics ~~(RHC)~~, and American Indian Health Service Programs.

B. Required Terms and Conditions for Network Provider Agreements with Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC)

Contractor shall submit to DHCS, within 30 calendar days of a request and in the form and manner specified by DHCS, the services provided and the reimbursement level and amount for each of Contractor's FQHC and RHC Network Provider Agreements. Contractor shall certify in writing to DHCS within 30 calendar days of DHCS' written request that, pursuant to ~~Welfare and Institutions Code~~**W&I** ~~S~~**s**ection 14087.325(b) and (d), as amended by Chapter 894, Statutes of 1998, FQHC and RHC Network Provider Agreement terms and conditions are the same as offered to other Network Providers providing a similar scope of service and that reimbursement is not less than the level and amount of payment that Contractor makes for the same scope of services furnished by a Provider that is not a FQHC or

RHC. Contractor is not required to pay FQHCs and RHCs the Medi-Cal per visit rate for that facility.

Contractor must submit any FQHC and RHC Network Provider Agreements to DHCS for approval in accordance with W&I section 14087.325. Moreover, a~~A~~t its discretion, DHCS reserves the right to review and audit Contractor's FQHC and RHC reimbursement to ensure compliance with State and federal law and shall approve all FQHC and RHC Network Provider Agreements consistent with the provisions of W**&I** ~~elfare and Institutions Code S~~**s**ection 14087.325(h). **Contractor must fully cooperate with any DHCS review and audit of Contractor's operations and records related to FQHC and RHC reimbursement to ensure compliance with State and federal law.**

To the extent that American Indian Health Service Programs **chooses to participate in Medi-Cal** ~~qualify~~ as FQHCs or RHCs, the above reimbursement requirements shall apply to Network Provider Agreements with American Indian Health Service Programs. Contractor must also pay an amount equal to what Contractor would pay a subcontracted FQHC or RHC and DHCS must pay any supplemental payment, pursuant to 42 CFR **section** 438.14(c), to an American Indian Health Service Program that qualifies as a FQHC or RHC but is not a Network Provider.

C. American Indian Health Service Program Providers

2) For services provided on or after January 1, 2018**,** to Members who are qualified to receive services from an American Indian Health Service Program as set forth under Supplement 6, Attachment 4.19-B, of the California Medicaid State Plan, regardless of whether the American Indian Health Service Program is a Network Provider:

a) Contractor shall reimburse American Indian Health Service Programs at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service and in accordance with APL 17-020 **and APL 21-008**. Contractor shall adjust any payments to American Indian Health Service Programs if necessary to comply with any retroactive changes to the outpatient per-visit rates published in the Federal Register by the Indian Health Service.

VI. Exhibit A, Attachment 9, Provider ACCESS AND AVAILABILITY, Provision 16, is amended to read:

16. Out-of-Network Providers

B. Contractor shall provide for the completion of **C**~~c~~overed **S**~~s~~ervices 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 ~~S~~**s**ection 1373.96.

C. Contractor must allow all Members to request continuity of care in accordance with 42 CFR section 438.62 and APL 22-032.

~~C~~**D**. For newly enrolled beneficiaries who request continued access, Contractor shall provide continued access for up to 12 months to an Out-of-Network Provider with whom they have an ongoing relationship if there are no quality of care issues with the Provider and the Provider will accept Contractor or Medi-Cal FFS rates, whichever is higher, in accordance with W&I ~~Code~~ section 14182(b)(13) and (14). An ongoing relationship shall be determined by Contractor identifying a link between a newly enrolled SPD beneficiary and an Out-of-Network Provider using FFS utilization data provided by DHCS.

~~D~~**E**. In determining access to Out-of-Network Providers for mental health or substance use disorder benefits, Contractor must use processes, strategies, evidentiary standards, or other factors that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors for services identified within this Provision, in accordance with 42 CFR **section** 438.910(d)(3).

VII. Exhibit A, Attachment 10, SCOPE OF SERVICES, Provision 7, is amended to read:

7. Pregnant ~~Women~~ Members

C. Referral to Specialists

Contractor must ensure that pregnant Members are referred to medically appropriate Specialists, including, as appropriate, perinatologists, Freestanding Birthing Centers, Certified Nurse Midwives, ~~and~~ Licensed Midwives**, and are informed about Doula coverage. Pregnant Members may request and receive a recommendation for Doula services from a Physician or other licensed practitioner of the healing arts acting within their scope of practice under State law and receive services**. In addition, Contractor must ensure that postpartum Members ~~have~~ **receive a recommendation for Doula services within one year after pregnancy, if requested by the Member, and must ensure** access to genetic screening with appropriate referrals. Contractor must also ensure that appropriate hospitals are available within the Network to provide necessary high-risk pregnancy services.

VIII. Exhibit A, Attachment 11, CASE MANAGEMENT AND EXTERNAL COORDINATION OF CARE, Provision 4, is amended to read:

4. Specialty Mental Health

A. Specialty Mental Health Services

3) Disputes between Contractor and the county mental health plan regarding this section shall be addressed collaboratively within the Contract as specified by the MOU to achieve a timely and satisfactory resolution. If Contractor and the county mental health plan cannot agree, disputes shall be resolved pursuant to ~~Title~~ 9 CCR~~, S~~**s**ection 1850.505. **Any decision rendered by DHCS regarding a dispute between Contractor and the county mental health plan concerning provision of mental health services or Covered Services required under this Contract shall not be subject to the dispute procedures specified in Exhibit E, Attachment 2, Provision 19 regarding Contractor's Dispute Resolution Requirements.**

IX. Exhibit A, Attachment 14, MEMBER GRIEVANCE AND APPEAL SYSTEM, is amended to read:

5. Appeal Process

~~D. Contractor may extend the timeframe to resolve an Appeal by up to 14 calendar days if the Member requests an extension or Contractor shows that there is a need for additional information. Contractor shall maintain documentation to demonstrate to the Department, why the delay is in the Member's interest. If the timeframe extension has not been requested by the Member, Contractor shall:~~

~~1) Make reasonable efforts to give the Member prompt oral notice of the delay.~~

~~2) Give the Member a written notice of the reason to extend the timeframe within two (2) calendar days, including information on the right to file an additional Grievance for the delay.~~

~~3) Resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.~~

~~E~~**D**. Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later

than 72 hours from the date it reverses the action, if the services are not furnished while the Appeal is pending and Contractor reverses a decision to deny, limit, or delay services.

~~F~~**E**. Contractor must pay for disputed services if the Member received the disputed services while the Appeal was pending.

~~G~~**F**. Contractor shall continue providing Covered Services while the Appeal is pending if all of the following conditions are met:

~~H~~**G**. If Contractor, at the Member's request, continues or reinstates the provision of Covered Services while an Appeal or State Hearing is pending, those services must continue until:

~~I~~**H**. The Member must be given the opportunity before and during their Appeals process to examine their case file, including medical records and any other documents and records considered during the Appeals process. Contractor shall provide, sufficiently in advance of the resolution timeframe and free of charge, the Member's case file, including medical records and any other documents and records considered during the Appeal process.

6. Responsibilities in Expedited Appeals

C. Contractor must provide a Member notice, as quickly as the Member's health condition requires, within 72 hours from the day Contractor receives the request for an Appeal.

~~Contractor may extend the timeframe to resolve an expedited Appeal by up to 14 days if the Member requests an extension or if Contractor shows that there is a need for additional information and how the delay is in the Member's interest. If the extension was not requested by the Member, Contractor shall make reasonable efforts to give the Member a prompt oral notice of the delay, and within two (2) calendar days, provide the Member with written notice that includes the reason Contractor needs the extension. The notice shall include information on the right to file a Grievance if the Member disagrees Contractor's extension is appropriate. Contractor shall resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires. Contractor shall maintain documentation to demonstrate to the Department, why the extension is necessary.~~

7. State Hearings and Independent Medical Reviews

A. State Hearings

8) Contractor shall notify Members that the State must reach its

decision for a standard State Hearing within 90 days of the date of the request. For an expedited State Hearing, the State must reach its decision within 72 hours of receipt of the expedited State Hearing request. Contractor shall also comply with all other requirements as required by 42 CFR section 438.410, W&I ~~Code~~ section 10951.5**,** and as outlined in APL ~~21-011~~**XX-XXX**.

X. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, Provision 13, is amended to read:

13. Member Services

O. Submit policies and procedures to demonstrate how Contractor will update its Provider directory API at least weekly after receiving updated Provider information or being notified of any information that affects the content or accuracy of the Provider directory.

P. Submit **a hard copy of the patient access API and Provider directory API documentation and the publicly accessible link or web URL where each API is located. The documentation must be accessible without any preconditions to access, and contents must include at a minimum the following information:**

1) API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns;

2) The software components and configurations an application shall use to successfully interact with the API and process its response(s); and

3) All applicable technical requirements and attributes necessary for an application's registration with any authorized server(s) deployed in conjunction with the API.~~website mock-ups showing where a third-party applicant can easily access Contractor's patient access and provider directory APIs.~~

Q. Submit a **hard copy of and a** link to Contractor's publicly accessible Member educational resources that will achieve the following:

XI. Exhibit A, Attachment 23, WHOLE CHILD MODEL PROGRAM, is amended to read:

1. Whole Child Model Program Compliance

Contractor agrees to implement the Whole Child Model, as directed by DHCS and in accordance with Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016) and APL **21-005 or any superseding APL** ~~18-011~~, in order to cover benefits that were previously covered by the California Children's Services (CCS) program.

G. Annual Medical Eligibility Redeterminations

1) Contractor shall provide all necessary documentation, dated within the last six months but no later than twelve months prior to the Member's CCS program eligibility end date to allow for an annual medical eligibility redetermination by the county CCS program, including but not limited to:

a) The Member's current medical records that document the Member's medical history;

b) Results of physical examinations by a Physician;

c) Laboratory test results;

d) Radiologic findings; and

e) Other tests and examinations that support the diagnosis of the eligible condition(s), including any medical therapy unit diagnosis or high-risk infant follow-up reports.

2) Contractor must provide the documentation to the county CCS program no later than 60 calendar days before the Member's CCS program eligibility end date. If documentation is received after the 60-day timeframe, the Contractor and county CCS program should collaborate to determine the best approach for submitting documents.

3) If the county CCS program requires additional documentation, the Contractor must, upon notification from the county CCS program, coordinate with the Member's Provider(s) to obtain any needed documentation, within the agreed upon timeframe, to support the county CCS program's medical redetermination efforts.

4) Contractor must proactively engage in a collaborative process with the county CCS program to remedy any issues or challenges related to timeliness or completeness of records

for the medical eligibility redetermination process.

~~G~~**H.** For disputes between Contractor and the county CCS program regarding CCS medical eligibility determinations where a resolution cannot be reached, Contractor may refer the dispute directly to DHCS for review and a final determination.

5. Covered Services

In addition to the requirements found in Exhibit A, Attachment 10, Scope of Services, Contractor shall cover CCS 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, Contractor shall refer the Member to the county CCS office for eligibility determination.

B. For the identification of Members eligible for CCS, Contractor shall ensure the following:

3) Contractor shall provide all Medically Necessary CCS **Covered Services** for the Member's CCS-eligible condition(s).

XII. Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, is amended to read:

Budget Detail and Payment Provisions

1. Budget Contingency Clause
2. Amounts Payable
3. Contractor Risk in Providing Services
4. Capitation Rates
5. Capitation Rates Constitute Payment in Full
6. Determination of Rates
7. Redetermination of Rates-Obligation Changes
8. Reinsurance
9. Catastrophic Coverage Limitation
10. Financial Performance Guarantee
11. Recovery of Amounts Paid to Contractor
12. Medical Loss Ratio (MLR)
13. Adult Expansion Medical Loss Ratio and Risk Corridor
14. Supplemental Payments
15. Additional Payments
16. Special Contract Provisions Related to Payment
17. Medicare Coordination
~~18. COVIDid-19 Risk Corridor~~
~~19~~**18**. State Programs Receiving Federal Financial Participation

~~20~~**19**. Enhanced Care Management (ECM) Risk Corridor

4. Capitation Rates

A. DHCS shall remit to Contractor a Capitation Payment **no later than 45 calendar days after the first day of** each month for each Member that appears on the approved list of Members supplied to Contractor by DHCS. ~~The payment period for health care services shall commence on the first day of operations, as determined by DHCS.~~

Capitation Payments shall be made in accordance with the ~~following~~schedule of ~~c~~**C**apitation **Payment** rates **set forth below**. For **the list of** aid codes **included in each aid group below**, **please** see **the definition of potential Member set forth in Exhibit E, Attachment 1,** D**efinitions**~~EFINITIONS~~ **of this contract. Supplemental and additional payments listed below will be made in accordance with the requirements stated in Provision 14, Supplemental Payments, and Provision 15, Additional Payments, of this Exhibit.**~~, Eligible Beneficiary:~~

For the period 01/01/2023 – 12/31/2023	**[County]**
Aid Groups	**Rates**
Adult/Family/OTLIC Under 19 - SIS	
Adult/Family/OTLIC Under 19 - UIS	
Adult/Family/OTLIC 19 & Over - SIS	
Adult/Family/OTLIC 19 & Over - SIS	
SPD - SIS	
SPD - UIS	
SPD/Dual - SIS	
SPD/Dual - UIS	
Adult Expansion - SIS	
Adult Expansion - UIS	
Long-Term Care/Full Dual - SIS	
Long-Term Care/Full Dual – UIS	
Long-Term Care/Non-Full Dual - SIS	
Long-Term Care/Non-Full Dual - UIS	
[Whole Child Model-Selected COHS Only] - SIS	
[Whole Child Model-Selected COHS Only] - UIS	

For the period 01/01/2023 – 12/31/2023	**County**
Supplemental and Additional Payment Groups	**Rates**
Maternity - SIS	
Maternity - UIS	

10. Financial Performance Guarantee

In accordance with ~~Title~~ 22 CCR **s**~~S~~ection 53865, **subject to DHCS approval,** Contractor must annually provide **DHCS** satisfactory evidence of, and maintain**,** a Financial Performance Guarantee in the form specified by DHCS and in an amount ~~at least one million dollars or~~ equal to at least **one** ~~three (3)~~ months' Contract Revenues **or one million dollars**~~based on Contractor's average monthly Contract Revenues for last 12 months~~, whichever is higher, subject to approval by DHCS. ~~At Contractor's request, and with~~ **Upon** DHCS**'** approval~~,~~ **of** Contractor**'s proffered form of** ~~may establish a phasein schedule to accumulate the required~~ Financial Performance Guarantee**,** ~~. Unless DHCS has a financial claim or offset against Contractor, the Financial Performance Guarantee shall remain in effect through the completion of the phaseout period in accordance with Exhibit E, Provision 15 of this Contract.~~ DHCS shall take possession of the Financial Performance Guarantee **and any related instrument(s), which** ~~in an amount sufficient to indemnify~~ DHCS **shall hold as a security** in the event that Contractor materially breaches or defaults on one or more terms **in** this Contract.

At Contractor's request, subject to DHCS approval, Contractor may establish a phase-in schedule in order to accumulate the necessary funds to meet this Financial Performance Guarantee requirement. Contractor may also request DHCS approval to satisfy the Financial Performance Guarantee requirement on a post-payment basis by assigning to DHCS in writing Contractor's contract revenues for the last month of the term of this Contract, which DHCS shall hold as security in the event that Contractor materially breaches or defaults on one or more terms in this Contract.

Unless DHCS has a financial claim or offset against Contractor, the Financial Performance Guarantee shall remain in effect through the completion of the Phaseout Period in accordance with Exhibit E, Attachment 2, Provision 15, Phaseout Requirements.

16. Special Contract Provisions Related to Payment

~~A. Contractor must reimburse Network Providers pursuant to the terms of each applicable Directed Payment Initiative established in accordance with 42 CFR section 438.6(c), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS shall make the terms of each Directed Payment Initiative available on the DHCS website at www.dhcs.ca.gov.~~

~~B~~**A**. Contractor must reimburse Network Providers pursuant to the terms of each **of the following** applicable Pass-Through Payment**s** established pursuant to 42 CFR section 438.6(d), in accordance with the CMS-

approved rate certification, and in a form and manner specified by DHCS through APLs or other technical guidance~~.~~**:**

1) **Hospital Quality Assurance Fee (HQAF) and District Municipal Public Hospital (DMPH) Pass-Through Payments, which requires Contractor to make increased payments to private hospitals and DMPHs in accordance with DHCS guidance.**

2) **Martin Luther King Jr. (MLK) Community Hospital Pass-Through Payment, which requires Contractor to make increased payments to MLK Community Hospital in Los Angeles County in accordance with W&I section 14165.50 and DHCS guidance.**

3) **Benioff Children's Hospital Oakland (BCHO) Pass-Through Payment, which requires Contractor to make increased payments to BCHO in Alameda County in accordance with DHCS guidance.**

4) **Distinct part nursing facilities Pass-Through Payment, which requires Contractor to make increased payments to publicly-owned hospitals in accordance with DHCS guidance.**

B. **Contractor must reimburse Providers pursuant to the terms of each applicable Directed Payment Initiative established in accordance with 42 CFR section 438.6(c), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each Directed Payment Initiative, including the Directed Payment Initiative preprint as applicable, available on the DHCS website at https://www.dhcs.ca.gov. Directed Payment Initiatives are subject to change in accordance with the requirements of 42 CFR section 438.6(c) and currently include:**

1) **Designated Public Hospital (DPH) enhanced payment program, which requires Contractor to make uniform dollar or percentage increase payments to DPH systems for every qualifying service or assigned Member months in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(b).**

2) **Private Hospital Directed Payments Program (PHDP), which requires Contractor to make uniform dollar increase payments to eligible private hospitals for every qualifying service in accordance with DHCS guidance, including but not limited to APL 21-018, and the Directed Payment Initiative preprint.**

3) **District Hospital Directed Payments Program (DHDP), which requires Contractor to make uniform dollar increase payments to eligible DMPHs for every qualifying service in accordance with DHCS guidance, including but not limited to APL 21-018, and the Directed Payment Initiative preprint.**

4) **DPH Quality Incentive Pool (QIP), which requires Contractor to make performance-based quality incentive payments to DPH systems based on DHCS' evaluation of DPH systems' performance on specified quality measures in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(c).**

5) **DMPH QIP, which requires Contractor to make performance-based quality incentive payments to DMPH systems based on DHCS' evaluation of DMPH systems' performance on specified quality measures in accordance with DHCS guidance, including but not limited to APL 21-018, the Directed Payment Initiative preprint, and W&I section 14197.4(c).**

6) **Directed Payments for developmental screening services, which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every adjudicated claim for specified developmental screening services in accordance with DHCS guidance, including but not limited to APL 23-016, the Directed Payment Initiative preprint, and W&I section 14105.197(a)(3).**

7) **Proposition 56 Directed Payments for Physician services, which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every adjudicated claim for specified Physician services in accordance with DHCS guidance, including but not limited**

to APL 19-015, and the Directed Payment Initiative preprint.

8) Directed Payments for Adverse Childhood Experiences (ACEs), which requires Contractor to pay eligible Network Providers at no less than the California Medicaid State Plan approved rates for every adjudicated claim for specified ACEs screening services in accordance with DHCS guidance, including but not limited to APL 23-017, and W&I section 14105.197(a)(4).

9) Proposition 56 Directed Payments for family planning services, which requires Contractor to make uniform dollar increase payments to eligible Providers for every adjudicated claim for specified family planning services in accordance with DHCS guidance, including but not limited to APL 23-008, and the Directed Payment Initiative preprint.

10) Organ and bone marrow transplants, which requires Contractor to pay eligible contracted and non-contracted Providers at exactly the California Medicaid State Plan approved rates for specified organ and bone marrow transplant services using the methodology developed and published by DHCS on an annual basis in accordance with DHCS guidance, including but not limited to APL 21-015, the Directed Payment Initiative, and W&I section 14184.201(d).

11) Long-Term Care Fee-For-Service (FFS) equivalent base directed payment, which requires Contractors to pay Network Providers, in specified counties where services were traditionally covered in the FFS delivery system, at exactly the California Medicaid State Plan approved case or service rates for Skilled Nursing Facility (SNF) services effective January 1, 2023, and Intermediate Care Facility (ICF) and subacute services effective January 1, 2024. In all other counties, it requires Contractors to pay Network Providers at no less than the California Medicaid State Plan approved case or service rates for SNF services effective January 1, 2023, and ICF and subacute services effective January 1, 2024, at minimum. All payments must be made in accordance with DHCS guidance, including but not limited to APL 23-004, the Directed Payment Initiative, and W&I section 14184.201(b) - (c).

12) Workforce quality incentive program, which requires Contractor to make uniform dollar increase payments to eligible Network Providers for every qualifying service adjusted based on DHCS' evaluation of their performance on specified quality and workforce measures in accordance with DHCS guidance, including but not limited to APL XX-XX, the Directed Payment Initiative preprint, and W&I section 14126.024.

13) Proposition 56 directed payments for dental services, which requires Contractor to make uniform dollar increase payments to eligible Network Providers of dental health in accordance with DHCS guidance, including but not limited to APL 22-012, and the Directed Payment Initiative preprint.

14) Dental preventive services, which requires Contractor to pay eligible Network Providers at the California Medicaid State Plan approved rates at a minimum for certain dental preventive services in accordance with DHCS guidance, including but not limited to APL 21-005, and the Directed Payment Initiative.

C. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APL XX-XXX or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Risk Sharing Mechanism available on the DHCS website at www.dhcs.ca.gov.

~~C~~**D**. Contractor must comply with the terms of any **applicable** Incentive Arrangements approved by CMS under 42 CFR section 438.6(b)(2), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Incentive Arrangement available on the DHCS website at **https://**www.dhcs.ca.gov. **Incentive Arrangement payments must not exceed 105 percent of the approved capitation payments attributable to the Members or services covered by the Incentive Arrangement, as specified in 42 CFR section 438.6(b)(2) and as calculated by DHCS. DHCS may impose a cap on incentive payments and/or participation in applicable Incentive Arrangements if DHCS determines that the incentive payment(s) are likely to exceed 105 percent of the approved Capitation Payments. Contractor will be required to remit to DHCS any incentive payment amounts in excess of 105 percent of approved Capitation**

Payments. Incentive Arrangements are subject to change in accordance with the requirements of 42 CFR section 438.6(b)(2). Current Incentive Arrangements include:

1) **California Advancing and Innovating Medi-Cal (CalAIM) Incentive Payment Program (IPP), through which Contractor may earn incentive payments for achievement of specified IPP milestones and metrics associated with implementation of CalAIM initiatives as determined by DHCS and in accordance with DHCS guidance, including but not limited to the IPP terms specified on the DHCS website at https://www.dhcs.ca.gov, APL 23-003, and W&I section 14184.207.**

2) **Student behavioral health incentive program, through which Contractor may earn incentive payments for achievement of specified milestones and metrics associated with targeted interventions that increase access to preventive, early intervention, and behavioral health services by school-affiliated Behavioral Health Treatment Providers as determined by DHCS and in accordance with DHCS guidance, including but not limited to the terms on the DHCS website at https://www.dhcs.ca.gov, APL XX-XXX, and W&I section 5961.3.**

3) **Housing and homelessness incentive program, through which Contractor may earn incentive payments for achievement of specified milestones and metrics associated with improving health outcomes and access to whole person care services by addressing homelessness and housing insecurity as Social Drivers of Health and health disparities as determined by DHCS and in accordance with DHCS guidance, including but not limited to the terms on the DHCS website at https://www.dhcs.ca.gov, and APL 22-007.**

4) **Health equity and practice transformation payments, through which Contractor may earn incentive payments for achievement of specified milestones and metrics associated with partnering with Providers to support development of data exchanges, advanced data analytics, practice transformation plans, and applications as determined by DHCS and in accordance with DHCS guidance, including but not limited to the terms on the DHCS website at https://www.dhcs.ca.gov and APL XX-XXX.**

D. To participate in Member direct incentive programs approved in the Public Assistance Cost Allocation Plan (PACAP) by the U.S. Department of Health and Human Services Division of Cost Allocation Services, with CMS concurrence, Contractor must comply with the terms of those programs as set forth in the PACAP in a form and manner specified by DHCS through APLs or other technical guidance. For Rating Periods in which Member direct incentive programs are effective, commencing with the Rating Period starting January 1, 2021, DHCS shall make the terms of each approved Member direct incentive program available on the DHCS website at www.dhcs.ca.gov.

E. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Risk Sharing Mechanism available on the DHCS website at www.dhcs.ca.gov.

18. COVID-19 Risk Corridor

A risk-sharing arrangement shall be in effect for complete Rating Periods covering dates of services between July 1, 2019 and December 31, 2020, for those capitation increments, services and populations, as determined by DHCS.

A. The risk-sharing arrangement described in this Provision may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through All Plan Letters or other technical guidance.

B. The risk-sharing arrangement shall be symmetrical as to risk and profit and will be based on the results of a COVID-19 Risk Corridor calculation performed in a form and manner specified by DHCS through All Plan Letters or other technical guidance, aggregated across applicable Medi-Cal Managed Care Contracts between Contractor and the State for those capitation increments, services and populations, as determined by DHCS.

C. Contractor shall provide and certify allowable medical expense data necessary for the COVID-19 Risk Corridor calculation in a form and manner specified by the State. The data and any related substantiating documentation is subject to review and adjustment at the State's discretion in a form and manner specified by DHCS through All Plan Letters or other technical guidance, and may be subject to audit by the State or its designee.

~~D. The State or its designee will initiate the COVID-19 Risk Corridor calculation no sooner than 12 months after the end of the applicable Rating Period.~~

~~19~~18. State Programs Receiving Federal Financial Participation

~~20~~19. Enhanced Care Management ~~(ECM)~~ Risk Corridor

~~A.~~A risk-sharing arrangement shall be in effect for **each of** the Rating Period**s** covering dates of services from January 1, 2022 through December 31, 202~~2~~**3**, for those capitation increments, services and populations associated with E**nhanced** C**are** M**anagement (ECM)**, as determined by DHCS.

~~1)~~**A.** The risk-sharing arrangement described in this Provision may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

~~2)~~**B.** The risk-sharing arrangement shall be symmetrical and based on the results of an ECM Risk Corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal Managed Care Contracts between Contractor and the State for those capitation increments, services, and populations associated with ECM, as determined by DHCS.

~~3)~~**C.** Contractor shall provide and certify Allowable Medical Expense data necessary for the ECM Risk Corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance~~,~~ and may be subject to audit by the State or its designee.

~~4)~~**D.** DHCS or its designee will initiate the ECM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

~~B. If DHCS determines that the continuation of the risk-sharing arrangement is actuarially appropriate and necessary to account for the impacts of the ECM implementation for a given Rating Period starting on or after January 1, 2023, the ECM Risk Corridor, as described in Paragraph A of this Provision, shall continue to apply in a form and manner specified by DHCS through APLs or other technical guidance for the applicable Rating Period(s).~~

XIII. Exhibit E, Attachment 1, DEFINITIONS, is amended to read:

Application-Programming Interface (API) means a way for two or more computer programs to communicate with each other. The calls that make up the API are also known as subroutines, methods, requests, or endpoints.

Directed Payment Initiative means a payment arrangement that directs certain expenditures made by Contractor under this Contract **and** that is either approved by Centers for Medicare and Medicaid Services (CMS) as described in 42 CFR section 438.6(c)~~,~~ or established pursuant to 42 CFR sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.

Doula means a birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum Members before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in APL 22-031.

Other Health Coverage (OHC) means health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member~~,~~ excluding tort liability. OHC may originate under State (other than the Medicaid program), ~~F~~**f**ederal, or local medical care program, or under other contractual or legal entitlements.

~~**Other Health Coverage (OHC)** means health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medicaid program), Federal, or local medical care program, or under other contractual or legal entitlements.~~

Phaseout Period means the period of time after the date the Operations Period or Contract extension ends. The Phaseout Period extends until all activities required during the Phaseout Period for each Service Area are fully completed.

Risk Sharing Mechanism means any payment arrangement, such as reinsurance, risk corridors, or stop-loss limits, documented in the CMS-approved rate certification documents for the applicable Rating Period prior to the start of the Rating Period, that is developed in accordance with 42 CFR section 438.4, the rate development standards in 42 CFR section 438.5, and generally accepted actuarial principles and practices

XIV. Exhibit E, Attachment 2, PROGRAM TERMS AND CONDITIONS, Provision 35, is amended to read:

35. Treatment of Recoveries

E. Contractor shall also comply with these requirements as directed in APL ~~17-003~~ **23-011**.

XV. All rights, duties, obligations, and liabilities of the parties hereto otherwise remain unchanged.

CalOptima Health

CY 2023-B Contract Amendment Detail

Category	Requirement	Sub-Regulatory Guidance
Provider Network	-All eligible Network Providers must comply with Electronic Visit Verification (EVV) requirements. -Verify that all Network Providers capture and transmit six mandatory data components when providing personal care services and home health services.	APL 22-014: Electronic Visit Verification Implementation Requirements
Compensation Arrangements	-Submit any FQHC and RHC Network Provider Agreements to DHCS for approval.	
Scope of Services	-Incorporates doula services as a covered benefit. -Members may request and receive a recommendation for doula services from a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.	APL 23-024: Doula Services
Case Management and External Coordination of Care	-Added clarification that any decision rendered by DHCS regarding a dispute between a MCP and MHP concerning provision of mental health services or covered services shall not be subject to dispute procedures.	APL 21-013: Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans
Implementation Plan and Deliverables	-Submit a hard copy of the patient access API and provider directory API and the publicly accessible link or web URL where each API is located.	APL 22-026: Interoperability and Patient Access Final Rule
Whole Child Model (WCM) Program	-Incorporates annual medical redetermination requirements. -Provide documentation to county CCS program no later than 60 calendar days before the member's CCS program eligibility end date.	
Budget Detail and Payment Provisions	-Allows MCPs to establish a phase-in schedule in order to accumulate necessary funds to meet Financial Performance Guarantee requirement or through a post-payment basis. -MCPs must reimburse Network Providers pursuant to pass – through and directed payment requirements. -Comply with the terms of any risk sharing mechanisms in a form and manner specified by DHCS and applicable incentive arrangements.	APL 23-008: Proposition 56 Directed Payments for Family Planning Services APL 23-014: Proposition 56

Back to Item

Back to Agenda

		Value-Based Payment Program Directed Payments APL 23-015: Proposition 56 Directed Payments For Private Services APL 23-016: Directed Payments for Developmental Screening Services APL 23-017: Directed Payments for Adverse Childhood Experiences Screening Services APL 23-019: Proposition 56 Directed Payments for Physician Services
Terminology Changes	-Update terms and definitions used in the agreement.	

Continued to a Future Meeting

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approve Modifications to CalOptima Health Policy GA.5002: Purchasing

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Approve modifications to CalOptima Health Policy GA.5002: Purchasing.

Background

California Government Code section 54202 requires that every local agency adopt policies and procedures, including bidding regulations, governing purchases of supplies and equipment by the local agency. Purchases of supplies and equipment by the local agency shall be in accordance with said duly adopted policies and all provisions of law governing.

The CalOptima Health Board of Directors (Board) may delegate certain authority to staff to execute purchasing decisions provided there are adequate transparency and safeguards to guide the use of the delegated authority and prevent abuse.

On September 10, 1996, the Board adopted CalOptima Health Policy GA.5002: Purchasing to provide guidance on the procurement of all goods and services related to CalOptima Health's operations. This policy was last revised on September 1, 2022.

Discussion

Staff, with the assistance of outside general legal counsel, reviewed and revised the policy to ensure its provisions align with federal and state statutory and regulatory requirements and reflect CalOptima Health's current operational processes. Staff now seeks Board approval of changes and clarifications to the policy to reflect current regulations and updated processes.

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

Back to Agenda

Sections	Proposed Change	Rationale
A.6	Adds "CalOptima Health business owners, with the assistance of Vendor Management, shall review vendor relationships periodically, as necessary, to ensure consistency in quality, service, competitive pricing, and to stay competitive in the industry."	Moves the language from Section I.1 and makes review periodic, rather than every five years, to ensure reviews occur when needed and consistency in quality, service, competitive pricing, and to stay competitive in the industry.
I.1	Removes "Pre-qualified vendor relationships shall be reviewed periodically, at least every five (5) years, to ensure consistency in quality, service, and competitive pricing."	Moves the language to Section A.6 and makes review periodic, rather than every five years, to ensure reviews occur when needed and consistency in quality, service, competitive pricing, and to stay competitive in the industry.
I.2, I.3, J.1.a	Adds "where CalOptima Health's purchase is"	Clarifies that bidding thresholds are based on CalOptima Health's spend (rather than, for example, employee shared costs), in alignment with the purchase definitions in 2 CFR § 200.1.
I.2, I.3, J.1.a	Adds "per Project" to the "per vendor, per fiscal year" qualifying bid threshold language.	Aligns with federal procurement definitions and clarifies that different projects with the same vendor are not to be counted in the aggregate.
I.2, I.3	Adds "and will review annual spend with vendors under the micro purchase process to ensure appropriate use of micro purchases moving forward."	Provides necessary oversight of "per Project" designation so that Vendor Management can ensure that projects are defined and limited correctly.
J.6.a, J.6.b, K.2	Adds "most cost and value-effective and beneficial solution"	Provides consistency to the definitions and terminology throughout the policy and aligns with California Public Contract Code and California court definitions for qualified bidders.
J.4.d	Adds "for a Public Works or MSSP contract"	Makes clear that the process requirement for a lowest price bidder to be able to rebut an adverse benefit determination and provide present evidence of bidder responsibility only applies to public works and MSSP bids, in accordance with the lowest responsible bidder requirements and processes in the California Public Contract Code and as interpreted by California courts.

Back to Agenda

Sections	Proposed Change	Rationale
J.4.e	Moves from Section J.3.b "CalOptima Health will not award any contract to a Vendor who bids that is found to be suspended or debarred by any regulatory agency."	Change makes clear that CalOptima Health will not award contracts – whether through a micro purchase, informal bid, or formal bid – to vendors suspended or debarred by any regulatory agency.
J.5	Changes responsibility for making negotiated purchase determinations from the CFO to the CEO.	This change shifts the authority from CFO to CEO to reduce possible conflicts of interest for the CFO should their departments need a negotiated purchase determination.
J.8	Adds "8. Notice to Non-Responsive Bidders: Whenever a bidder is disqualified from consideration for not submitting a Responsive Bid, CalOptima Health shall provide notice to the bidder and give the bidder three (3) business days to submit a response demonstrating the original bid was a Responsive Bid. The bidder' response is only an opportunity for the bidder to explain why its original bid, as submitted to CalOptima Health, is a Responsive Bid. The response is not an opportunity for the bidder to submit additional information, supplement its original bid, or revise its original information. CalOptima Health shall determine whether the bid is a Responsive Bid in its sole discretion."	Clarifies process for vendors deemed to have submitted non-responsive bids.
J.11	Adds "with guidance from Legal Counsel" and "when CalOptima Health receives no Responsive Bids and/or does not identify any Qualified Bidders in response to an RFP" and changes responsibility for making waiver determinations from the CFO to the CEO.	Clarifies that when CalOptima Health permits or waives deviations from its purchasing policy, the CEO (rather than the CFO) will make those determinations with guidance from Legal Counsel in situations limited to when CalOptima Health receives no responsive bids or no bids from qualified bidders.
L.1.a	Adds "*See* California Public Contract Code section 1101."	Provides clarity to CalOptima Health's requirements for public works projects under the California Public Contract Code.
R	Adds new section for Multipurpose Senior Services Program (MSSP) Purchases	Adds bidding requirements for MSSP purchases under CalOptima Health's contract with the California Department of Aging.

Back to Agenda

Sections	Proposed Change	Rationale
S.1	Adds following new section for Lowest Responsive, Qualified Bidder "CalOptima Health is not subject to the requirements of the California Public Contract Code calling for competitive bidding and award of contracts to the lowest responsive, Qualified Bidder, with the exception of Public Works Projects under Section L above and MSSP Subcontract Awards/Vendors of MSSP Services under Section R.2 above."	Clarifies which CalOptima Health purchases are subject to the lowest responsive, qualified bidder standard under California Public Contract Code and as interpreted by California courts.
Glossary	Removes "Pre-Qualification" definition	Clarifies current processes.
Glossary	Revises "Public Works" definition to "Any contract for a public entity (such as CalOptima Health) for the construction, alteration, addition, repair, or improvement, in whole or in part, of any building or road, whether owned or leased by the public entity."	New definition matches the public works definition in the California Public Contract Code.
Glossary	Adds "Project" definition as follows: "A pre-defined sequence of tasks that the vendor must complete to attain a desired outcome by CalOptima Health. A Project includes a specified scope comprised of measurable and time-based goals with clear deliverables to state when the Project is completed within a pre-determined budget."	Clarifies on how CalOptima Health will define and monitor projects for the bid thresholds.
Glossary	Adds "Qualified Bidder" definition as follows: "The bidder who submits a Responsive Bid that best responds to the RFP in quality, fitness, and capacity to satisfactorily perform the proposed work with the most cost and value-effective and beneficial solution, as determined in CalOptima Health's sole discretion"	Defines qualified bidder in accordance with the California Public Contract Code and as interpreted by California courts.
Glossary	Adds "Responsive Bid" definition as follows: "A bid that responds to and meets all the technical requirements and instructions of the RFP, RFQ, or RFQu, as determined by CalOptima Health in its sole discretion."	Defines responsive bid in accordance with the California Public Contract Code and as interpreted by California courts.

Back to Agenda

The procedures related to this policy will be addressed through internal desktop procedures.

Fiscal Impact
The recommended action to modify CalOptima Health GA.5002 is operational in nature and has no additional fiscal impact beyond what was included in the CalOptima Health Fiscal Year 2023-24 Operating and Capital Budgets.

Rationale for Recommendation
Updates to the CalOptima Health Purchasing policy is recommended to ensure compliance with the California Public Contract Code and the federal procurement regulations, and to enhance the efficiency and clarity of CalOptima Health's operations and governance.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed Revised CalOptima Health Policy GA.5002: Purchasing (redlined and clean)

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Policy:	GA.5002
Title:	**Purchasing**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	09/10/1996
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes the organization and administration of a ~~unified~~centralized, fair, and effective process for the procurement of goods and services essential to the operations of CalOptima Health and may be amended from time to time in order that it remains consistent with current best business practices. This policy applies to the procurement of goods and services for all CalOptima Health programs including Federal Awards Subject to OMB A-133 Single Audit Requirements.

II. POLICY

A. Unless exempted or otherwise stated by this policy herein and/or applicable law, the Chief Financial Officer (CFO) or their designee, with the assistance of the Vendor Management Department, is charged with the authority and responsibility for the following:

1. Acquiring equipment, supplies and services for all departments in an economical, expeditious and reasonable manner, in accordance with this policy;

2. Identifying qualified vendors and developing and promoting good vendor relationships;

3. Educating and training employees and vendors on this policy and the purchasing process;

4. Providing assistance to departments in preparing specifications and in analysis of bids received; and

5. Awarding contracts and assuring vendor performance through contract administration.

6. CalOptima Health business owners, with the assistance of Vendor Management, shall review vendor relationships periodically, as necessary, to ensure consistency in quality, service, competitive pricing, and to stay competitive in the industry.

B. A requisition for purchase of supplies, equipment or services shall be approved only by a person who has been properly authorized in accordance with this policy. The Board of Directors has delegated requisition authority to the Chief Executive Officer (CEO). The CEO has further delegated that authority and in the amounts provided below. Any person in a position of delegated authority below may appoint a designee of the same level or higher, in writing, to act in their stead when that person

Back to Item

Back to Agenda

is unavailable. The Vendor Management Department shall have full authority to question the quality, quantity, kind, and source of materials and services being requisitioned.

C. Requisition Approval Limits – Goods and Non-Medical Professional Services and Public Works Projects

Employee Position	Approval Limit
Manager	$ 1,000
Director	10,000
Executive Director or Officer	100,000
CEO or Chief Operating Officer (COO)	Over 100,000

D. Requisition Approval Limits – Capital Projects

Employee Position	Approval Limit
Manager	$ 0
Director	0
Executive Director or Officer	100,000
CEO or COO	Over 100,000

E. Requisition Approval Limits – Computer Hardware, Software and Other Peripheral Telecommunications Goods and Services Equipment and Related Services (collectively "Computer Equipment") and Telecommunications Goods and Services

Employee Position	Approval Limit
Manager	$ 10,000
Director	50,000
Executive Director or Officer	100,000
CEO or COO	Over 100,000

F. Funding for all requisitions shall be approved by the Board of Directors through:

1. The annual operating or capital budget;

2. Specific Board action; or

3. A Budget Allocation Change, in accordance with CalOptima Health Policy GA.5003: Budget Approval and ~~Operations~~Budget Reallocation Forecasting.

G. To enable the Board of Directors to consider approval through the operating and capital budgets, the budget submission must meet the requirements outlined in CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

H. Signature authorization for contracts, agreements, leases, and/or purchase orders resulting from this policy is addressed in CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

I. Informal Bidding

1. Set forth below are the generally accepted methods of purchasing, which may be adjusted from time to time for CalOptima Health's Best Interest and to reflect current best business practices. All formal and informal requests for prices in the form of bids, quotations or proposals for all materials, services and equipment purchased, must be made by the Vendor Management Department, unless otherwise delegated by the Vendor Management Department in writing. ~~Pre-qualified vendor relationships shall be reviewed periodically, at least every five (5) years, to~~

~~ensure consistency in quality, service and competitive pricing.~~ For the purposes of this policy, the response to any request for prices, requests for quotations or invitations for bids shall collectively be referred to as a ~~"~~"bid~~"~~" or ~~"~~"bids.~~"~~".

2. Micro purchases: Purchases of Goods and Non-Medical Professional Services and Public Works Projects, Capital Projects and Computer Equipment and Telecommunications Goods and Services~~,~~ where CalOptima Health's purchase is valued at under fifty thousand dollars ($50,000) per Project, per vendor, per fiscal year~~, not including applicable taxes and freight charges,~~ are referred to as micro purchases~~,~~ and may be made without solicitation of bids if the Vendor Management Department considers the purchase price to be reasonable based on research, experience, and purchase history. ~~-~~The Vendor Management Department will distribute micro purchases equitably among qualified suppliers to the maximum extent practicable~~.~~ And will review annual spend with vendors under the micro purchase process to ensure appropriate use of micro purchases moving forward.

   a. Pursuant to 2 C.F.R. § 200.320, CalOptima Health has increased its upper limit for micro purchases, from the $10,000 limit provided in the Federal Acquisition Regulation to $50,000, based on an evaluation of its internal controls, its risk, and this Purchasing Policy. The $50,000 limit is not prohibited under state or local laws or regulations. CalOptima Health must annually self-certify its $50,000 micro purchase limit by way of a CEO Memorandum.

   b. The CEO shall self-certify by way of a CEO Memorandum each fiscal year.

   c. The self-certification shall include a justification for the $50,000 limit, as well as supporting documentation showing CalOptima Health's eligibility for the increased limit.

3. Small purchases: Purchases of Goods and Non-Medical Professional Services and Public Works ~~projects~~Projects and Computer Equipment and Telecommunications Goods and Services where CalOptima Health's purchase is valued from fifty thousand dollars ($50,000) to two hundred fifty thousand dollars ($250,000) per Project, per vendor, per fiscal year~~, not including applicable taxes and freight charges~~, referred to as small purchases, require solicitation of at least two (2) informal bids and/or quotations from known suppliers. The Vendor Management Department will review annual spend with vendors under the small purchase process to ensure appropriate use of small purchases moving forward.

4. Contracts for software licenses or software maintenance agreements, or computer equipment purchases must be approved in writing by the Information Services Department.

5. Contracts for the provision of healthcare services must be coordinated by the Provider Operations Department with approval of an appropriate signing party under CalOptima Health Policy GA.3202: CalOptima Health Signature Authority, within limits delegated by the Board of Directors, and with approval of the contract template and any deviations therefrom by the Legal Counsel.

J. Formal Bidding

1. Provisions Applicable to purchases of Goods and Non-Medical Professional Services and Public Works ~~projects~~Projects, Capital Projects and Computer Equipment and Telecommunications Goods and Services shall be made by Request for Quotations (RFQ), Request for Proposals (RFP), Request for Qualifications (RFQu), or Invitations for Bid (IFB).

   a. Unless exempted in Section II.J.2 below or by applicable law, purchases of Goods and Non-

Medical Professional Services and Public Works ~~projects~~Projects, Capital Projects and Computer Equipment and Telecommunications Goods and Services where CalOptima Health's purchase is valued at more than two hundred fifty thousand dollars ($250,000) per Project, per vendor, per fiscal year shall be procured using a formal request for bids in the form of a formal RFQ, RFP, RFQu or IFB.

b. Public Works ~~projects~~Projects involving construction or demolition, including tenant improvements, when required shall include detailed plans and specifications prepared by an architect, engineer or other licensed professional acting within the scope of their license. Formal requests for bids for Public Works ~~projects~~Projects sent to Offerors will include a public works contract template.

2. Exceptions to Bidding

a. Contracts for the provision of certain health care and related services when criteria are set and open to all qualified providers.

b. Sole source or emergency purchases, which shall only be undertaken in accordance with Sections II.O. and II.P. respectively.

c. Acquisitions or transfers of real property, which shall only be undertaken in accordance with Section II.Q.

3. Bid Procedures for formal bidding.

a. Preparation: Before entering into any contract which requires formal bidding, CalOptima Health shall prepare a bid package. ~~-~~The bid package may take the form of a RFQ, RFP, RFQu, or IFB.~~-~~ To the extent practicable, the bid package shall include full, complete, and accurate plans and specifications, giving such direction as will enable any competent vendor to ascertain and carry out the contract requirements.

~~1. ***Notice*** of formal bids: All prospective bidders who have not been suspended or debarred by any regulatory agency within the last three (3) years, have registered on CalOptima Health's sourcing vendor tool, shall be furnished with an automated e-mail announcement that there is a RFQ, RFP, RFQu, or IFB for bids (as applicable) posted on the CalOptima Health website and CalOptima Health's sourcing tool for them to download. The RFQ, RFP, RFQu, or IFB shall include information as to the type, quality, quantity, date, location and other bid requirements. The notice shall specify the place bids are to be received and the time by which they are to be received. Any bids received after the due date and specified time shall be rejected by the sourcing tool, except as otherwise provided herein.~~

b. Advertising/Publication: Except in cases of emergency or where circumstances require the immediate letting of a contract, information advising interested parties how to obtain specifications, and specifying the place bids are to be received and the time by which they are to be received, shall be given via the automated sourcing tool. The RFQ, RFP, RFQu, or IFB will be posted on CalOptima Health's website from the issue date until the date the proposal is due.

i. Methods of publicizing of the bids shall include at least one (1) of the following:

a) RFQ's, RFP's, RFQu's or ~~IFB's~~IFB's will appear on the "work with CalOptima Health" page of CalOptima Health's website on the date the documents will be issued; or

b) Vendors registered with the CalOptima ~~Health~~Health's vendor sourcing tool will receive an automated email from the sourcing tool directly; or

c) The CEO or designee may waive any irregularity or informality in the publication procedures.

c. Bid ~~Form: The bid package~~ Package: CalOptima Health shall furnish the bid package to each prospective bidder ~~an appropriate bid form and bid package prepared by CalOptima Health~~ for the type of contract being ~~let. Bids not presented on forms so furnished~~ procured. CalOptima Health shall ~~be disregarded~~disqualify as non-responsive~~.~~ Bids not presented as specified by CalOptima Health. All ~~bids~~vendors must ~~be accompanied by~~include a non-collusion affidavit in their bids.

d. Presentation of Bids under Sealed Cover: All bids shall be presented under sealed cover on or before the bid deadline and submitted directly to the sourcing tool.

e. Withdrawal of Bids: Bids may be withdrawn at any time prior to the time fixed in the notice for the opening of bids only by written request made to the person or entity designated in charge of the bidding procedure.

f. Bidder's Conference: CalOptima Health may hold a bidders' conference, job walk, or conduct a site visit, as it deems necessary and appropriate. In such cases, CalOptima Health shall include the date, time and location in the bid documents. The conference or site visit shall be at least five (5) days after publication of the notice of formal bid.

4. Award of Contracts

a. Opening of Bids: CalOptima Health shall open the sealed bids after the date and time specified in the sourcing tool. CalOptima Health shall not accept any bids not fully submitted by the specific due date and time. Award of the contract shall be to ~~the lowest price, qualified and responsive bidder~~a Qualified Bidder, if at all, as determined at CalOptima Health's sole discretion. All bidders shall ~~have complied~~comply with the foregoing bid procedures, except as otherwise provided herein~~.~~, to be considered for the contract award. After a bid is opened it shall be deemed irrevocable for the period specified in the bid.

b. Awards to the second and third lowest price ~~qualified bidders~~Qualified Bidders: If it is deemed to be in CalOptima Health's Best Interest, CalOptima Health may, on refusal or failure of the successful ~~bidder~~Qualified Bidder to execute the contract or comply with other bid requirements, award it to the second lowest price ~~qualified bidder.~~Qualified Bidder. If the second lowest price ~~qualified bidder~~Qualified Bidder fails or refuses to execute the contract or comply with other bid requirements, CalOptima Health may likewise award it to the third lowest price ~~qualified bidder~~Qualified Bidder, and so on.

c. Only one (1) Bid or Proposal Received: If only one (1) bid or proposal is received in response to the RFQ, RFP, RFQu, or IFB, an award may be made to the sole ~~bidder~~Qualified Bidder provided that CalOptima Health finds that the price or proposal submitted is fair, reasonable and in CalOptima Health's Best Interest.

d. Qualified Bidder: CalOptima Health's determination of a ~~qualified bidder~~Qualified Bidder shall be based on analysis of each bidder's ability to perform~~,~~ the required obligations, its

financial ~~statement~~statements (if required), experience, past record, proposed solution, and any other factors ~~it~~CalOptima Health shall deem relevant. ~~-~~If the lowest price bidder for a Public Works or Multipurpose Senior Services Program (MSSP) contract is to be rejected because of an adverse determination of the bidder's responsibility based on CalOptima Health's decision, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility.

e. CalOptima Health will not award any contract to a vendor that bids that is found to be suspended or debarred by any regulatory agency.

5. Negotiated Purchase: CalOptima Health reserves the right and at its sole discretion, to informally solicit ~~one (1) or more~~ alternative proposals from one (1) or more qualified vendor(s) in the event that a procurement solicitation results in no acceptable ~~vendor responses~~Responsive Bids based on the criteria set forth in the solicitation package. ~~-~~The ~~CFO~~CEO or designee may use a procedure to select a vendor by "competitive means."~~-~~ This would include one (1) or more of the following methods when deemed by the CEO or designee as an appropriate means under the circumstances to permit CalOptima Health's Best Interests to be served:

   a. The preparation and circulation of an informal RFQ, RFP, RFQu, or IFB to an adequate number of qualified sources. An adequate number shall be defined as two (2) or more qualified ~~sources~~vendors, as determined by the ~~CFO~~CEO or their designee based on the number of qualified ~~sources~~vendors believed to be capable of submitting a satisfactory proposal after reasonable inquiry.

   b. Any other means determined by the ~~CFO~~CEO, or their designee as reasonably expected to disseminate the RFQ, RFP, RFQu, or IFB to an adequate number of qualified ~~sources~~vendors.

6. Criteria for Award of Contract via Negotiated Purchase

   a. Contracts shall be awarded to a qualified and responsive bidder based on which vendor has the most cost and value-effective and beneficial solution.

   b. These criteria shall be applied by the ~~CFO~~CEO or their designee using a scoring or other system designed to determine which of the proposals submitted provides the most ~~viable~~cost and value-effective and beneficial solution to CalOptima Health's requirements. The basis for such determination shall be documented by the Vendor Management Department in a manner which permits the Board, the ~~CFO~~CEO or their designee to reasonably evaluate compliance with this policy.

7. Waiver and Rejection Rights: CalOptima Health reserves the right to reject any and all bids or proposals or to waive any informality or non-substantive defects in bids or proposals to serve CalOptima Health's Best Interest. Only those bids or proposals which are deemed by CalOptima Health to be ~~responsive~~Responsive Bids to the RFQ, RFP, RFQu, or IFB shall be considered. The Vendor Management Department shall ensure maximum protection of CalOptima Health's Best Interest consistent with ensuring an equal opportunity and fair and equitable treatment for all ~~bidders and~~ Offerors.

8. Notice to Non-Responsive Bidders: Whenever a bidder is disqualified from consideration for not submitting a Responsive Bid, CalOptima Health shall provide notice to the bidder and give the bidder three (3) business days to submit a response demonstrating the original bid was a Responsive Bid. The bidder' response is only an opportunity for the bidder to explain why its original bid, as submitted to CalOptima Health, is a Responsive Bid. The response is not an opportunity for the bidder to submit additional information, supplement its original bid, or revise

its original information. CalOptima Health shall determine whether the bid is a Responsive Bid in its sole discretion.

~~8.~~9. Notice to Bidders Not Awarded the Contract: Whenever a contract is not to be awarded to a bidder, such bidder shall be notified within thirty (30) business days after an executed contract to another bidder.

~~9.~~10. Contract Documents: Contract documents shall be prepared in advance, with the approval of Legal Counsel and shall be incorporated into the bid package.

~~10.~~11. Flexibility: In recognition of the fact that the contracting and purchasing needs of CalOptima Health may from time to time render certain procedures herein impracticable, the ~~CFO~~CEO or their designee, with guidance from Legal Counsel, are authorized to permit or waive deviations from this policy when CalOptima Health receives no Responsive Bids and/or does not identify any Qualified Bidders in response to an RFP, to the extent permitted by law, upon making a written finding that such deviation is in CalOptima Health's Best Interest. Additionally, provisions required to be included in Public Works ~~projects~~Projects and construction contracts (e.g., requirements for performance bonds, insurance) may be included in other contracts, if appropriate.

K. Provisions Applicable to Procurement of Non-Medical Professional Services.

1. Except as otherwise provided for in this policy, all procurements for professional services shall be made, in accordance with limits as set forth in the Board-approved annual operating budget.

2. Criteria for Award of Contract: Contracts shall be awarded to ~~-~~a qualified and responsive vendor based on which vendor has the most cost and value-~~-~~effective and beneficial ~~-~~solution.

   a. Exception: Pursuant to 40 U.S.C. sections 1101-1104 and California Government Code sections 4525-4529.5, CalOptima Health shall not, for the purposes of ranking firms, evaluate any RFQ, RFP, RFQu, or IFB for architectural or engineering services primarily on the basis of price. ~~-~~Once firms are determined to have the requisite technical capabilities to meet the services required (e.g., experience, proposal, technical expertise) CalOptima Health may then use price as a factor for the purposes of final ranking determinations. ~~-~~CalOptima Health then shall seek to negotiate a fair and reasonable price with the top ranked firm. If agreement on a fair and reasonable price cannot be reached, CalOptima Health shall cease negotiations and move to the second ranked firm and seek to negotiate a fair and reasonable price. This process shall continue until agreement with a firm is reached.

L. Provisions Applicable to Public Works Projects

~~1. CalOptima Health is not subject to the requirements of the California Public Contract Code calling for competitive bidding and award of contracts to the lowest responsive, qualified bidder.~~

1. Procurement of Alterations to and Maintenance of Real Property and Other Public Works Projects.

   a. This section shall apply to any acquisition of goods and services for the physical construction, alteration, demolition, installation or repair of real property, including fixtures, painting, wiring, carpeting and other things incorporated into or permanently affixed to real property. *See* California Public Contract Code section 1101. CalOptima Health may elect to pre-qualify contractors to participate in informal and formal bids.

b. No alteration to real property requiring a building permit, including tenant improvements in leased spaces, shall be undertaken, except pursuant to detailed plans and specifications, if applicable will be prepared by an architect, engineer, or other California-licensed professional acting within the scope of her or his license. ~~-~~Any such alterations to CalOptima Health's leased spaces shall be consistent with the terms and conditions of the lease, if any.

c. Provisions of the policy may be waived by the CalOptima Health Board of Directors.

d. All contractors contracted by CalOptima Health for the performance of Public Works ~~projects~~Projects, as defined in California Labor Code section 1720, shall pay not less than the required prevailing wages, as provided in Section 1771 of the California Labor Code, if the total payments under that contract are more than one thousand dollars ($1,000).

e. Payment Bonds – Pursuant to California Civil Code section 9550, for any Public Works ~~project~~Project in excess of twenty five thousand dollars ($25,000), the prime contractor shall submit a payment bond, in a form approved by the CFO and from a surety authorized to do business in the State of California, in the amount of one hundred percent (100%) of the contract price.

f. See Section II.J. for additional formal bidding requirements.

M. Cooperative Purchases

1. When it is in CalOptima Health's Best Interest, the Vendor Management Department may enter into or use pre-existing cooperative purchasing agreements for acquisition of goods and services with any entity or group and execute respective contracts under those agreements.

N. Leveraged Procurement Agreements

1. Leveraged Procurement Agreements allow public entities, including CalOptima Health, to leverage the buying power of the State of California and allows those entities to purchase directly from suppliers through existing contracts and agreements without further competitive bidding.

2. When it is in CalOptima Health's Best Interest, CalOptima Health may use Leveraged Procurement Agreements.

O. Sole Source Purchases

1. Sole source purchases are not competitively bid and may be used if only one (1) acceptable source exists to fulfill CalOptima Health's requirements. ~~-~~Sole source purchases involve goods or services that are unique or novel to only one (1) supplier, or products and/or services that are designed to match others already in use.

P. Emergency Purchases

1. The CEO, or their designee, may authorize emergency purchases in cases that have or could impose significant provable loss to CalOptima Health or where human life or property is endangered. ~~-~~When an emergency condition arises, and the need cannot be met through normal procurement methods, the emergency purchase shall be made with such competition as is feasible under the circumstances. Contracts and other documents related to such emergency procurements

shall be executed in accordance with the requirements of CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

2. The person responsible for the emergency purchase shall provide written documentation stating the basis of the emergency purchase and the reasoning for the selection of the particular contractor. ~~-~~A written account of the emergency circumstances shall be sent promptly to the CEO and the Board of Directors. ~~–~~Normal purchasing procedures shall be followed as soon as the emergency is over.

Q. Real Property Transactions

1. CalOptima Health shall not enter into any transaction for the purchase, sale, lease (including any sublease or lease assignment, whether CalOptima Health is the lessor, lessee, sublessor, sublessee, assignor or assignee), or termination of lease of any real property, or enter into negotiations related to such transactions, without the prior approval of the Board of Directors, pursuant to a Board action addressed solely to the transaction or set of related transactions, and setting forth the parameters under which the negotiations may proceed. Such negotiations and transactions on behalf of CalOptima Health shall be carried out exclusively by the person or persons designated by the Board of Directors.

R. Multipurpose Senior Services Program (MSSP) Purchases

1. Equipment and Supply Purchases

a. Equipment and supplies procured by CalOptima Health with funding from the MSSP waiver is the property of the State of California. CalOptima Health will ensure its equipment and supply purchases with MSSP funding comply with procedures and standards outlined by the California Department of Aging (CDA), including those procedures outlined in Chapter 10 of the CDA MSSP Site Manual and associated appendix, and California State procedures regarding the acquisition, inventory, control and disposition of equipment and payment for administrative services. Equipment and supply purchases under the MSSP do not include equipment and supplies purchased for an individual member, which become the property of the individual member.

2. Subcontract Awards/Vendors of MSSP Services

a. CalOptima Health will award subcontracts and select vendors of MSSP services based on equitable criteria and provide for awards to the lowest-priced responsible and responsive bidder(s), as defined in and required by the California State Contracting Manuals.

b. CalOptima Health will ensure that subcontractors complete the CDA-approved vendor application and comply with applicable requirements as outlined in Chapter 8 of the CDA MSSP Site Manual and associated appendices.

~~R.~~S. Ethics

1. CalOptima Health employees, officers, Board of Directors, and agents shall conduct themselves in such a manner as to foster public confidence in the integrity of the CalOptima Health procurement process.

2. CalOptima Health employees, officers, Board of Directors, and agents shall perform their duties impartially to ensure that vendors have fair and competitive access to do business with CalOptima Health.

3. Employees, officers, Board of Directors, and agents of CalOptima Health shall be subject to the Conflict of Interest Laws of the State of California and the CalOptima Health Code of Conduct. Employees, officers or agents of CalOptima Health who violate these standards shall be subject to the penalties, sanctions or other disciplinary actions provided for therein.

4. Gratuities, Kickbacks, and Contingency Fees

   a. No CalOptima Health employee, officer, Board of Director, or agent shall solicit, demand, or accept from any person anything of monetary value for, or because of, any action taken, or to be taken, in the performance of their duties. ~~-~~An employee, officer, Board of Director, or agent failing to adhere to the above shall be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, including possible dismissal.

   b. CalOptima Health employees shall adhere to all provisions of the CalOptima Health Policy AA.1204: Gift, Honoraria, and Travel Payments.

5. Confidential Information

   a. No CalOptima Health employee, officer, Board of Director, or agent shall use confidential information for their actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such CalOptima Health employee by blood, marriage, or by common commercial or financial interest. ~~-~~An employee, officer, Board of Director, or agent failing to adhere to this requirement shall be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

   b. CalOptima Health employees shall not divulge confidential information to any vendor, consultant, or contractor.

6. Vendor Relations

   a. CalOptima Health employees may discuss, on an informal basis, non-financial requirements with contractors, consultants, and vendors. ~~-~~Employees may also solicit information such as brochures and other descriptive material from vendors, consultants, and contractors.

   b. CalOptima Health employees, officers, Board of Directors, and agents shall not meet with vendors, consultants, and/or contractors regarding financial agreements unless a representative of the Vendor Management Department is present at the meeting.

   c. If a CalOptima Health employee requests a demo from a ~~Vendor~~vendor outside of a bidding process, that CalOptima Health employee shall ensure that the demo will be used for high level information gathering only, ~~and~~ shall ensure to review more than one (1) system to provide fairness in any future process, and shall provide documentation to Vendor Management.

   d. CalOptima Health employees, officers, Board of Directors, and agents shall not bind, or appear to bind, CalOptima Health in any way, financially, or otherwise, except as provided for in accordance with CalOptima Health Policy GA.3202: CalOptima Health Signature Authority. Only the Board, Chief Executive Officer or their designee, and those staff designated as signing authorities in CalOptima Health Policy GA.3202: ~~-~~CalOptima Health Signature Authority may financially or contractually bind CalOptima Health.

   e. No employee, officer, Board of Director, or agent of CalOptima Health shall participate in the selection, award or administration of an agreement, or in any decision that may have a foreseeable impact on a vendor if a conflict of interest, real or implied, exists. ~~-~~Such a conflict

arises when any one of the following has a financial or other interest in the firm selected for award:

i. A CalOptima Health employee, officer, Board of Director, or agent;

ii. The employee, officer or Board of Director, agent's spouse or dependent children;

iii. The employee, officer or Board of Director, agent's domestic or business partner;

iv. An organization that employs or has made an offer of employment to any of the above.

T. Lowest, Responsive, Qualified Bidder

1. CalOptima Health is not subject to the requirements of the California Public Contract Code calling for competitive bidding and award of contracts to the lowest responsive, Qualified Bidder, with the exception of Public Works Projects under Section L above and MSSP Subcontract Awards/Vendors of MSSP Services under Section R.2 above.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Fair Political Practices Commission Form 700 - Statement of Economic Interests
B. CalOptima Health Code of Conduct
C. CalOptima Health Compliance Plan
D. CalOptima Health Conflict of Interest Code
E. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
F. CalOptima Health Policy GA.3202: CalOptima Health Signature Authority
G. CalOptima Health Policy GA.5003: Budget Approval and ~~Operations Forecasting~~Budget Reallocation
H. CalOptima Health Resolution No. 12-03101-01
I. Title 2, Code of Federal Regulations (CFR) Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards
J. California Department of Aging, Multipurpose Senior Services Program (MSSP) Contract; Exhibit E, Article 1, Section B; Exhibit D, Article VII
K. California Department of Aging, Multipurpose Senior Services Program (MSSP) Site Manual, Chapter 8: Service Vendors
L. California Department of Aging, Multipurpose Senior Services Program (MSSP) Site Manual, Chapter 10: Equipment

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

11/01/1994	Regular Meeting of the CalOptima Board of Directors
09/10/1996	Regular Meeting of the CalOptima Board of Directors
11/04/1997	Regular Meeting of the CalOptima Board of Directors
12/02/1997	Regular Meeting of the CalOptima Board of Directors
01/11/2000	Regular Meeting of the CalOptima Board of Directors
09/09/2003	Regular Meeting of the CalOptima Board of Directors
03/01/2012	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
09/01/2022	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/10/1996	GA.5002	Procurement Policy	Administrative
Revised	11/04/1997	GA.5002	Procurement Policy	Administrative
Revised	12/02/1997	GA.5002	Procurement Policy	Administrative
Revised	01/11/2000	GA.5002	Procurement Policy	Administrative
Revised	01/01/2004	GA.5002	Procurement Policy	Administrative
Revised	03/01/2012	GA.5002	Purchasing Policy	Administrative
Revised	06/07/2018	GA.5002	Purchasing	Administrative
Revised	09/01/2022	GA.5002	Purchasing	Administrative
Revised		GA.5002	Purchasing	Administrative

IX. GLOSSARY

Term	Definition
Bidder's Conference	A meeting to discuss technical, operational and performance specifications, and/or the full extent of financial, security and other contractual obligations with potential bidders, related to bid solicitation before the bid closes.
CalOptima Health's Best Interest	The discretionary rationale used by a purchasing official in taking action most advantageous to the jurisdiction when it is impossible to adequately delineate a specific response by law or regulation.
Invitation for Bids (IFB)	The document used to solicit bids from potential contractors for a fixed project with established plans and specifications. This is generally used for the procurement of Public Works.
~~Pre-Qualification (of bidders)~~	~~The screening of potential vendors in which such factors as financial capability, reputation, and management are considered in order to develop a list of qualified businesses who may then be allowed to submit bids.~~
~~Public Works~~	~~Works means any work of improvement contracted for by a public entity (such as CalOptima Health). Work of improvement includes, but is not restricted to, the construction, alteration, addition to, or repair, in whole or in part, of any building, whether owned or leased by a public entity.~~
Offeror	The person/entity who submits a proposal in response to a Request for Proposal or Request for Quotation.
Public Works	Any contract for a public entity (such as CalOptima Health) for the construction, alteration, addition, repair, or improvement, in whole or in part, of any building or road, whether owned or leased by the public entity.
Project	A pre-defined sequence of tasks that the vendor must complete to attain a desired outcome by CalOptima Health. A Project includes a specified scope comprised of measurable and time-based goals with clear deliverables to state when the Project is completed within a pre-determined budget.
Qualified Bidder	The bidder who submits a Responsive Bid that best responds to the RFP in quality, fitness, and capacity to satisfactorily perform the proposed work with the most cost and value-effective and beneficial solution, as determined in CalOptima Health's sole discretion.
Request for Proposal (RFP)	The document used to solicit proposals from potential vendors for goods and services. This is generally used when the specification for the good or service is known, but the vendor's advice is needed regarding how to buy the good or implement the service. The price is usually not the primary evaluation factor. It provides for the negotiation of all terms, including price prior to contract award. The RFP may include a provision for the negotiation of Best and Final offers. -It may be a single or multi-step process.
Request for Quotation (RFQ)	A purchasing method generally used when specifications are known for goods and services of all types. A request is sent to vendors along with a specification of the commodity needed or a description of the services required. The vendor is asked to respond with price and other information by a pre-determined date. Evaluation and recommendation for award should be based on the quotation that best meets price, quality, delivery, service, past performance and reliability.

Term	Definition
Request for Qualification (RFQu)	A purchasing method to either qualify a short list of vendors who will then be invited to a private RFP with only those short listed vendors, or a method where CalOptima Health will develop a pool of vendors to contract with that will be awarded contracts for similar work that will be spread between each vendor as determined by CalOptima Health. CalOptima Health may establish an additional pool where they can add contracts for additional vendors as needed.
Responsive Bid	A bid that responds to and meets all the technical requirements and instructions of the RFP, RFQ, or RFQu, as determined by CalOptima Health in its sole discretion.
Scope of Work (SOW)	A written description of the contractual requirements for materials and services contained within a RFQ or RFP. A well-conceived and clearly written SOW serves four main purposes: • Establishes clear understanding of what is needed; • Encourages competition in the marketplace and promotes economic stimulus; • Satisfies a critical need of government; and • Obtains the best value for the taxpayer.

1

Policy:	GA.5002
Title:	**Purchasing**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	09/10/1996
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes the organization and administration of a centralized, fair, and effective process for the procurement of goods and services essential to the operations of CalOptima Health and may be amended from time to time in order that it remains consistent with current best business practices. This policy applies to the procurement of goods and services for all CalOptima Health programs including Federal Awards Subject to OMB A-133 Single Audit Requirements.

II. POLICY

A. Unless exempted or otherwise stated by this policy herein and/or applicable law, the Chief Financial Officer (CFO) or their designee, with the assistance of the Vendor Management Department, is charged with the authority and responsibility for the following:

1. Acquiring equipment, supplies and services for all departments in an economical, expeditious and reasonable manner, in accordance with this policy;

2. Identifying qualified vendors and developing and promoting good vendor relationships;

3. Educating and training employees and vendors on this policy and the purchasing process;

4. Providing assistance to departments in preparing specifications and in analysis of bids received; and

5. Awarding contracts and assuring vendor performance through contract administration.

6. CalOptima Health business owners, with the assistance of Vendor Management, shall review vendor relationships periodically, as necessary, to ensure consistency in quality, service, competitive pricing, and to stay competitive in the industry.

B. A requisition for purchase of supplies, equipment or services shall be approved only by a person who has been properly authorized in accordance with this policy. The Board of Directors has delegated requisition authority to the Chief Executive Officer (CEO). The CEO has further delegated that authority and in the amounts provided below. Any person in a position of delegated authority below may appoint a designee of the same level or higher, in writing, to act in their stead when that person

Back to Item

Back to Agenda

is unavailable. The Vendor Management Department shall have full authority to question the quality, quantity, kind, and source of materials and services being requisitioned.

C. Requisition Approval Limits – Goods and Non-Medical Professional Services and Public Works Projects

Employee Position	Approval Limit
Manager	$ 1,000
Director	10,000
Executive Director or Officer	100,000
CEO or Chief Operating Officer (COO)	Over 100,000

D. Requisition Approval Limits – Capital Projects

Employee Position	Approval Limit
Manager	$ 0
Director	0
Executive Director or Officer	100,000
CEO or COO	Over 100,000

E. Requisition Approval Limits – Computer Hardware, Software and Other Peripheral Telecommunications Goods and Services Equipment and Related Services (collectively "Computer Equipment") and Telecommunications Goods and Services

Employee Position	Approval Limit
Manager	$ 10,000
Director	50,000
Executive Director or Officer	100,000
CEO or COO	Over 100,000

F. Funding for all requisitions shall be approved by the Board of Directors through:

1. The annual operating or capital budget;

2. Specific Board action; or

3. A Budget Allocation Change, in accordance with CalOptima Health Policy GA.5003: Budget Approval and Budget Reallocation Forecasting.

G. To enable the Board of Directors to consider approval through the operating and capital budgets, the budget submission must meet the requirements outlined in CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

H. Signature authorization for contracts, agreements, leases, and/or purchase orders resulting from this policy is addressed in CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

I. Informal Bidding

1. Set forth below are the generally accepted methods of purchasing, which may be adjusted from time to time for CalOptima Health's Best Interest and to reflect current best business practices. All formal and informal requests for prices in the form of bids, quotations or proposals for all materials, services and equipment purchased, must be made by the Vendor Management Department, unless otherwise delegated by the Vendor Management Department in writing. For

the purposes of this policy, the response to any request for prices, requests for quotations or invitations for bids shall collectively be referred to as a "bid" or "bids".

2. Micro purchases: Purchases of Goods and Non-Medical Professional Services and Public Works Projects, Capital Projects and Computer Equipment and Telecommunications Goods and Services where CalOptima Health's purchase is valued at under fifty thousand dollars ($50,000) per Project, per vendor, per fiscal year are referred to as micro purchases and may be made without solicitation of bids if the Vendor Management Department considers the purchase price to be reasonable based on research, experience, and purchase history. The Vendor Management Department will distribute micro purchases equitably among qualified suppliers to the maximum extent practicable And will review annual spend with vendors under the micro purchase process to ensure appropriate use of micro purchases moving forward.

    a. Pursuant to 2 C.F.R. § 200.320, CalOptima Health has increased its upper limit for micro purchases, from the $10,000 limit provided in the Federal Acquisition Regulation to $50,000, based on an evaluation of its internal controls, its risk, and this Purchasing Policy. The $50,000 limit is not prohibited under state or local laws or regulations. CalOptima Health must annually self-certify its $50,000 micro purchase limit by way of a CEO Memorandum.

    b. The CEO shall self-certify by way of a CEO Memorandum each fiscal year.

    c. The self-certification shall include a justification for the $50,000 limit, as well as supporting documentation showing CalOptima Health's eligibility for the increased limit.

3. Small purchases: Purchases of Goods and Non-Medical Professional Services and Public Works Projects and Computer Equipment and Telecommunications Goods and Services where CalOptima Health's purchase is valued from fifty thousand dollars ($50,000) to two hundred fifty thousand dollars ($250,000) per Project, per vendor, per fiscal year, referred to as small purchases, require solicitation of at least two (2) informal bids and/or quotations from known suppliers. The Vendor Management Department will review annual spend with vendors under the small purchase process to ensure appropriate use of small purchases moving forward.

4. Contracts for software licenses or software maintenance agreements, or computer equipment purchases must be approved in writing by the Information Services Department.

5. Contracts for the provision of healthcare services must be coordinated by the Provider Operations Department with approval of an appropriate signing party under CalOptima Health Policy GA.3202: CalOptima Health Signature Authority, within limits delegated by the Board of Directors, and with approval of the contract template and any deviations therefrom by the Legal Counsel.

J. Formal Bidding

1. Provisions Applicable to purchases of Goods and Non-Medical Professional Services and Public Works Projects, Capital Projects and Computer Equipment and Telecommunications Goods and Services shall be made by Request for Quotations (RFQ), Request for Proposals (RFP), Request for Qualifications (RFQu), or Invitations for Bid (IFB).

    a. Unless exempted in Section II.J.2 below or by applicable law, purchases of Goods and Non-Medical Professional Services and Public Works Projects, Capital Projects and Computer Equipment and Telecommunications Goods and Services where CalOptima Health's purchase is valued at more than two hundred fifty thousand dollars ($250,000) per Project, per vendor, per fiscal year shall be procured using a formal request for bids in the form of a formal RFQ, RFP, RFQu or IFB.

b. Public Works Projects involving construction or demolition, including tenant improvements, when required shall include detailed plans and specifications prepared by an architect, engineer or other licensed professional acting within the scope of their license. Formal requests for bids for Public Works Projects sent to Offerors will include a public works contract template.

2. Exceptions to Bidding

a. Contracts for the provision of certain health care and related services when criteria are set and open to all qualified providers.

b. Sole source or emergency purchases, which shall only be undertaken in accordance with Sections II.O. and II.P. respectively.

c. Acquisitions or transfers of real property, which shall only be undertaken in accordance with Section II.Q.

3. Bid Procedures for formal bidding.

a. Preparation: Before entering into any contract which requires formal bidding, CalOptima Health shall prepare a bid package. The bid package may take the form of a RFQ, RFP, RFQu, or IFB. To the extent practicable, the bid package shall include full, complete, and accurate plans and specifications, giving such direction as will enable any competent vendor to ascertain and carry out the contract requirements.

b. Advertising/Publication: Except in cases of emergency or where circumstances require the immediate letting of a contract, information advising interested parties how to obtain specifications, and specifying the place bids are to be received and the time by which they are to be received, shall be given via the automated sourcing tool. The RFQ, RFP, RFQu, or IFB will be posted on CalOptima Health's website from the issue date until the date the proposal is due.

i. Methods of publicizing of the bids shall include at least one (1) of the following:

a) RFQ's, RFP's, RFQu's or IFB's will appear on the "work with CalOptima Health" page of CalOptima Health's website on the date the documents will be issued; or

b) Vendors registered with the CalOptima Health's vendor sourcing tool will receive an automated email from the sourcing tool directly; or

c) The CEO or designee may waive any irregularity or informality in the publication procedures.

c. Bid Package: CalOptima Health shall furnish the bid package to each prospective bidder for the type of contract being procured. CalOptima Health shall disqualify as non-responsive Bids not presented as specified by CalOptima Health. All vendors must include a non-collusion affidavit in their bids.

d. Presentation of Bids under Sealed Cover: All bids shall be presented under sealed cover on or before the bid deadline and submitted directly to the sourcing tool.

e. Withdrawal of Bids: Bids may be withdrawn at any time prior to the time fixed in the notice for the opening of bids only by written request made to the person or entity designated in

charge of the bidding procedure.

f. Bidder's Conference: CalOptima Health may hold a bidders' conference, job walk, or conduct a site visit, as it deems necessary and appropriate. In such cases, CalOptima Health shall include the date, time and location in the bid documents. The conference or site visit shall be at least five (5) days after publication of the notice of formal bid.

4. Award of Contracts

a. Opening of Bids: CalOptima Health shall open the sealed bids after the date and time specified in the sourcing tool. CalOptima Health shall not accept any bids not fully submitted by the specific due date and time. Award of the contract shall be to a Qualified Bidder, if at all, as determined at CalOptima Health's sole discretion. All bidders shall comply with the foregoing bid procedures, except as otherwise provided herein, to be considered for the contract award. After a bid is opened it shall be deemed irrevocable for the period specified in the bid.

b. Awards to the second and third lowest price Qualified Bidders: If it is deemed to be in CalOptima Health's Best Interest, CalOptima Health may, on refusal or failure of the successful Qualified Bidder to execute the contract or comply with other bid requirements, award it to the second lowest price Qualified Bidder. If the second lowest price Qualified Bidder fails or refuses to execute the contract or comply with other bid requirements, CalOptima Health may likewise award it to the third lowest price Qualified Bidder, and so on.

c. Only one (1) Bid or Proposal Received: If only one (1) bid or proposal is received in response to the RFQ, RFP, RFQu, or IFB, an award may be made to the sole Qualified Bidder provided that CalOptima Health finds that the price or proposal submitted is fair, reasonable and in CalOptima Health's Best Interest.

d. Qualified Bidder: CalOptima Health's determination of a Qualified Bidder shall be based on analysis of each bidder's ability to perform the required obligations, its financial statements (if required), experience, past record, proposed solution, and any other factors CalOptima Health shall deem relevant. If the lowest price bidder for a Public Works or Multipurpose Senior Services Program (MSSP) contract is to be rejected because of an adverse determination of the bidder's responsibility based on CalOptima Health's decision, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility.

e. CalOptima Health will not award any contract to a vendor that bids that is found to be suspended or debarred by any regulatory agency.

5. Negotiated Purchase: CalOptima Health reserves the right and at its sole discretion, to informally solicit alternative proposals from one (1) or more qualified vendor(s) in the event that a procurement solicitation results in no acceptable Responsive Bids based on the criteria set forth in the solicitation package. The CEO or designee may use a procedure to select a vendor by "competitive means." This would include one (1) or more of the following methods when deemed by the CEO or designee as an appropriate means under the circumstances to permit CalOptima Health's Best Interests to be served:

a. The preparation and circulation of an informal RFQ, RFP, RFQu, or IFB to an adequate number of qualified sources. An adequate number shall be defined as two (2) or more qualified vendors, as determined by the CEO or their designee based on the number of qualified vendors believed to be capable of submitting a satisfactory proposal after reasonable

inquiry.

b. Any other means determined by the CEO, or their designee as reasonably expected to disseminate the RFQ, RFP, RFQu, or IFB to an adequate number of qualified vendors.

6. Criteria for Award of Contract via Negotiated Purchase

a. Contracts shall be awarded to a qualified and responsive bidder based on which vendor has the most cost and value-effective and beneficial solution.

b. These criteria shall be applied by the CEO or their designee using a scoring or other system designed to determine which of the proposals submitted provides the most cost and value-effective and beneficial solution to CalOptima Health's requirements. The basis for such determination shall be documented by the Vendor Management Department in a manner which permits the Board, the CEO or their designee to reasonably evaluate compliance with this policy.

7. Waiver and Rejection Rights: CalOptima Health reserves the right to reject any and all bids or proposals or to waive any informality or non-substantive defects in bids or proposals to serve CalOptima Health's Best Interest. Only those bids or proposals which are deemed by CalOptima Health to be Responsive Bids to the RFQ, RFP, RFQu, or IFB shall be considered. The Vendor Management Department shall ensure maximum protection of CalOptima Health's Best Interest consistent with ensuring an equal opportunity and fair and equitable treatment for all Offerors.

8. Notice to Non-Responsive Bidders: Whenever a bidder is disqualified from consideration for not submitting a Responsive Bid, CalOptima Health shall provide notice to the bidder and give the bidder three (3) business days to submit a response demonstrating the original bid was a Responsive Bid. The bidder' response is only an opportunity for the bidder to explain why its original bid, as submitted to CalOptima Health, is a Responsive Bid. The response is not an opportunity for the bidder to submit additional information, supplement its original bid, or revise its original information. CalOptima Health shall determine whether the bid is a Responsive Bid in its sole discretion.

9. Notice to Bidders Not Awarded the Contract: Whenever a contract is not to be awarded to a bidder, such bidder shall be notified within thirty (30) business days after an executed contract to another bidder.

10. Contract Documents: Contract documents shall be prepared in advance, with the approval of Legal Counsel and shall be incorporated into the bid package.

11. Flexibility: In recognition of the fact that the contracting and purchasing needs of CalOptima Health may from time to time render certain procedures herein impracticable, the CEO or their designee, with guidance from Legal Counsel, are authorized to permit or waive deviations from this policy when CalOptima Health receives no Responsive Bids and/or does not identify any Qualified Bidders in response to an RFP, to the extent permitted by law, upon making a written finding that such deviation is in CalOptima Health's Best Interest. Additionally, provisions required to be included in Public Works Projects and construction contracts (e.g., requirements for performance bonds, insurance) may be included in other contracts, if appropriate.

K. Provisions Applicable to Procurement of Non-Medical Professional Services.

1. Except as otherwise provided for in this policy, all procurements for professional services shall be made, in accordance with limits as set forth in the Board-approved annual operating budget.

2. Criteria for Award of Contract: Contracts shall be awarded to a qualified and responsive vendor based on which vendor has the most cost and value-effective and beneficial solution.

   a. Exception: Pursuant to 40 U.S.C. sections 1101-1104 and California Government Code sections 4525-4529.5, CalOptima Health shall not, for the purposes of ranking firms, evaluate any RFQ, RFP, RFQu, or IFB for architectural or engineering services primarily on the basis of price. Once firms are determined to have the requisite technical capabilities to meet the services required (e.g., experience, proposal, technical expertise) CalOptima Health may then use price as a factor for the purposes of final ranking determinations. CalOptima Health then shall seek to negotiate a fair and reasonable price with the top ranked firm. If agreement on a fair and reasonable price cannot be reached, CalOptima Health shall cease negotiations and move to the second ranked firm and seek to negotiate a fair and reasonable price. This process shall continue until agreement with a firm is reached.

L. Provisions Applicable to Public Works Projects

1. Procurement of Alterations to and Maintenance of Real Property and Other Public Works Projects.

   a. This section shall apply to any acquisition of goods and services for the physical construction, alteration, demolition, installation or repair of real property, including fixtures, painting, wiring, carpeting and other things incorporated into or permanently affixed to real property. *See* California Public Contract Code section 1101. CalOptima Health may elect to pre-qualify contractors to participate in informal and formal bids.

   b. No alteration to real property requiring a building permit, including tenant improvements in leased spaces, shall be undertaken, except pursuant to detailed plans and specifications, if applicable will be prepared by an architect, engineer, or other California-licensed professional acting within the scope of her or his license. Any such alterations to CalOptima Health's leased spaces shall be consistent with the terms and conditions of the lease, if any.

   c. Provisions of the policy may be waived by the CalOptima Health Board of Directors.

   d. All contractors contracted by CalOptima Health for the performance of Public Works Projects, as defined in California Labor Code section 1720, shall pay not less than the required prevailing wages, as provided in Section 1771 of the California Labor Code, if the total payments under that contract are more than one thousand dollars ($1,000).

   e. Payment Bonds – Pursuant to California Civil Code section 9550, for any Public Works Project in excess of twenty five thousand dollars ($25,000), the prime contractor shall submit a payment bond, in a form approved by the CFO and from a surety authorized to do business in the State of California, in the amount of one hundred percent (100%) of the contract price.

   f. See Section II.J. for additional formal bidding requirements.

M. Cooperative Purchases

1. When it is in CalOptima Health's Best Interest, the Vendor Management Department may enter into or use pre-existing cooperative purchasing agreements for acquisition of goods and services with any entity or group and execute respective contracts under those agreements.

N. Leveraged Procurement Agreements

1. Leveraged Procurement Agreements allow public entities, including CalOptima Health, to leverage the buying power of the State of California and allows those entities to purchase directly from suppliers through existing contracts and agreements without further competitive bidding.

2. When it is in CalOptima Health's Best Interest, CalOptima Health may use Leveraged Procurement Agreements.

O. Sole Source Purchases

1. Sole source purchases are not competitively bid and may be used if only one (1) acceptable source exists to fulfill CalOptima Health's requirements. Sole source purchases involve goods or services that are unique or novel to only one (1) supplier, or products and/or services that are designed to match others already in use.

P. Emergency Purchases

1. The CEO, or their designee, may authorize emergency purchases in cases that have or could impose significant provable loss to CalOptima Health or where human life or property is endangered. When an emergency condition arises, and the need cannot be met through normal procurement methods, the emergency purchase shall be made with such competition as is feasible under the circumstances. Contracts and other documents related to such emergency procurements shall be executed in accordance with the requirements of CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

2. The person responsible for the emergency purchase shall provide written documentation stating the basis of the emergency purchase and the reasoning for the selection of the particular contractor. A written account of the emergency circumstances shall be sent promptly to the CEO and the Board of Directors. Normal purchasing procedures shall be followed as soon as the emergency is over.

Q. Real Property Transactions

1. CalOptima Health shall not enter into any transaction for the purchase, sale, lease (including any sublease or lease assignment, whether CalOptima Health is the lessor, lessee, sublessor, sublessee, assignor or assignee), or termination of lease of any real property, or enter into negotiations related to such transactions, without the prior approval of the Board of Directors, pursuant to a Board action addressed solely to the transaction or set of related transactions, and setting forth the parameters under which the negotiations may proceed. Such negotiations and transactions on behalf of CalOptima Health shall be carried out exclusively by the person or persons designated by the Board of Directors.

R. Multipurpose Senior Services Program (MSSP) Purchases

1. Equipment and Supply Purchases

a. Equipment and supplies procured by CalOptima Health with funding from the MSSP waiver is the property of the State of California. CalOptima Health will ensure its equipment and supply purchases with MSSP funding comply with procedures and standards outlined by the California Department of Aging (CDA), including those procedures outlined in Chapter 10 of the CDA MSSP Site Manual and associated appendix, and California State procedures regarding the acquisition, inventory, control and disposition of equipment and payment for administrative services. Equipment and supply purchases under the MSSP do not include equipment and supplies purchased for an individual member, which become the property of the individual member.

2. Subcontract Awards/Vendors of MSSP Services

   a. CalOptima Health will award subcontracts and select vendors of MSSP services based on equitable criteria and provide for awards to the lowest-priced responsible and responsive bidder(s), as defined in and required by the California State Contracting Manuals.

   b. CalOptima Health will ensure that subcontractors complete the CDA-approved vendor application and comply with applicable requirements as outlined in Chapter 8 of the CDA MSSP Site Manual and associated appendices.

S. Ethics

1. CalOptima Health employees, officers, Board of Directors, and agents shall conduct themselves in such a manner as to foster public confidence in the integrity of the CalOptima Health procurement process.

2. CalOptima Health employees, officers, Board of Directors, and agents shall perform their duties impartially to ensure that vendors have fair and competitive access to do business with CalOptima Health.

3. Employees, officers, Board of Directors, and agents of CalOptima Health shall be subject to the Conflict of Interest Laws of the State of California and the CalOptima Health Code of Conduct. Employees, officers or agents of CalOptima Health who violate these standards shall be subject to the penalties, sanctions or other disciplinary actions provided for therein.

4. Gratuities, Kickbacks, and Contingency Fees

   a. No CalOptima Health employee, officer, Board of Director, or agent shall solicit, demand, or accept from any person anything of monetary value for, or because of, any action taken, or to be taken, in the performance of their duties. An employee, officer, Board of Director, or agent failing to adhere to the above shall be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, including possible dismissal.

   b. CalOptima Health employees shall adhere to all provisions of the CalOptima Health Policy AA.1204: Gift, Honoraria, and Travel Payments.

5. Confidential Information

   a. No CalOptima Health employee, officer, Board of Director, or agent shall use confidential information for their actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such CalOptima Health employee by blood, marriage, or by common commercial or financial interest. An employee, officer, Board of Director, or agent failing to adhere to this requirement shall be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

   b. CalOptima Health employees shall not divulge confidential information to any vendor, consultant, or contractor.

6. Vendor Relations

   a. CalOptima Health employees may discuss, on an informal basis, non-financial requirements with contractors, consultants, and vendors. Employees may also solicit information such as brochures and other descriptive material from vendors, consultants, and contractors.

b. CalOptima Health employees, officers, Board of Directors, and agents shall not meet with vendors, consultants, and/or contractors regarding financial agreements unless a representative of the Vendor Management Department is present at the meeting.

c. If a CalOptima Health employee requests a demo from a vendor outside of a bidding process, that CalOptima Health employee shall ensure that the demo will be used for high level information gathering only, shall ensure to review more than one (1) system to provide fairness in any future process, and shall provide documentation to Vendor Management.

d. CalOptima Health employees, officers, Board of Directors, and agents shall not bind, or appear to bind, CalOptima Health in any way, financially, or otherwise, except as provided for in accordance with CalOptima Health Policy GA.3202: CalOptima Health Signature Authority. Only the Board, Chief Executive Officer or their designee, and those staff designated as signing authorities in CalOptima Health Policy GA.3202: CalOptima Health Signature Authority may financially or contractually bind CalOptima Health.

e. No employee, officer, Board of Director, or agent of CalOptima Health shall participate in the selection, award or administration of an agreement, or in any decision that may have a foreseeable impact on a vendor if a conflict of interest, real or implied, exists. Such a conflict arises when any one of the following has a financial or other interest in the firm selected for award:

i. A CalOptima Health employee, officer, Board of Director, or agent;

ii. The employee, officer or Board of Director, agent's spouse or dependent children;

iii. The employee, officer or Board of Director, agent's domestic or business partner;

iv. An organization that employs or has made an offer of employment to any of the above.

T. Lowest, Responsive, Qualified Bidder

1. CalOptima Health is not subject to the requirements of the California Public Contract Code calling for competitive bidding and award of contracts to the lowest responsive, Qualified Bidder, with the exception of Public Works Projects under Section L above and MSSP Subcontract Awards/Vendors of MSSP Services under Section R.2 above.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Fair Political Practices Commission Form 700 - Statement of Economic Interests
B. CalOptima Health Code of Conduct
C. CalOptima Health Compliance Plan
D. CalOptima Health Conflict of Interest Code
E. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
F. CalOptima Health Policy GA.3202: CalOptima Health Signature Authority

G. CalOptima Health Policy GA.5003: Budget Approval and Budget Reallocation
H. CalOptima Health Resolution No. 12-03101-01
I. Title 2, Code of Federal Regulations (CFR) Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards
J. California Department of Aging, Multipurpose Senior Services Program (MSSP) Contract; Exhibit E, Article 1, Section B; Exhibit D, Article VII
K. California Department of Aging, Multipurpose Senior Services Program (MSSP) Site Manual, Chapter 8: Service Vendors
L. California Department of Aging, Multipurpose Senior Services Program (MSSP) Site Manual, Chapter 10: Equipment

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
11/01/1994	Regular Meeting of the CalOptima Board of Directors
09/10/1996	Regular Meeting of the CalOptima Board of Directors
11/04/1997	Regular Meeting of the CalOptima Board of Directors
12/02/1997	Regular Meeting of the CalOptima Board of Directors
01/11/2000	Regular Meeting of the CalOptima Board of Directors
09/09/2003	Regular Meeting of the CalOptima Board of Directors
03/01/2012	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
09/01/2022	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/10/1996	GA.5002	Procurement Policy	Administrative
Revised	11/04/1997	GA.5002	Procurement Policy	Administrative
Revised	12/02/1997	GA.5002	Procurement Policy	Administrative
Revised	01/11/2000	GA.5002	Procurement Policy	Administrative
Revised	01/01/2004	GA.5002	Procurement Policy	Administrative
Revised	03/01/2012	GA.5002	Purchasing Policy	Administrative
Revised	06/07/2018	GA.5002	Purchasing	Administrative
Revised	09/01/2022	GA.5002	Purchasing	Administrative
Revised		GA.5002	Purchasing	Administrative

IX. GLOSSARY

Term	Definition
Bidder's Conference	A meeting to discuss technical, operational and performance specifications, and/or the full extent of financial, security and other contractual obligations with potential bidders, related to bid solicitation before the bid closes.
CalOptima Health's Best Interest	The discretionary rationale used by a purchasing official in taking action most advantageous to the jurisdiction when it is impossible to adequately delineate a specific response by law or regulation.
Invitation for Bids (IFB)	The document used to solicit bids from potential contractors for a fixed project with established plans and specifications. This is generally used for the procurement of Public Works.
Offeror	The person/entity who submits a proposal in response to a Request for Proposal or Request for Quotation.
Public Works	Any contract for a public entity (such as CalOptima Health) for the construction, alteration, addition, repair, or improvement, in whole or in part, of any building or road, whether owned or leased by the public entity.
Project	A pre-defined sequence of tasks that the vendor must complete to attain a desired outcome by CalOptima Health. A Project includes a specified scope comprised of measurable and time-based goals with clear deliverables to state when the Project is completed within a pre-determined budget.
Qualified Bidder	The bidder who submits a Responsive Bid that best responds to the RFP in quality, fitness, and capacity to satisfactorily perform the proposed work with the most cost and value-effective and beneficial solution, as determined in CalOptima Health's sole discretion.
Request for Proposal (RFP)	The document used to solicit proposals from potential vendors for goods and services. This is generally used when the specification for the good or service is known, but the vendor's advice is needed regarding how to buy the good or implement the service. The price is usually not the primary evaluation factor. It provides for the negotiation of all terms, including price prior to contract award. The RFP may include a provision for the negotiation of Best and Final offers. It may be a single or multi-step process.
Request for Quotation (RFQ)	A purchasing method generally used when specifications are known for goods and services of all types. A request is sent to vendors along with a specification of the commodity needed or a description of the services required. The vendor is asked to respond with price and other information by a pre-determined date. Evaluation and recommendation for award should be based on the quotation that best meets price, quality, delivery, service, past performance and reliability.
Request for Qualification (RFQu)	A purchasing method to either qualify a short list of vendors who will then be invited to a private RFP with only those short listed vendors, or a method where CalOptima Health will develop a pool of vendors to contract with that will be awarded contracts for similar work that will be spread between each vendor as determined by CalOptima Health. CalOptima Health may establish an additional pool where they can add contracts for additional vendors as needed.
Responsive Bid	A bid that responds to and meets all the technical requirements and instructions of the RFP, RFQ, or RFQu, as determined by CalOptima Health in its sole discretion.

Term	Definition
Scope of Work (SOW)	A written description of the contractual requirements for materials and services contained within a RFQ or RFP. A well-conceived and clearly written SOW serves four main purposes: ● Establishes clear understanding of what is needed; ● Encourages competition in the marketplace and promotes economic stimulus; ● Satisfies a critical need of government; and ● Obtains the best value for the taxpayer.

1

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
8. Approve Modifications to CalOptima Health Policy GA.3400: Annual Investments

Contact
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action
Approve modifications to CalOptima Health Policy GA.3400: Annual Investments.

Background
At the February 27, 1996, meeting, the Board approved the Annual Investment Policy (AIP) covering investments made between March 1, 1996, and February 28, 1997. In September 1996, the Board authorized the creation of the Investment Advisory Committee (IAC). The IAC reviews the AIP annually and recommends policy revisions, if necessary, to the FAC and the Board for their respective approvals.

At the December 1, 2022, meeting, the Board approved changes to CalOptima Health Policy GA.3400: Annual Investments for Calendar Year (CY) 2023. The policy was revised to clarify that floating rate securities should be comparable to fixed rate securities and that the maximum term allowed for commercial paper per the California Government Code (Code) is 40%.

Discussion
Payden & Rygel and MetLife Investment Management, CalOptima Health's investment managers, and Meketa Investment Group, Inc., CalOptima Health's investment adviser, submitted proposed revisions to CalOptima Health Policy GA.3400: Annual Investments for CY 2024. Staff has reviewed the proposed revisions and recommends approval of the following modifications.

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

Policy Section	Proposed Change	Rationale	Impact
III.D.2.k.iv	Delete "stated final maturity" from column "Term Assigned" in the table	Redundant language; already included in section III.F.1	None
III.D.2.l.ii.a)	Delete "from the date of purchase" under permitted variable and floating rate securities	Redundant language; already included in section III.F.1	None
III.D.2.m.i.d) and e)	Add "European Bank for Reconstruction and	Both investments are considered high quality	None

Back to Agenda

Policy Section	Proposed Change	Rationale	Impact
	Development (EBRD)" and "European Investment Bank (EIB)" as eligible investments	additions that will expand the rather limited universe of investment options and will provide opportunity for diversification without taking on added risk	
III.E.3	Change maximum percentage of investment portfolio for commercial paper from 25% to 30%	Increase provides more investment flexibility	None
III.F.1	Add "Any forward settlement that exceeds 45 days from the time of investment is prohibited" under maximum stated term	Updates current policy with new language from the Code that is helpful to include	None

At its October 23, 2023, meeting, the IAC recommended revising the maximum percentage of the investment portfolio at the time of purchase for commercial paper from 25% to 30% to provide increased investment flexibility for CalOptima Health's investment managers.

Fiscal Impact
There is no immediate fiscal impact.

Rationale for Recommendation
The proposed changes to CalOptima Health Policy GA.3400: Annual Investments reflect the recommendations of CalOptima Health's investment managers, Payden & Rygel and MetLife Investment Management, with concurrence from CalOptima Health's investment adviser, Meketa Investment Group, Inc, and a recommendation from the IAC. These recommended changes continue to support CalOptima Health's goals to maintain safety of principal and achieve a market rate of return, while maintaining necessary liquidity during periods of uncertainty. Per the review conducted by Meketa Investment Group, Inc., there were no changes in the Code affecting local agencies noted for CY 2024.

Concurrence
Meketa Investment Group, Inc.
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Investment Advisory Committee
Board of Directors' Finance and Audit Committee

Back to Agenda

Attachments

1. Policy GA.3400: Annual Investment Policy – redline and clean versions

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

Policy:	GA.3400
Title:	**Annual Investments**
Department:	CalOptima Health Administrative
Section:	Finance
CEO Approval:	*/s/*
Effective Date:	01/01/2018
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy sets forth the investment guidelines for all Operating Funds and Board-Designated Reserve Funds of CalOptima Health invested on or after January 10, 2006, to ensure CalOptima Health's funds are prudently invested according to the Board of Directors' objectives and the California Government Code to preserve Capital, provide necessary Liquidity, and achieve a market-average Rate of Return through Economic Cycles. Each annual review takes effect upon its adoption by the Board of Directors.

II. POLICY

A. CalOptima Health investments may only be made as authorized by this Policy.

1. This Policy shall conform to California Government Code, Section 53600 et seq. (hereinafter, the Code) as well as customary standards of prudent investment management. Should the provisions of the Code be, or become, more restrictive than those contained herein, such provisions shall be considered immediately incorporated into this Policy and adhered to.

2. Safety of Principal: Safety of Principal is the primary objective of CalOptima Health and, as such, each investment transaction shall seek to ensure that large Capital losses are avoided from securities or Broker-Dealer default.

   a. CalOptima Health shall seek to ensure that Capital losses are minimized from the erosion of market value and preserve principal by mitigating the two (2) types of Risk: Credit Risk and Market Risk.

      i. Credit Risk shall be mitigated by investing in only permitted investments and by diversifying the Investment Portfolio, in accordance with this Policy.

      ii. Market Risk shall be mitigated by matching Maturity Dates, to the extent possible, with CalOptima Health's expected cash flow needs and other factors.

   b. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

3. Liquidity: Liquidity is the second most important objective of CalOptima Health. It is important that each portfolio contain investments for which there is a secondary market, and

Back to Item

Back to Agenda

which offer the flexibility to be easily sold at any time with minimal Risk of loss of either the principal or interest based upon then prevailing rates.

4. Total Return: CalOptima Health's Investment Portfolios shall be designed to attain a market-average Rate of Return through Economic Cycles given an acceptable level of Risk, established by the Board of Directors' and the CalOptima Health Treasurer's objectives.

   a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices as primary Benchmark, and Custom Peer Group Reports, as necessary, for short-term investments of comparable Risk and duration.

      i. These performance Benchmarks shall be reviewed monthly by CalOptima Health staff, and quarterly by CalOptima Health's Treasurer and the Investment Advisory Committee members and shall be reported to the Board of Directors.

B. The investments purchased by an Investment Manager shall be held by the Custodian Bank acting as the agent of CalOptima Health under the terms of a custody agreement in compliance with California Government Code, Section 53608.

C. Investment Managers must certify that they will purchase securities from Broker-Dealers (other than themselves) or financial institutions in compliance with California Government Code, Section 53601.5 and this Policy.

D. The Board of Directors, or persons authorized to make investment decisions on behalf of CalOptima Health (e.g., Chief Officers), are trustees and fiduciaries subject to the Prudent Person Standard, as defined in the Code, which shall be applied in the context of managing an overall portfolio.

E. CalOptima Health's Officers, employees, Board members, and Investment Advisory Committee members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to fulfill their roles in the investment process.

   1. CalOptima Health's Officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with CalOptima Health, and are not permitted to have any personal financial, or investment holdings, that could be materially related to the performance of CalOptima Health's investments.

F. On an annual basis, CalOptima Health's Treasurer shall provide the Board of Directors with this Policy for review and adoption by the Board, to ensure that all investments made ~~are following~~follow this Policy.

   1. This Policy shall be reviewed annually by the Board of Directors at a public meeting pursuant to California Government Code, Section 53646, Subdivision (a).

   2. This policy may only be changed by the Board of Directors.

III. PROCEDURE

A. Delegation of Authority

   1. The Authority to manage CalOptima Health's investment program is derived from an order of the Board of Directors.

a. Management responsibility for the investment program shall be delegated to CalOptima Health's Treasurer, as appointed by the Board of Directors, for a one (1)-year period following the approval of this Policy.

i. The Board of Directors may renew the delegation of authority annually.

b. No person may engage in investment transactions except as provided under the terms of this Policy and the procedures established by CalOptima Health's Treasurer.

B. CalOptima Health Treasurer Responsibilities

1. The Treasurer shall be responsible for:

a. All actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board-approved Investment Managers;

b. The oversight of CalOptima Health's Investment Portfolio;

c. Directing CalOptima Health's investment program and for compliance with this Policy pursuant to the delegation of authority to invest funds or to sell or exchange securities; and

d. Providing a quarterly report to the Board of Directors in accordance with California Government Code, Section 53646, Subdivision (b).

2. The Treasurer shall also be responsible for ensuring that:

a. The Operating Funds and Board-Designated Reserve Funds targeted average maturities are established and reviewed monthly.

b. All Investment Managers are provided a copy of this Policy, which shall be appended to an Investment Manager's investment contract.

i. Any investments made by an Investment Manager outside this Policy may subject the Investment Manager to termination for cause or other appropriate remedies or sanctions, as determined by the Board of Directors.

c. Investment diversification and portfolio performance is reviewed monthly to ensure that Risk levels and returns are reasonable and that investments are diversified in accordance with this Policy.

d. All Investment Managers are selected and evaluated for review by the Chief Executive Officer and the Board of Directors.

C. Investment Advisory Committee

1. The Investment Advisory Committee shall not make, or direct, CalOptima Health staff to make any particular investment, purchase any particular investment product, or conduct business with any particular investment companies, or brokers.

a. It shall not be the purpose of the Investment Advisory Committee to advise on particular investment decisions of CalOptima Health.

2. The Investment Advisory Committee shall be responsible for the following functions:

   a. Annual review of this Policy before its consideration by the Board of Directors and revision recommendations, as necessary, to the Finance and Audit Committee of the Board of Directors.

   b. Quarterly review of CalOptima Health's Investment Portfolio for conformance with this Policy's diversification and maturity guidelines, and recommendations to the Finance and Audit Committee of the Board of Directors, as appropriate.

   c. Provision of comments to CalOptima Health's staff regarding potential investments and potential investment strategies.

   d. Performance of such additional duties and responsibilities pertaining to CalOptima Health's investment program as may be required from time to time by specific action and direction of the Board of Directors.

D. Permitted Investments

1. CalOptima Health shall invest only in Instruments as permitted by the Code, subject to the limitations of this Policy.

   a. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of three (3) years. Note that the Code allows for up to five (5) years.

   b. Permitted investments under the Board-Designated Reserve Funds, unless otherwise specified, are subject to a maximum stated term of five (5) years. Note that the Code allows for up to five (5) years.

   c. The Board of Directors must grant express written authority to make an investment, or to establish an investment program, of a longer term.

2. Permitted investments shall include:

   a. U.S. Treasuries

      i. These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

      ii. U.S. Government securities include:

         a) Treasury Bills: U.S. Government securities issued and traded at a discount;

         b) Treasury Notes and Bonds: Interest bearing debt obligations of the U.S. Government which guarantees interest and principal payments;

         c) Treasury Separate Trading of Registered Interest and Principal Securities (STRIPS): U.S. Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system;

d) Treasury Inflation Protected (TIPs) securities: Special U.S. Treasury notes, or Bonds, that offer protection from Inflation. Coupon payments and underlying principal are automatically increased to compensate for Inflation, as measured by the Consumer Price Index (CPI); and

e) Treasury Floating Rate Notes (FRNs): U.S. Treasury Bonds issued with a variable coupon.

iii. U.S. Treasury coupon and principal STRIPS, as well as TIPs, are not considered to be derivatives for the purposes of this Policy and are, therefore, permitted investments pursuant to this Policy.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

b. Federal Agencies and U.S. Government Sponsored Enterprises

i. These investments represent obligations, participations, or other Instruments of, or issued by, a federal agency or a U.S. government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers.

ii. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (e.g., housing, agriculture). Often simply referred to as "Agencies," the following are specifically allowed:

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

j) U.S. Department of Housing & Urban Development;

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

m) Federal Deposit Insurance Corporation (FDIC)-backed Structured Sale Guaranteed Notes (SSGNs); and

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

iv. Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or Rated F1 by Fitch, or equivalent or better for short-term obligations, or an "A-" rating or its equivalent or better by a Nationally Recognized Statistical Rating Organization (NRSRO) for long-term obligations. Public agency Bonds issued for private purposes (e.g., industrial development Bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

d. Banker's Acceptances

i. Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the Banker's Acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances:

a) Are eligible for purchase by the Federal Reserve System and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	180 days	180 days

Fund Type	Term Assigned	Term Allowed by the Code
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 180 days 180 days	 180 days 180 days

e. Commercial Paper (CP)

i. CP is negotiable (i.e., marketable or transferable), although it is typically held to maturity. The maximum maturity is two hundred seventy (270) days, with most CP issued for terms of less than thirty (30) days. CP must meet the following criteria:

a) CP of "prime" quality, rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term by Moody's, or are comparably rated by a nationally recognized statistical rating organization (NRSRO);

b) The entity that issues the CP shall meet all of the following conditions in either paragraph (1) or (2):

(1) The entity meets the following criteria:

(A) Is organized and operating in the United States as a general corporation.

(B) Has total assets in excess of five hundred million dollars ($500,000,000).

(C) Has debt other than commercial paper, if any, that is rated in a Rating Category of "A" or its equivalent or higher by an NRSRO.

(2) The entity meets the following criteria:

(A) Is organized within the United States as a special purpose corporation, trust, or limited liability company.

(B) Has program wide credit enhancements including, but not limited to, overcollateralization, letters of credit, or a surety bond.

(C) Has commercial paper that is rated "A-1" or higher, or the equivalent, by an NRSRO; and

c) May not represent more than ten percent (10%) of the outstanding CP of the issuing corporation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	270 days	270 days
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 270 days 270 days	 270 days 270 days

f. Negotiable Certificates of Deposit

i. Negotiable Certificates of Deposit must be issued by a Nationally- or state-chartered bank, or state or federal association or by a state licensed branch of a foreign bank, which have been rated F1 or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	1 year	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 1 year 1 year	 5 years 5 years

g. Repurchase Agreements

i. U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary Broker-Dealer subject to the Securities Investors Protection Act, or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured, and unguaranteed obligation rated P-1 short-term, or A-2 long-term, or better, by Moody's, and A-1 short-term, or A long-term, or better, by Standard & Poor's, and F1 short-term, or A long-term or better by Fitch Ratings Service provided:

a) A Broker-Dealer master repurchase agreement signed by the Investment Manager (acting as "Agent") and approved by CalOptima Health;

b) The securities are held free and clear of any Lien by CalOptima Health's custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined Capital, Surplus and undivided profits of not less than fifty million dollars ($50,000,000) and the custodian receives written confirmation from such third party that it holds such securities, free and clear of any Lien, as agent for CalOptima Health's custodian;

c) A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at Title 31, Code of Federal Regulations, Section 306.1 et seq., and such securities are created for the benefit of CalOptima Health's custodian and CalOptima Health; and

d) The Agent will notify CalOptima Health's custodian and CalOptima Health if the Valuation of the Collateral Securities falls outside of policy. Upon direction by the CalOptima Health Treasurer, the Agent will liquidate the Collateral Securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such Valuation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	30 days	1 year

Fund Type	Term Assigned	Term Allowed by the Code
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 30 days 30 days	 1 year 1 year

iii. Reverse Repurchase Agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible Corporate Securities shall be rated in a Rating Category of "A" or its equivalent or better by an NRSRO and:

a) Be issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state and operating within the U.S. and have total assets in excess of five hundred million dollars ($500,000,000), and

b) May not represent more than ten percent (10%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to CP, i.e., Medium Term Notes (MTNs).

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

i. Money Market Funds

i. Shares of beneficial interest issued by diversified management companies (i.e., money market funds):

a) Which are rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services; and

b) Such investment may not represent more than ten percent (10%) of the money market fund's assets.

j. Joint Powers Authority Pool

i. A joint powers authority formed pursuant to California Government Code; Section 6509.7 may issue shares of beneficial interest to participating public agencies. The joint powers authority issuing the shares shall have retained an Investment Advisor that meets all of the following criteria:

a) Registered or exempt from registration with the Securities and Exchange Commission;

b) No less than five (5) years of experience investing in the securities and obligations authorized in the Code; and

c) Assets under management in excess of five hundred million dollars ($500,000,000).

ii. A Joint Powers Authority Pool shall be rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services.

iii. Such an investment may not represent more than ten percent (10%) of the Joint Powers Authority Pool's assets.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	Not Applicable	Not Applicable
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 Not Applicable Not Applicable	 Not Applicable Not Applicable

k. Mortgage or Asset-backed Securities

i. Pass-through securities are Instruments by which the cash flow from the mortgages, receivables, or other assets underlying the security, is passed-through as principal and interest payments to the investor.

ii. Though these securities may contain a third-party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt Instruments have assets (e.g., leases or consumer receivables) pledged to support the debt service.

iii. Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which:

a) Are rated AA or its equivalent or better by an NRSRO.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years ~~stated final maturity~~ 5 years ~~stated final maturity~~	 5 years 5 years

l. Variable and Floating Rate Securities

i. Variable and floating rate securities are appropriate investments when used to enhance yield and reduce Risk.

a) They should have the same stability, Liquidity, and quality as comparable fixed rate securities.

b) A variable rate security provides for the automatic establishment of a new interest rate on pre-determined reset dates.

c) For the purposes of this Policy, a variable rate security and floating rate security shall be deemed to have a maturity equal to the period remaining to that pre-determined interest rate reset date, so long as no investment shall be made in a security that at the time of the investment has a term remaining to a stated final maturity in excess of five (5) years.

ii. Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, Corporate Securities, Mortgage or Asset-backed Securities, Negotiable Certificates of Deposit, and Municipal Bonds (State and California Local Agency Obligations) must utilize a single, market-determined short-term index rate, such as U. S. Treasury bills, federal funds, CP, London Interbank Offered Rate (LIBOR), the Secured Overnight Financing Rate (SOFR), or Securities Industry and Financial Markets Association (SIFMA) that is pre-determined at the time of issuance of the security.

a) Permitted variable and floating rate securities that have an embedded unconditional put option must have a stated final maturity of the security no greater than five (5) years ~~from the date of purchase.~~.

b) Investments in floating rate securities whose reset is calculated using more than one (1) of the above indices are not permitted, i.e., dual index notes.

c) Ratings for variable and floating rate securities shall be limited to the same minimum ratings as applied to the appropriate asset security class outlined elsewhere in this Policy.

iii. Maximum Term:

Fund Type	**Term Assigned**	**Term Allowed by the Code**
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

m. Supranational Obligations

i. The five~~three~~ (5~~3~~) Supranational Institutions that issue, or unconditionally guarantee, obligations that are eligible investments are:

a) International Bank for Reconstruction and Development (IBRD);

b) International Finance Corporation (IFC); ~~and~~

c) Inter-American Development Bank (IADB~~).~~);

d) European Bank for Reconstruction and Development (EBRD); and

e) European Investment Bank (EIB).

ii. Supranational obligations shall be rated in a Rating Category of "AA" or its equivalent or better by a Nationally Statistical Rating Organization (NRSRO).

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

n. Pooled Investments

i. Pooled investments include deposits, or investments pooled with those of other local agencies consistent with the requirements of California Government Code, Section 53635 et seq. Such pools may contain a variety of investments but are limited to those permissible under the Code.

E. Diversification Guidelines

1. Diversification guidelines ensure the portfolio is not unduly concentrated in the securities of one (1) type, industry, or entity, thereby assuring adequate portfolio Liquidity should one (1) sector or company experience difficulties.

2. CalOptima Health's Investment Managers must review the respective portfolios they manage to ensure compliance with CalOptima Health's diversification guidelines on a continuous basis.

3. *Table 1: Maximum Percentage (%) of Investment Portfolio, by Instrument Type*

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100% (Code)
B. Federal Agencies and U.S. Government Sponsored Enterprises	100% (Code)
C. State and California Local Agency Obligations	40% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)
E. Commercial Paper	30~~25~~% (Code 40%[1])
F. Negotiable Certificates of Deposit	30% (Code)
G. Repurchase Agreements	100% (Code)
H. Corporate Securities	30% (Code)
I. Money Market Funds	20% (Code)
J. Joint Powers Authority Pool	100% (Code)
K. Mortgage or Asset-backed Securities	20% (Code)
L. Variable and Floating Rate Securities	30% (Code)
M. Supranational Obligations	30% (Code)

[1] The Code allows up to 40% for Pooled Funds and Non-Pooled Funds with a minimum $100,000,000 of investments. The Maximum Allocation is limited to 25% for Non-Pooled Funds with under $100,000,000 of investments.

4. Issuer or Counterparty Diversification Guidelines: The percentages specified below shall be adhered to on the basis of the entire portfolio:

    a. Any one (1) Federal Agency or Government Sponsored Enterprise: None

    b. Any one (1) repurchase agreement counterparty name:

        If maturity/term is ≤ 7 days: 50%
        If maturity/term is > 7 days: 25%

5. Issuer or Counterparty Diversification Guidelines for all other permitted investments described in Section III.D.2.a-n. of this Policy.

    a. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum issuer limits apply at the deal level with each securitized trust being considered a unique "issuer."

    b. Except for U.S. Government or Agency securities, no more than five percent (5%) of the Portfolio's market value will be invested in securities of a single issuer.

6. Each Investment Manager shall adhere to the diversification limits discussed in this subsection.

    a. If an Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform CalOptima Health's Treasurer and Investment Advisory consultant (if any) by close of business on the day of the occurrence.

    b. Within the parameters authorized by the Code, the Investment Advisory Committee recognizes the practicalities of portfolio management, securities maturing and changing status, and market volatility, and, as such, will consider breaches in the context of.

        i. The amount in relation to the total portfolio concentration;

        ii. Market and security specific conditions contributing to a breach of this Policy; and

        iii. The Investment Managers' actions to enforce the spirit of this Policy and decisions made in the best interest of the portfolio.

F. Maximum Stated Term

1. Maximum stated terms for permitted investments shall be determined based on the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security. Any forward settlement that exceeds 45 days from the time of investment is prohibited.

G. Rating Downgrades

1. CalOptima Health may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this Policy.

2. If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify CalOptima Health's Treasurer, or Designee, within two (2) business days of the downgrade.

a. A decision to retain a downgraded security shall be approved by CalOptima Health's Treasurer, or Designee, within five (5) business days of the downgrade.

H. Investment Restrictions

1. Investment securities shall not be lent to an Investment Manager, or Broker-Dealer.

2. The Investment Portfolio or Investment Portfolios, managed by an Investment Manager, shall not be used as collateral to obtain additional investable funds.

3. Any investment not specifically referred to herein shall be considered a prohibited investment.

4. CalOptima Health reserves the right to prohibit its Investment Managers from making investments in organizations which have a line of business that conflicts with the interests of public health, as determined by the Board of Directors.

5. CalOptima Health reserves the right to prohibit investments in organizations with which it has a business relationship through contracting, purchasing, or other arrangements.

6. Except as expressly permitted by this Policy, investments in derivative securities shall not be allowed.

7. A list of prohibited investments does not currently exist, however, the Board of Directors shall provide CalOptima Health's Treasurer, Investment Managers, Investment Advisory consultant, and Investment Advisory Committee with a list, should such a list be adopted by CalOptima Health in the future, of organizations that do not comply with this Policy and shall immediately notify CalOptima Health's Treasurer, Investment Managers, Investment Advisory consultant and Investment Advisory Committee of any changes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

~~A.~~ California Government Code, §~~6509.7~~
~~B.~~A. ~~California Government Code, §~~53600 et seq.
~~C.~~B. California Government Code, §53601(h), (k), (q)
~~D.~~C. California Government Code, §53635 et seq.
~~E.~~D. California Government Code. §53646, Subdivision (a) and Subdivision (b)
E. California Government Code, §6509.7
F. California Government Code, §16430(m)
~~F.~~G. Title 31, Code of Federal Regulations (C.F.R.), §306.1 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/30/2017	Special Meeting of the CalOptima Investment Advisory Committee

Date	Meeting
11/16/2017	Regular Meeting of the CalOptima Finance and Audit Committee
12/07/2017	Regular Meeting of the CalOptima Board of Directors
11/05/2018	Special Meeting of the CalOptima Investment Advisory Committee
11/15/2018	Regular Meeting of the CalOptima Finance and Audit Committee
12/06/2018	Regular Meeting of the CalOptima Board of Directors
10/21/2019	Regular Meeting of the CalOptima Investment Advisory Committee
11/15/2019	Regular Meeting of the CalOptima Finance and Audit Committee
12/05/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
10/19/2020	Regular Meeting of the CalOptima Investment Advisory Committee
11/19/2020	Regular Meeting of the CalOptima Finance and Audit Committee
12/03/2020	Regular Meeting of the CalOptima Board of Directors
10/25/2021	Regular Meeting of the CalOptima Investment Advisory Committee
11/18/2021	Regular Meeting of the CalOptima Finance and Audit Committee
12/20/2021	Special Meeting of the CalOptima Board of Directors
10/24/2022	Regular Meeting of the CalOptima Health Investment Advisory Committee
11/17/2022	Regular Meeting of the CalOptima Health Finance and Audit Committee
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
10/23/2023	Regular Meeting of the CalOptima Health Investment Advisory Committee
11/16/2023	Regular Meeting of the CalOptima Health Finance and Audit Committee
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2018	GA.3400	Annual Investments	Administrative
Revised	01/01/2019	GA.3400	Annual Investments	Administrative
Revised	01/01/2020	GA.3400	Annual Investments	Administrative
Revised	06/04/2020	GA.3400	Annual Investments	Administrative
Revised	01/01/2021	GA.3400	Annual Investments	Administrative
Revised	01/01/2022	GA.3400	Annual Investments	Administrative
Revised	01/01/2023	GA.3400	Annual Investments	Administrative
Revised	TBD	GA.3400	Annual Investments	Administrative

IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: • Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and • May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, Risk and return of a portfolio.
Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working Capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues as specified by CalOptima Health Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows: 1. Tier One a. Used for the benefit and protection of CalOptima Health's long-term financial viability; b. Used to cover "Special Purposes" as defined in CalOptima Health Policy GA.3001: Board-Designated Reserve Funds; or c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements. 2. Tier Two a. Used to meet CalOptima Health's regulatory compliance requirements; or b. Currently defined as CalOptima Health's tangible net equity requirements as defined by Subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.

Term	Definition
Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.
CalOptima Health Treasurer	Appointed by CalOptima Health's Board of Directors, the treasurer is a person responsible for overseeing CalOptima Health's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima Health business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The Risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Custom Peer Group Report	Developed based on a small peer universe with similar investment guidelines. The Purpose of the report is to provide more accurate performance comparison.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Health Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Health Board of Directors with oversight responsibilities for all financial matters of CalOptima Health including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima Health program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial Instrument or asset that can be traded. These assets can be cash, Bonds, or shares in a company
Investment Advisor(s)	Registered or non-registered person or group that makes investment recommendations or conducts securities analysis in return for a fee.

Term	Definition
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Health Board of Directors who provide advice and recommendations regarding CalOptima Health's Investment Policies, Procedures and Practices.
Investment Manager(s)	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, Bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the Underlying Pool of Securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The Risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt Instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Nationally Recognized Statistical Ratings Organization (NRSRO)	A credit rating agency that the Securities and Exchange Commission in the United States registers and uses for regulatory purposes. Current NRSROs listed at www.sec.gov/ocr/ocr-current-nrsros.html.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima Health to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CalOptima Health's monthly capitation revenues from its State contracts. Disbursements from this fund to CalOptima Health's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the Liquidity needs of the agency (California Government Code, Section 53600.3)

Term	Definition
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial Instrument or asset. CalOptima Health's asset managers provide CalOptima Health with reporting that shows the Valuation of each financial Instrument that they own on behalf of CalOptima Health. Each asset manager uses a variety of market sources to determine individual Valuations.

1

Policy:	GA.3400
Title:	**Annual Investments**
Department:	CalOptima Health Administrative
Section:	Finance
CEO Approval:	*/s/*
Effective Date:	01/01/2018
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy sets forth the investment guidelines for all Operating Funds and Board-Designated Reserve Funds of CalOptima Health invested on or after January 10, 2006, to ensure CalOptima Health's funds are prudently invested according to the Board of Directors' objectives and the California Government Code to preserve Capital, provide necessary Liquidity, and achieve a market-average Rate of Return through Economic Cycles. Each annual review takes effect upon its adoption by the Board of Directors.

II. POLICY

A. CalOptima Health investments may only be made as authorized by this Policy.

1. This Policy shall conform to California Government Code, Section 53600 et seq. (hereinafter, the Code) as well as customary standards of prudent investment management. Should the provisions of the Code be, or become, more restrictive than those contained herein, such provisions shall be considered immediately incorporated into this Policy and adhered to.

2. Safety of Principal: Safety of Principal is the primary objective of CalOptima Health and, as such, each investment transaction shall seek to ensure that large Capital losses are avoided from securities or Broker-Dealer default.

   a. CalOptima Health shall seek to ensure that Capital losses are minimized from the erosion of market value and preserve principal by mitigating the two (2) types of Risk: Credit Risk and Market Risk.

      i. Credit Risk shall be mitigated by investing in only permitted investments and by diversifying the Investment Portfolio, in accordance with this Policy.

      ii. Market Risk shall be mitigated by matching Maturity Dates, to the extent possible, with CalOptima Health's expected cash flow needs and other factors.

   b. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

3. Liquidity: Liquidity is the second most important objective of CalOptima Health. It is important that each portfolio contain investments for which there is a secondary market, and

Back to Item

Back to Agenda

which offer the flexibility to be easily sold at any time with minimal Risk of loss of either the principal or interest based upon then prevailing rates.

4. Total Return: CalOptima Health's Investment Portfolios shall be designed to attain a market-average Rate of Return through Economic Cycles given an acceptable level of Risk, established by the Board of Directors' and the CalOptima Health Treasurer's objectives.

   a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices as primary Benchmark, and Custom Peer Group Reports, as necessary, for short-term investments of comparable Risk and duration.

      i. These performance Benchmarks shall be reviewed monthly by CalOptima Health staff, and quarterly by CalOptima Health's Treasurer and the Investment Advisory Committee members and shall be reported to the Board of Directors.

B. The investments purchased by an Investment Manager shall be held by the Custodian Bank acting as the agent of CalOptima Health under the terms of a custody agreement in compliance with California Government Code, Section 53608.

C. Investment Managers must certify that they will purchase securities from Broker-Dealers (other than themselves) or financial institutions in compliance with California Government Code, Section 53601.5 and this Policy.

D. The Board of Directors, or persons authorized to make investment decisions on behalf of CalOptima Health (e.g., Chief Officers), are trustees and fiduciaries subject to the Prudent Person Standard, as defined in the Code, which shall be applied in the context of managing an overall portfolio.

E. CalOptima Health's Officers, employees, Board members, and Investment Advisory Committee members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to fulfill their roles in the investment process.

   1. CalOptima Health's Officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with CalOptima Health, and are not permitted to have any personal financial, or investment holdings, that could be materially related to the performance of CalOptima Health's investments.

F. On an annual basis, CalOptima Health's Treasurer shall provide the Board of Directors with this Policy for review and adoption by the Board, to ensure that all investments made follow this Policy.

   1. This Policy shall be reviewed annually by the Board of Directors at a public meeting pursuant to California Government Code, Section 53646, Subdivision (a).

   2. This policy may only be changed by the Board of Directors.

III. PROCEDURE

A. Delegation of Authority

   1. The Authority to manage CalOptima Health's investment program is derived from an order of the Board of Directors.

a. Management responsibility for the investment program shall be delegated to CalOptima Health's Treasurer, as appointed by the Board of Directors, for a one (1)-year period following the approval of this Policy.

i. The Board of Directors may renew the delegation of authority annually.

b. No person may engage in investment transactions except as provided under the terms of this Policy and the procedures established by CalOptima Health's Treasurer.

B. CalOptima Health Treasurer Responsibilities

1. The Treasurer shall be responsible for:

a. All actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board-approved Investment Managers;

b. The oversight of CalOptima Health's Investment Portfolio;

c. Directing CalOptima Health's investment program and for compliance with this Policy pursuant to the delegation of authority to invest funds or to sell or exchange securities; and

d. Providing a quarterly report to the Board of Directors in accordance with California Government Code, Section 53646, Subdivision (b).

2. The Treasurer shall also be responsible for ensuring that:

a. The Operating Funds and Board-Designated Reserve Funds targeted average maturities are established and reviewed monthly.

b. All Investment Managers are provided a copy of this Policy, which shall be appended to an Investment Manager's investment contract.

i. Any investments made by an Investment Manager outside this Policy may subject the Investment Manager to termination for cause or other appropriate remedies or sanctions, as determined by the Board of Directors.

c. Investment diversification and portfolio performance is reviewed monthly to ensure that Risk levels and returns are reasonable and that investments are diversified in accordance with this Policy.

d. All Investment Managers are selected and evaluated for review by the Chief Executive Officer and the Board of Directors.

C. Investment Advisory Committee

1. The Investment Advisory Committee shall not make, or direct, CalOptima Health staff to make any particular investment, purchase any particular investment product, or conduct business with any particular investment companies, or brokers.

a. It shall not be the purpose of the Investment Advisory Committee to advise on particular investment decisions of CalOptima Health.

2. The Investment Advisory Committee shall be responsible for the following functions:

a. Annual review of this Policy before its consideration by the Board of Directors and revision recommendations, as necessary, to the Finance and Audit Committee of the Board of Directors.

b. Quarterly review of CalOptima Health's Investment Portfolio for conformance with this Policy's diversification and maturity guidelines, and recommendations to the Finance and Audit Committee of the Board of Directors, as appropriate.

c. Provision of comments to CalOptima Health's staff regarding potential investments and potential investment strategies.

d. Performance of such additional duties and responsibilities pertaining to CalOptima Health's investment program as may be required from time to time by specific action and direction of the Board of Directors.

D. Permitted Investments

1. CalOptima Health shall invest only in Instruments as permitted by the Code, subject to the limitations of this Policy.

a. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of three (3) years. Note that the Code allows for up to five (5) years.

b. Permitted investments under the Board-Designated Reserve Funds, unless otherwise specified, are subject to a maximum stated term of five (5) years. Note that the Code allows for up to five (5) years.

c. The Board of Directors must grant express written authority to make an investment, or to establish an investment program, of a longer term.

2. Permitted investments shall include:

a. U.S. Treasuries

i. These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

ii. U.S. Government securities include:

a) Treasury Bills: U.S. Government securities issued and traded at a discount;

b) Treasury Notes and Bonds: Interest bearing debt obligations of the U.S. Government which guarantees interest and principal payments;

c) Treasury Separate Trading of Registered Interest and Principal Securities (STRIPS): U.S. Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system;

d) Treasury Inflation Protected (TIPs) securities: Special U.S. Treasury notes, or Bonds, that offer protection from Inflation. Coupon payments and underlying

principal are automatically increased to compensate for Inflation, as measured by the Consumer Price Index (CPI); and

e) Treasury Floating Rate Notes (FRNs): U.S. Treasury Bonds issued with a variable coupon.

iii. U.S. Treasury coupon and principal STRIPS, as well as TIPs, are not considered to be derivatives for the purposes of this Policy and are, therefore, permitted investments pursuant to this Policy.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

b. Federal Agencies and U.S. Government Sponsored Enterprises

i. These investments represent obligations, participations, or other Instruments of, or issued by, a federal agency or a U.S. government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers.

ii. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (e.g., housing, agriculture). Often simply referred to as "Agencies," the following are specifically allowed:

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

j) U.S. Department of Housing & Urban Development;

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

m) Federal Deposit Insurance Corporation (FDIC)-backed Structured Sale Guaranteed Notes (SSGNs); and

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

iv. Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or Rated F1 by Fitch, or equivalent or better for short-term obligations, or an "A-" rating or its equivalent or better by a Nationally Recognized Statistical Rating Organization (NRSRO) for long-term obligations. Public agency Bonds issued for private purposes (e.g., industrial development Bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

d. Banker's Acceptances

i. Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the Banker's Acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances:

a) Are eligible for purchase by the Federal Reserve System and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	180 days	180 days

Fund Type	Term Assigned	Term Allowed by the Code
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 180 days 180 days	 180 days 180 days

e. Commercial Paper (CP)

i. CP is negotiable (i.e., marketable or transferable), although it is typically held to maturity. The maximum maturity is two hundred seventy (270) days, with most CP issued for terms of less than thirty (30) days. CP must meet the following criteria:

a) CP of "prime" quality, rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term by Moody's, or are comparably rated by a nationally recognized statistical rating organization (NRSRO);

b) The entity that issues the CP shall meet all of the following conditions in either paragraph (1) or (2):

(1) The entity meets the following criteria:

(A) Is organized and operating in the United States as a general corporation.

(B) Has total assets in excess of five hundred million dollars ($500,000,000).

(C) Has debt other than commercial paper, if any, that is rated in a Rating Category of "A" or its equivalent or higher by an NRSRO.

(2) The entity meets the following criteria:

(A) Is organized within the United States as a special purpose corporation, trust, or limited liability company.

(B) Has program wide credit enhancements including, but not limited to, overcollateralization, letters of credit, or a surety bond.

(C) Has commercial paper that is rated "A-1" or higher, or the equivalent, by an NRSRO; and

c) May not represent more than ten percent (10%) of the outstanding CP of the issuing corporation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	270 days	270 days
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 270 days 270 days	 270 days 270 days

f. Negotiable Certificates of Deposit

i. Negotiable Certificates of Deposit must be issued by a Nationally- or state-chartered bank, or state or federal association or by a state licensed branch of a foreign bank, which have been rated F1 or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	1 year	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 1 year 1 year	 5 years 5 years

g. Repurchase Agreements

i. U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary Broker-Dealer subject to the Securities Investors Protection Act, or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured, and unguaranteed obligation rated P-1 short-term, or A-2 long-term, or better, by Moody's, and A-1 short-term, or A long-term, or better, by Standard & Poor's, and F1 short-term, or A long-term or better by Fitch Ratings Service provided:

a) A Broker-Dealer master repurchase agreement signed by the Investment Manager (acting as “Agent”) and approved by CalOptima Health;

b) The securities are held free and clear of any Lien by CalOptima Health's custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined Capital, Surplus and undivided profits of not less than fifty million dollars ($50,000,000) and the custodian receives written confirmation from such third party that it holds such securities, free and clear of any Lien, as agent for CalOptima Health's custodian;

c) A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at Title 31, Code of Federal Regulations, Section 306.1 et seq., and such securities are created for the benefit of CalOptima Health's custodian and CalOptima Health; and

d) The Agent will notify CalOptima Health's custodian and CalOptima Health if the Valuation of the Collateral Securities falls outside of policy. Upon direction by the CalOptima Health Treasurer, the Agent will liquidate the Collateral Securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such Valuation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	30 days	1 year
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 30 days 30 days	 1 year 1 year

iii. Reverse Repurchase Agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible Corporate Securities shall be rated in a Rating Category of "A" or its equivalent or better by an NRSRO and:

a) Be issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state and operating within the U.S. and have total assets in excess of five hundred million dollars ($500,000,000), and

b) May not represent more than ten percent (10%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to CP, i.e., Medium Term Notes (MTNs).

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

i. Money Market Funds

i. Shares of beneficial interest issued by diversified management companies (i.e., money market funds):

a) Which are rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services; and

b) Such investment may not represent more than ten percent (10%) of the money market fund's assets.

j. Joint Powers Authority Pool

i. A joint powers authority formed pursuant to California Government Code; Section 6509.7 may issue shares of beneficial interest to participating public agencies. The joint powers authority issuing the shares shall have retained an Investment Advisor that meets all of the following criteria:

a) Registered or exempt from registration with the Securities and Exchange Commission;

b) No less than five (5) years of experience investing in the securities and obligations authorized in the Code; and

c) Assets under management in excess of five hundred million dollars ($500,000,000).

ii. A Joint Powers Authority Pool shall be rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services.

iii. Such an investment may not represent more than ten percent (10%) of the Joint Powers Authority Pool's assets.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	Not Applicable	Not Applicable
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 Not Applicable Not Applicable	 Not Applicable Not Applicable

k. Mortgage or Asset-backed Securities

i. Pass-through securities are Instruments by which the cash flow from the mortgages, receivables, or other assets underlying the security, is passed-through as principal and interest payments to the investor.

ii. Though these securities may contain a third-party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt Instruments have assets (e.g., leases or consumer receivables) pledged to support the debt service.

iii. Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which:

a) Are rated AA or its equivalent or better by an NRSRO.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

l. Variable and Floating Rate Securities

i. Variable and floating rate securities are appropriate investments when used to enhance yield and reduce Risk.

a) They should have the same stability, Liquidity, and quality as comparable fixed rate securities.

b) A variable rate security provides for the automatic establishment of a new interest rate on pre-determined reset dates.

c) For the purposes of this Policy, a variable rate security and floating rate security shall be deemed to have a maturity equal to the period remaining to that pre-determined interest rate reset date, so long as no investment shall be made in a security that at the time of the investment has a term remaining to a stated final maturity in excess of five (5) years.

ii. Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, Corporate Securities, Mortgage or Asset-backed Securities, Negotiable Certificates of Deposit, and Municipal Bonds (State and California Local Agency Obligations) must utilize a single, market-determined short-term index rate, such as U. S. Treasury bills, federal funds, CP, London Interbank Offered Rate (LIBOR), the Secured Overnight Financing Rate (SOFR), or Securities Industry and Financial Markets Association (SIFMA) that is pre-determined at the time of issuance of the security.

a) Permitted variable and floating rate securities that have an embedded unconditional put option must have a stated final maturity of the security no greater than five (5) years.

b) Investments in floating rate securities whose reset is calculated using more than one (1) of the above indices are not permitted, i.e., dual index notes.

c) Ratings for variable and floating rate securities shall be limited to the same minimum ratings as applied to the appropriate asset security class outlined elsewhere in this Policy.

iii. Maximum Term:

Fund Type	**Term Assigned**	**Term Allowed by the Code**
Operating Funds	3 years	5 years
Board-Designated Reserve Funds		
▪ Tier One (1)	5 years	5 years
▪ Tier Two (2)	5 years	5 years

m. Supranational Obligations

i. The five (5) Supranational Institutions that issue, or unconditionally guarantee, obligations that are eligible investments are:

a) International Bank for Reconstruction and Development (IBRD);

b) International Finance Corporation (IFC);

c) Inter-American Development Bank (IADB);

d) European Bank for Reconstruction and Development (EBRD); and

e) European Investment Bank (EIB).

ii. Supranational obligations shall be rated in a Rating Category of "AA" or its equivalent or better by a Nationally Statistical Rating Organization (NRSRO).

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

n. Pooled Investments

i. Pooled investments include deposits, or investments pooled with those of other local agencies consistent with the requirements of California Government Code, Section 53635 et seq. Such pools may contain a variety of investments but are limited to those permissible under the Code.

E. Diversification Guidelines

1. Diversification guidelines ensure the portfolio is not unduly concentrated in the securities of one (1) type, industry, or entity, thereby assuring adequate portfolio Liquidity should one (1) sector or company experience difficulties.

2. CalOptima Health's Investment Managers must review the respective portfolios they manage to ensure compliance with CalOptima Health's diversification guidelines on a continuous basis.

3. *Table 1: Maximum Percentage (%) of Investment Portfolio, by Instrument Type*

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100% (Code)
B. Federal Agencies and U.S. Government Sponsored Enterprises	100% (Code)
C. State and California Local Agency Obligations	40% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)
E. Commercial Paper	30% (Code 40%[1])
F. Negotiable Certificates of Deposit	30% (Code)
G. Repurchase Agreements	100% (Code)
H. Corporate Securities	30% (Code)
I. Money Market Funds	20% (Code)
J. Joint Powers Authority Pool	100% (Code)
K. Mortgage or Asset-backed Securities	20% (Code)
L. Variable and Floating Rate Securities	30% (Code)
M. Supranational Obligations	30% (Code)

4. Issuer or Counterparty Diversification Guidelines: The percentages specified below shall be adhered to on the basis of the entire portfolio:

a. Any one (1) Federal Agency or Government Sponsored Enterprise: None

[1] The Code allows up to 40% for Pooled Funds and Non-Pooled Funds with a minimum $100,000,000 of investments. The Maximum Allocation is limited to 25% for Non-Pooled Funds with under $100,000,000 of investments.

b. Any one (1) repurchase agreement counterparty name:

If maturity/term is ≤ 7 days: 50%
If maturity/term is > 7 days: 25%

5. Issuer or Counterparty Diversification Guidelines for all other permitted investments described in Section III.D.2.a-n. of this Policy.

a. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum issuer limits apply at the deal level with each securitized trust being considered a unique "issuer."

b. Except for U.S. Government or Agency securities, no more than five percent (5%) of the Portfolio's market value will be invested in securities of a single issuer.

6. Each Investment Manager shall adhere to the diversification limits discussed in this subsection.

a. If an Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform CalOptima Health's Treasurer and Investment Advisory consultant (if any) by close of business on the day of the occurrence.

b. Within the parameters authorized by the Code, the Investment Advisory Committee recognizes the practicalities of portfolio management, securities maturing and changing status, and market volatility, and, as such, will consider breaches in the context of.

i. The amount in relation to the total portfolio concentration;

ii. Market and security specific conditions contributing to a breach of this Policy; and

iii. The Investment Managers' actions to enforce the spirit of this Policy and decisions made in the best interest of the portfolio.

F. Maximum Stated Term

1. Maximum stated terms for permitted investments shall be determined based on the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security. Any forward settlement that exceeds 45 days from the time of investment is prohibited.

G. Rating Downgrades

1. CalOptima Health may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this Policy.

2. If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify CalOptima Health's Treasurer, or Designee, within two (2) business days of the downgrade.

a. A decision to retain a downgraded security shall be approved by CalOptima Health's Treasurer, or Designee, within five (5) business days of the downgrade.

H. Investment Restrictions

1. Investment securities shall not be lent to an Investment Manager, or Broker-Dealer.

2. The Investment Portfolio or Investment Portfolios, managed by an Investment Manager, shall not be used as collateral to obtain additional investable funds.

3. Any investment not specifically referred to herein shall be considered a prohibited investment.

4. CalOptima Health reserves the right to prohibit its Investment Managers from making investments in organizations which have a line of business that conflicts with the interests of public health, as determined by the Board of Directors.

5. CalOptima Health reserves the right to prohibit investments in organizations with which it has a business relationship through contracting, purchasing, or other arrangements.

6. Except as expressly permitted by this Policy, investments in derivative securities shall not be allowed.

7. A list of prohibited investments does not currently exist, however, the Board of Directors shall provide CalOptima Health's Treasurer, Investment Managers, Investment Advisory consultant, and Investment Advisory Committee with a list, should such a list be adopted by CalOptima Health in the future, of organizations that do not comply with this Policy and shall immediately notify CalOptima Health's Treasurer, Investment Managers, Investment Advisory consultant and Investment Advisory Committee of any changes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Government Code, §53600 et seq.
B. California Government Code, §53601(h), (k), (q)
C. California Government Code, §53635 et seq.
D. California Government Code. §53646, Subdivision (a) and Subdivision (b)
E. California Government Code, §6509.7
F. California Government Code, §16430(m)
G. Title 31, Code of Federal Regulations (C.F.R.), §306.1 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/30/2017	Special Meeting of the CalOptima Investment Advisory Committee
11/16/2017	Regular Meeting of the CalOptima Finance and Audit Committee
12/07/2017	Regular Meeting of the CalOptima Board of Directors
11/05/2018	Special Meeting of the CalOptima Investment Advisory Committee
11/15/2018	Regular Meeting of the CalOptima Finance and Audit Committee

Date	Meeting
12/06/2018	Regular Meeting of the CalOptima Board of Directors
10/21/2019	Regular Meeting of the CalOptima Investment Advisory Committee
11/15/2019	Regular Meeting of the CalOptima Finance and Audit Committee
12/05/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
10/19/2020	Regular Meeting of the CalOptima Investment Advisory Committee
11/19/2020	Regular Meeting of the CalOptima Finance and Audit Committee
12/03/2020	Regular Meeting of the CalOptima Board of Directors
10/25/2021	Regular Meeting of the CalOptima Investment Advisory Committee
11/18/2021	Regular Meeting of the CalOptima Finance and Audit Committee
12/20/2021	Special Meeting of the CalOptima Board of Directors
10/24/2022	Regular Meeting of the CalOptima Health Investment Advisory Committee
11/17/2022	Regular Meeting of the CalOptima Health Finance and Audit Committee
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
10/23/2023	Regular Meeting of the CalOptima Health Investment Advisory Committee
11/16/2023	Regular Meeting of the CalOptima Health Finance and Audit Committee
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2018	GA.3400	Annual Investments	Administrative
Revised	01/01/2019	GA.3400	Annual Investments	Administrative
Revised	01/01/2020	GA.3400	Annual Investments	Administrative
Revised	06/04/2020	GA.3400	Annual Investments	Administrative
Revised	01/01/2021	GA.3400	Annual Investments	Administrative
Revised	01/01/2022	GA.3400	Annual Investments	Administrative
Revised	01/01/2023	GA.3400	Annual Investments	Administrative
Revised	TBD	GA.3400	Annual Investments	Administrative

IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: • Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and • May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, Risk and return of a portfolio.
Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working Capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues as specified by CalOptima Health Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows: 1. Tier One a. Used for the benefit and protection of CalOptima Health's long-term financial viability; b. Used to cover "Special Purposes" as defined in CalOptima Health Policy GA.3001: Board-Designated Reserve Funds; or c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements. 2. Tier Two a. Used to meet CalOptima Health's regulatory compliance requirements; or b. Currently defined as CalOptima Health's tangible net equity requirements as defined by Subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.

Term	Definition
Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.
CalOptima Health Treasurer	Appointed by CalOptima Health's Board of Directors, the treasurer is a person responsible for overseeing CalOptima Health's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima Health business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The Risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Custom Peer Group Report	Developed based on a small peer universe with similar investment guidelines. The Purpose of the report is to provide more accurate performance comparison.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Health Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Health Board of Directors with oversight responsibilities for all financial matters of CalOptima Health including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima Health program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial Instrument or asset that can be traded. These assets can be cash, Bonds, or shares in a company
Investment Advisor(s)	Registered or non-registered person or group that makes investment recommendations or conducts securities analysis in return for a fee.

Term	Definition
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Health Board of Directors who provide advice and recommendations regarding CalOptima Health's Investment Policies, Procedures and Practices.
Investment Manager(s)	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, Bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the Underlying Pool of Securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The Risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt Instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Nationally Recognized Statistical Ratings Organization (NRSRO)	A credit rating agency that the Securities and Exchange Commission in the United States registers and uses for regulatory purposes. Current NRSROs listed at www.sec.gov/ocr/ocr-current-nrsros.html.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima Health to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CalOptima Health's monthly capitation revenues from its State contracts. Disbursements from this fund to CalOptima Health's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the Liquidity needs of the agency (California Government Code, Section 53600.3)

Term	Definition
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial Instrument or asset. CalOptima Health's asset managers provide CalOptima Health with reporting that shows the Valuation of each financial Instrument that they own on behalf of CalOptima Health. Each asset manager uses a variety of market sources to determine individual Valuations.

1

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Approve Modifications to CalOptima Health PACE Policy PA. 6001 Medical Records Maintenance.

Contacts

Javier Sanchez, Executive Director, Operations Management, (714) 986-6115
Monica Macias, LCSW, PACE Director III, (714) 468-1077

Recommended Action

Authorize CalOptima Health's' Chief Executive Officer to approve revisions to Policy PA. 6001 Medical Records Maintenance in accordance with regulatory requirements.

Background

Approve recommended modifications to CalOptima Health PACE Policy PA.6001 Medical Records Maintenance in accordance with CalOptima Health PACE's regular review process and consistent with regulatory requirements.

Discussion

CalOptima Health PACE regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements, contractual obligations, and laws, as well as CalOptima Health PACE operations.

CalOptima Health PACE PA.6001 Medical Records Maintenance outlines and defines the standards that the CalOptima Health PACE Center is required to maintain and request medical records. Staff has updated the policy and provides a redline version outlining all the changes staff has made to the policy for the Board of Directors' approval.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation

Approval of CalOptima Health PACE Policy PA. 6001 ensures CalOptima Health is meeting regulatory requirements for maintenance of medical records.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Back to Agenda

Attachments

1. CalOptima Health PACE Policy PA.6001 Medical Records Maintenance (Redline and Clean versions)

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

Policy:	PA.6001
Title:	**Medical Records Maintenance**
Department:	CalOptima Health PACE
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/2013
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ~~☐ OneCare Connect~~ ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the minimum standards for maintaining the ~~medical record~~Medical Record of a CalOptima Health Program for All-Inclusive Care for the Elderly (PACE) Participant.

II. POLICY

A. CalOptima Health PACE shall establish and maintain ~~medical records~~Medical Records for a Participant that meet the required standards for maintenance and documentation of care as set forth in this Policy.

B. CalOptima Health PACE shall release a Participant's ~~medical records~~Medical Records, in accordance with the provisions of this policy and applicable statutory, regulatory, contractual, other CalOptima Health policies and requirements.

C. CalOptima Health PACE retains the ownership and assurance of accurate ~~medical records~~Medical Records of PACE Participants. CalOptima Health PACE shall protect and safeguard all ~~medical records~~Medical Records in an organized manner in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

III. PROCEDURE

A. Organization

1. Each PACE Center site shall have ~~a~~at least one (1) Program Specialist, Medical Records, or designee, as the individual(s) responsible for the ~~medical record~~Medical Record system by which the site collects, processes, maintains, stores, secures, retrieves, and distributes clinical information.

2. Active ~~medical records~~Medical Records shall be organized in a systematic filing method that facilitates retrieval upon demand.

3. Active ~~medical records~~Medical Records shall be stored in the electronic health record that protects the ~~medical records~~Medical Records from loss, tampering, alteration, or destruction.

Back to Item

Back to Agenda

4. Inactive ~~medical records~~Medical Records (through disenrollment or deceased) for a Participant shall be retained for ten (10) years.

    a. Inactive ~~medical records~~Medical Records may be stored in electronic or hard copy format.

    b. Inactive ~~medical records~~Medical Records shall be stored in a secured approved ~~medical record~~Medical Record storage location with restricted access that meets the same security requirements for active medical records.

    c. Inactive ~~medical records~~Medical Records shall be retrievable within thirty (30) business days, if necessary.

B. Format and Filing

1. An individual ~~medical record~~Medical Record shall be established for each Participant and shall be updated for each visit or encounter in accordance with the standards of documentation by each respective discipline that provides services to the Participant.

2. A Participant's ~~medical record~~Medical Record shall be legible, current, detailed, and organized ~~and~~in a comprehensive manner (records may be electronic or paper copies).

3. If paper-based, all documents shall be filed chronologically within the ~~medical record~~Medical Record with the Participant's name and the name of the site location for which that Participant is assigned on each document. Serial reports such as laboratory or x-ray reports may be filed in a segregated manner in chronological order. Documents must be secured in the folder to prevent loss.

4. Authorized discipline documentation into a Participant's ~~medical record~~Medical Record shall be completed by the end of the day for such encounter. Any deviation from this requirement shall be noted as a late entry in all capital letters and shall designate the actual date of the encounter for which the documentation entry refers.

5. All external reports shall be filed or entered into the ~~medical record~~Medical Record within forty-eight (48) hours after receipt of the report. Reports subject to this provision include, but are not limited to:

    a. Laboratory reports;

    b. Radiology and other imaging reports;

    c. Consultation reports;

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

    e. Emergency department reports, if available.

C. Content

1. A Participant's ~~medical record~~Medical Record shall reflect all aspects of patient care, including ancillary, and dental services. Each ~~medical record~~Medical Record shall comply with the requirements of Title 42 Code of Federal Regulation, §460.210(b) and include documentation of all services furnished as follows:

a. The identity of the Participant's PCP;

b. A summary of Emergency Care and other inpatient or long-term care services, including hospital discharge summaries for all hospital admissions;

c. Services furnished by employees of the PACE Center;

d. Services furnished by contractors and their reports;

e. A problem list, including significant illnesses and medical and psychological conditions;

f. Presenting subjective complaints, the objective findings, and the plan for diagnosis and treatment;

g. Information on allergies and adverse reactions (or notation that the Participant has no known allergies or history of adverse reactions);

h. Prescribed medications, including dosages and dates of initial or refill prescriptions;

i. Information on Advance Directives or Do Not Resuscitate (DNR) orders, including documentation on whether the Participant has been informed and has executed any such Advanced Directive or DNR order;

j. All informed consent documentation;

k. Consultations, referrals, laboratory, pathology, and specialists' reports, with any abnormal results having an explicit notation in the record;

l. Past medical history, physical examinations, necessary treatments, and possible risk factors for the Participant relevant to the particular treatment;

m. Assessments or interventions by the respective disciplines of the Interdisciplinary Team (IDT) that are, in accordance with documentation standards of such IDT member's clinical standards;

n. All Service Determination Requests (SDR) for care and services and, if the service is not approved, the reason for not approving or providing that care or service, in accordance with PA.2022: Service Determination Requests (SDR); and

o. Any additional identifying information or preferences of the Participant.

2. Participant's demographic information including, but not limited to the Participant's:

a. Name and address;

b. Age and birth date;

c. Sex;

d. Telephone number;

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

f. Primary or preferred language spoken, including any request or refusal of language or interpretation services; and

g. Use of auxiliary aids and services for effective communication with Participants with disabilities.

3. Participant health education shall be documented in the ~~medical record~~Medical Record, including information on applicable chronic care maintenance and nutritional guidelines.

4. Participant's noncompliance with any aspect of the Plan of Care shall be documented by the appropriate discipline responsible for such aspect of the Plan of Care; the documentation shall include ~~staff~~employee efforts to obtain compliance and reasons for noncompliance.

5. Immunizations and tuberculosis screening results shall be recorded in a Participant's ~~medical record~~Medical Record with a lot number and expiration date.

D. Authentication of Medical Record Entries

1. All ~~medical record~~Medical Record entries shall be dated and signed, either in-person or electronically, by each ~~staff person~~employee providing the service.

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

3. An electronic signature shall be by secured computer entry by a unique identifier of the primary author who has reviewed and approved the entry.

E. Confidential Information

1. The PACE Director shall be responsible for maintaining, monitoring, and enforcing ~~staff~~employee compliance in keeping Participant information confidential.

2. Participant ~~medical records~~Medical Records and Participant-related information shall be handled in a confidential manner, in accordance with applicable statutory, regulatory, federal (including HIPAA), contractual, CalOptima Health policy, and other applicable requirements.

3. Access to a Participant's ~~medical record~~Medical Record is limited to the ~~staff~~employee and ~~consultants~~contract provider providing service to the Participant, subject to the requirements of Medical Record Release outlined below.

4. ~~Any~~A Participant ~~may review~~or their ~~own medical records,~~Representative may review or request ~~and receive~~ a copy of their ~~medical record, and request that the record be amended or corrected. Such requests must be submitted to the PACE Center Manager in writing by the Participant or their authorized Representative,~~Medical Record, by utilizing the *Individual Request for Access to PHI Form*. CalOptima Health PACE shall respond to all requests for copying and reviewing ~~medical records in a timely manner. Any request to amend or correct a medical record shall be~~Medical Records within thirty (30) days after receipt of request, in accordance with CalOptima Health Policy HH.~~3004A~~3001: Member Access to Designated Record Set.

~~4.~~5. A Participant or their Representative may request to amend or correct their Medical Record in accordance with CalOptima Policy HH.3004: Member Request to Amend Records.

a. ~~CalOptima~~Any requests for amended medical diagnoses or corrections to the care plan must be in writing by the Participant or their Representative and submitted to the CalOptima Health Privacy Officer for review utilizing the *Member Request to Amend Protected Health Information Form.*

b. The CalOptima Health Privacy Officer shall discuss any request for amendment with the PACE Center Manager and Medical Director.

~~5.~~6. CalOptima Health PACE shall advise each new employee and contractor of the importance of maintaining confidentiality of Participants' ~~medical records~~Medical Records and shall provide the new employee and contractor with a written copy of the confidentiality requirements. The employee shall be responsible for reading and affixing his or her signature to the statement indicating his or her understanding and willingness to abide by such requirements.

F. Medical Record Release

1. CalOptima Health PACE shall follow all applicable statutory, regulatory, federal, contractual, CalOptima Health policy, and other requirements pertaining to the release of a Participant's ~~medical record~~Medical Record.

2. CalOptima Health PACE shall release a Participant's Medical Record or portion thereof in accordance with CalOptima Health Policies HH.~~3015A.~~3015: Member Authorization for ~~Release~~ the Use and Disclosure of Protected Health Information (PHI), HH.~~3009A~~3009: Access by Member's ~~Authorized~~ Representative, HH.~~3011A~~3011: Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations, and HH.~~3010A~~3010: Protected Health Information (PHI) Disclosures Required by Law.

IV. ATTACHMENT(S)

A. ~~A.~~ Individual Request for Access to PHI Form
B. Member Request to Amend Protected Health Information Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for PACE
B. CalOptima Health PACE Program Agreement
C. CalOptima Health Policy HH.~~3004A~~3001: Member Access to Designated Record Set
~~C.~~D. CalOptima Health Policy HH.3004: Member Request to Amend Records
~~D.~~E. CalOptima Health Policy HH.~~3009A~~3009: Access by Member's Personal Representative
~~E.~~F. CalOptima Health Policy HH.~~3010A~~3010: Protected Health Information (PHI) Disclosures Required by Law
~~F.~~G. CalOptima Health Policy HH.~~3011A~~3011: Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
~~G.~~H. CalOptima Health Policy HH.~~3015A.~~3015: Member Authorization for ~~Release~~the Use and Disclosure of Protected Health Information (PHI)
~~H.~~I. PACE Desk Reference: Documentation
~~I.~~J. Medi-Cal Managed Care Policy Letter 14-004
~~J.~~K. Title 22, California Code of Regulation (C.CR.), §§~~-~~53861, 78431,~~-~~ and 78433
~~K.~~L. Title 28, California Code of Regulation (C.CR.), §§1300.67.1(c), and 1300.80(b)(4)
~~L.~~M. Title 42, Code of Federal Regulation (C.F.R.), §§~~-~~422.112(b), 423.505(d), 423.505(e)(4)(ii), 456.111, 456.~~211and~~211 and 460.210
N. Title 45, Code of Federal Regulation (C.F.R.), §§164.524 and 164.526 (2014)
~~M.~~O. Title 42, United States Code (USC) Section 1396a(w)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2013	PA.6001	Medication Records Maintenance	PACE
Revised	10/01/2014	PA.6001	Medication Records Maintenance	PACE
Reviewed	04/01/2015	PA.6001	Medication Records Maintenance	PACE
Revised	05/01/2016	PA.6001	Medication Records Maintenance	PACE
Revised	04/01/2017	PA.6001	Medication Records Maintenance	PACE
Revised	11/01/2018	PA.6001	Medication Records Maintenance	PACE
Revised	10/01/2019	PA.6001	Medication Records Maintenance	PACE
Revised	06/01/2022	PA.6001	Medication Records Maintenance	PACE
Revised	TBD	PA.6001	Medication Records Maintenance	PACE

IX. GLOSSARY

Term	Definition
Advance Directive	A written instruction, such as a living will or durable power of attorney for health care, recognized under California law, relating to the provision of health care when the Participant is incapacitated.
Confidential Information	Specific facts or documents identified as "confidential" by any law, regulations or contractual language.
Emergency Care	Covered services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima Health PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive prior authorization for emergency care.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Interdisciplinary Team (IDT)	A team composed of members qualified to fill, at minimum, the following roles, in accordance with 42 CFR 460.102. One individual may fill two separate roles on the interdisciplinary team where the individual meets applicable state licensure requirements and is qualified to fill the two roles and able to provide appropriate care to meet the needs of Participants: 1. Primary Care Provider; Primary medical care must be furnished to a Participant by any of the following a. A primary care physician. b. A community-based physician. c. A physician assistant who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority. d. A nurse practitioner who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority. 2. Registered Nurse; 3. Master's – level Social Worker; 4. Physical Therapist; 5. Occupational Therapist; 6. Recreational Therapist or Activity Coordinator; 7. Dietician; 8. PACE Center Manager; 9. Home Care Coordinator; 10. Personal Care Attendant or his or her representative; and 11. Driver or his or her representative
Medical Records	Written documentary evidence of treatments rendered to PACE Members.
Participant	An individual enrolled in the CalOptima Health PACE program.
Plan of Care	As defined in Title 42, section 460.106 of the Code of Federal Regulations, a comprehensive care plan developed by the interdisciplinary team for each Participant to identify the care needed to meet the medical, physical, emotional, and social needs of the Participant, as identified in the initial comprehensive assessment.

Term	Definition
Program of All-Inclusive Care for the Elderly (PACE)	PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.
Representative	A person who is acting on behalf of or assisting a Participant, and may include, but is not limited to, a family member, a friend, a CalOptima Health PACE ~~staff member~~employee , or a person legally identified in a Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.
Service Delivery Request (SDR)	A request to initiate a service; a request to modify an existing service, including to increase, reduce, eliminate, or otherwise change a service. -The SDR can also be defined as a request to continue coverage of a service that the PACE Interdisciplinary Team (IDT) recommends be discontinued or reduced.

Policy:	PA.6001
Title:	**Medical Records Maintenance**
Department:	CalOptima Health PACE
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/2013
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the minimum standards for maintaining the Medical Record of a CalOptima Health Program for All-Inclusive Care for the Elderly (PACE) Participant.

II. POLICY

A. CalOptima Health PACE shall establish and maintain Medical Records for a Participant that meet the required standards for maintenance and documentation of care as set forth in this Policy.

B. CalOptima Health PACE shall release a Participant's Medical Records, in accordance with the provisions of this policy and applicable statutory, regulatory, contractual, other CalOptima Health policies and requirements.

C. CalOptima Health PACE retains the ownership and assurance of accurate Medical Records of PACE Participants. CalOptima Health PACE shall protect and safeguard all Medical Records in an organized manner in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

III. PROCEDURE

A. Organization

1. Each PACE Center site shall have at least one (1) Program Specialist, Medical Records, or designee, as the individual(s) responsible for the Medical Record system by which the site collects, processes, maintains, stores, secures, retrieves, and distributes clinical information.

2. Active Medical Records shall be organized in a systematic filing method that facilitates retrieval upon demand.

3. Active Medical Records shall be stored in the electronic health record that protects the Medical Records from loss, tampering, alteration, or destruction.

4. Inactive Medical Records (through disenrollment or deceased) for a Participant shall be retained for ten (10) years.

Back to Item

Back to Agenda

a. Inactive Medical Records may be stored in electronic or hard copy format.

b. Inactive Medical Records shall be stored in a secured approved Medical Record storage location with restricted access that meets the same security requirements for active medical records.

c. Inactive Medical Records shall be retrievable within thirty (30) business days, if necessary.

B. Format and Filing

1. An individual Medical Record shall be established for each Participant and shall be updated for each visit or encounter in accordance with the standards of documentation by each respective discipline that provides services to the Participant.

2. A Participant's Medical Record shall be legible, current, detailed, and organized in a comprehensive manner (records may be electronic or paper copies).

3. If paper-based, all documents shall be filed chronologically within the Medical Record with the Participant's name and the name of the site location for which that Participant is assigned on each document. Serial reports such as laboratory or x-ray reports may be filed in a segregated manner in chronological order. Documents must be secured in the folder to prevent loss.

4. Authorized discipline documentation into a Participant's Medical Record shall be completed by the end of the day for such encounter. Any deviation from this requirement shall be noted as a late entry in all capital letters and shall designate the actual date of the encounter for which the documentation entry refers.

5. All external reports shall be filed or entered into the Medical Record within forty-eight (48) hours after receipt of the report. Reports subject to this provision include, but are not limited to:

a. Laboratory reports;

b. Radiology and other imaging reports;

c. Consultation reports;

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

e. Emergency department reports, if available.

C. Content

1. A Participant's Medical Record shall reflect all aspects of patient care, including ancillary, and dental services. Each Medical Record shall comply with the requirements of Title 42 Code of Federal Regulation, §460.210(b) and include documentation of all services furnished as follows:

a. The identity of the Participant's PCP;

b. A summary of Emergency Care and other inpatient or long-term care services, including hospital discharge summaries for all hospital admissions;

c. Services furnished by employees of the PACE Center;

d. Services furnished by contractors and their reports;

e. A problem list, including significant illnesses and medical and psychological conditions;

f. Presenting subjective complaints, the objective findings, and the plan for diagnosis and treatment;

g. Information on allergies and adverse reactions (or notation that the Participant has no known allergies or history of adverse reactions);

h. Prescribed medications, including dosages and dates of initial or refill prescriptions;

i. Information on Advance Directives or Do Not Resuscitate (DNR) orders, including documentation on whether the Participant has been informed and has executed any such Advanced Directive or DNR order;

j. All informed consent documentation;

k. Consultations, referrals, laboratory, pathology, and specialists' reports, with any abnormal results having an explicit notation in the record;

l. Past medical history, physical examinations, necessary treatments, and possible risk factors for the Participant relevant to the particular treatment;

m. Assessments or interventions by the respective disciplines of the Interdisciplinary Team (IDT) that are, in accordance with documentation standards of such IDT member's clinical standards;

n. All Service Determination Requests (SDR) for care and services and, if the service is not approved, the reason for not approving or providing that care or service, in accordance with PA.2022: Service Determination Requests (SDR); and

o. Any additional identifying information or preferences of the Participant.

2. Participant's demographic information including, but not limited to the Participant's:

a. Name and address;

b. Age and birth date;

c. Sex;

d. Telephone number;

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

f. Primary or preferred language spoken, including any request or refusal of language or interpretation services; and

g. Use of auxiliary aids and services for effective communication with Participants with disabilities.

3. Participant health education shall be documented in the Medical Record, including information on applicable chronic care maintenance and nutritional guidelines.

4. Participant's noncompliance with any aspect of the Plan of Care shall be documented by the appropriate discipline responsible for such aspect of the Plan of Care; the documentation shall include employee efforts to obtain compliance and reasons for noncompliance.

5. Immunizations and tuberculosis screening results shall be recorded in a Participant's Medical Record with a lot number and expiration date.

D. Authentication of Medical Record Entries

1. All Medical Record entries shall be dated and signed, either in-person or electronically, by each employee providing the service.

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

3. An electronic signature shall be by secured computer entry by a unique identifier of the primary author who has reviewed and approved the entry.

E. Confidential Information

1. The PACE Director shall be responsible for maintaining, monitoring, and enforcing employee compliance in keeping Participant information confidential.

2. Participant Medical Records and Participant-related information shall be handled in a confidential manner, in accordance with applicable statutory, regulatory, federal (including HIPAA), contractual, CalOptima Health policy, and other applicable requirements.

3. Access to a Participant's Medical Record is limited to the employee and contract provider providing service to the Participant, subject to the requirements of Medical Record Release outlined below.

4. A Participant or their Representative may review or request a copy of their Medical Record, by utilizing the *Individual Request for Access to PHI Form*. CalOptima Health PACE shall respond to all requests for copying and reviewing Medical Records within thirty (30) days after receipt of request, in accordance with CalOptima Health Policy HH.3001: Member Access to Designated Record Set.

5. A Participant or their Representative may request to amend or correct their Medical Record in accordance with CalOptima Policy HH.3004: Member Request to Amend Records.

   a. Any requests for amended medical diagnoses or corrections to the care plan must be in writing by the Participant or their Representative and submitted to the CalOptima Health Privacy Officer for review utilizing the *Member Request to Amend Protected Health Information Form.*

   b. The CalOptima Health Privacy Officer shall discuss any request for amendment with the PACE Center Manager and Medical Director.

6. CalOptima Health PACE shall advise each new employee and contractor of the importance of maintaining confidentiality of Participants' Medical Records and shall provide the new employee and contractor with a written copy of the confidentiality requirements. The employee

Back to Item

Back to Agenda

shall be responsible for reading and affixing his or her signature to the statement indicating his or her understanding and willingness to abide by such requirements.

F. Medical Record Release

1. CalOptima Health PACE shall follow all applicable statutory, regulatory, federal, contractual, CalOptima Health policy, and other requirements pertaining to the release of a Participant's Medical Record.

2. CalOptima Health PACE shall release a Participant's Medical Record or portion thereof in accordance with CalOptima Health Policies HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI), HH.3009: Access by Member's Representative, HH.3011: Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations, and HH.3010: Protected Health Information (PHI) Disclosures Required by Law.

IV. ATTACHMENT(S)

A. Individual Request for Access to PHI Form
B. Member Request to Amend Protected Health Information Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for PACE
B. CalOptima Health PACE Program Agreement
C. CalOptima Health Policy HH.3001: Member Access to Designated Record Set
D. CalOptima Health Policy HH.3004: Member Request to Amend Records
E. CalOptima Health Policy HH.3009: Access by Member's Personal Representative
F. CalOptima Health Policy HH.3010: Protected Health Information (PHI) Disclosures Required by Law
G. CalOptima Health Policy HH.3011: Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
H. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
I. PACE Desk Reference: Documentation
J. Medi-Cal Managed Care Policy Letter 14-004
K. Title 22, California Code of Regulation (C.CR.), §§53861, 78431, and 78433
L. Title 28, California Code of Regulation (C.CR.), §§1300.67.1(c), and 1300.80(b)(4)
M. Title 42, Code of Federal Regulation (C.F.R.), §§422.112(b), 423.505(d), 423.505(e)(4)(ii), 456.111, 456.211 and 460.210
N. Title 45, Code of Federal Regulation (C.F.R.), §§164.524 and 164.526 (2014)
O. Title 42, United States Code (USC) Section 1396a(w)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

Back to Item

Back to Agenda

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2013	PA.6001	Medication Records Maintenance	PACE
Revised	10/01/2014	PA.6001	Medication Records Maintenance	PACE
Reviewed	04/01/2015	PA.6001	Medication Records Maintenance	PACE
Revised	05/01/2016	PA.6001	Medication Records Maintenance	PACE
Revised	04/01/2017	PA.6001	Medication Records Maintenance	PACE
Revised	11/01/2018	PA.6001	Medication Records Maintenance	PACE
Revised	10/01/2019	PA.6001	Medication Records Maintenance	PACE
Revised	06/01/2022	PA.6001	Medication Records Maintenance	PACE
Revised	TBD	PA.6001	Medication Records Maintenance	PACE

IX. GLOSSARY

Term	Definition
Advance Directive	A written instruction, such as a living will or durable power of attorney for health care, recognized under California law, relating to the provision of health care when the Participant is incapacitated.
Confidential Information	Specific facts or documents identified as "confidential" by any law, regulations or contractual language.
Emergency Care	Covered services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima Health PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive prior authorization for emergency care.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Interdisciplinary Team (IDT)	A team composed of members qualified to fill, at minimum, the following roles, in accordance with 42 CFR 460.102. One individual may fill two separate roles on the interdisciplinary team where the individual meets applicable state licensure requirements and is qualified to fill the two roles and able to provide appropriate care to meet the needs of Participants: 1. Primary Care Provider; Primary medical care must be furnished to a Participant by any of the following a. A primary care physician. b. A community-based physician. c. A physician assistant who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority. d. A nurse practitioner who is licensed in the State and practices within his or her scope of practice as defined by State laws with regard to oversight, practice authority and prescriptive authority. 2. Registered Nurse; 3. Master's – level Social Worker; 4. Physical Therapist; 5. Occupational Therapist; 6. Recreational Therapist or Activity Coordinator; 7. Dietician; 8. PACE Center Manager; 9. Home Care Coordinator; 10. Personal Care Attendant or his or her representative; and 11. Driver or his or her representative
Medical Records	Written documentary evidence of treatments rendered to PACE Members.
Participant	An individual enrolled in the CalOptima Health PACE program.
Plan of Care	As defined in Title 42, section 460.106 of the Code of Federal Regulations, a comprehensive care plan developed by the interdisciplinary team for each Participant to identify the care needed to meet the medical, physical, emotional, and social needs of the Participant, as identified in the initial comprehensive assessment.

Term	Definition
Program of All-Inclusive Care for the Elderly (PACE)	PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.
Representative	A person who is acting on behalf of or assisting a Participant, and may include, but is not limited to, a family member, a friend, a CalOptima Health PACE employee , or a person legally identified in a Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.
Service Delivery Request (SDR)	A request to initiate a service; a request to modify an existing service, including to increase, reduce, eliminate, or otherwise change a service. The SDR can also be defined as a request to continue coverage of a service that the PACE Interdisciplinary Team (IDT) recommends be discontinued or reduced.

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INDIVIDUAL REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION (PHI) CONTAINED IN THE DESIGNATED RECORD SET (DRS)

You have the right to inspect your protected health information (PHI) in the Designated Record Set (DRS). You also have the right to request copies of those records in the format of your choice if it is readily available. You will receive a response to your request within 30 days after we receive the completed form. CalOptima Health PACE may charge a fee of $0.10 per page and any postage fees if you ask for copies of the records to be mailed to you.

To Request a Copy of Your Medical Records or PHI in the DRS:

1. Fill out the entire form and print clearly. **In order to process your request, a photocopy of your valid photo identification (ID) must be included with your request form.**

2. If you would like to appoint another person to have access to or receive your PHI, then you must also complete the CalOptima Health Authorization for Release of Protected Health Information form. Requests by your Personal Representative are subject to verification.

3. Please select the type of records you need from the list provided. If you are not sure what you need, please call CalOptima Health PACE at **1-714-468-1100** for help.

4. Records noted with an asterisk (*) are maintained by CalOptima Health PACE and are also considered part of the DRS.

5. If you have any questions about your request, please call CalOptima Health PACE at 1-714-468-1100 Monday through Friday from 8 a.m. to 4:30 p.m. TDD/TTY users can call at 1-714-468-1063.We have staff who speak your language.

6. Your records may be picked up at the CalOptima Health PACE center or sent via email or certified postal mail. Requests for records to be faxed must be approved by CalOptima Health PACE. Records sent via email will be sent secure (encrypted) to the email address provided. However, CalOptima Health PACE is not responsible for loss of PHI on personal email accounts.

Individual Request For Access To Protected Health Information (PHI)
Contained In The Designated Record Set (DRS)

Member Name: _____ Date of Birth: _____
(mm/dd/yyyy)

Phone: (____)_____ CalOptima Health CIN: _____

Reason for your request: _____

I am requesting copies of records for the following dates of service: _____ to _____
(mm/dd/yyyy) *(mm/dd/yyyy)*

Requests submitted without a date range will be considered incomplete.

The types of records listed below are part of the DRS maintained by CalOptima Health . Please select the types of records you wish to view or receive as well as the date range.

Medical Records (Provide by PACE)
- ☐ Consultant reports
- ☐ Emergency Room reports
- ☐ History and Physical
- ☐ Hospitalization reports
- ☐ Immunization records
- ☐ Lab/Radiology reports
- ☐ Medication Records
- ☐ Nurses notes
- ☐ Occupational Therapy notes
- ☐ Operation or procedure notes
- ☐ Outpatient Clinic reports
- ☐ Pathology reports
- ☐ Physical Therapy notes
- ☐ Physician orders
- ☐ Physician visit notes
- ☐ Social Worker notes

***Authorizations**
- ☐ Medical Authorization Request
- ☐ Pharmacy Prior Authorization
- ☐ Notice of Action

***Behavioral Health Record**
- ☐ Behavioral Health Authorization/Denials
- ☐ Care Management Notes

***Case Management**
- ☐ Case Management Notes; Care Plan; Assessment

***Claims/Billing**
- ☐ Medical Claims Record
- ☐ Pharmacy Claims Record

Customer Service
- ☐ Member Call Logs

Eligibility
- ☐ Eligibility Record
- ☐ Auto Assignment and Health Network Changes
- ☐ Enrollment Form

***Grievances and Appeals (GARS)**
- ☐ Grievance Case File Record
- ☐ Appeal Case File Record
- ☐ State Hearing Record

Health Education and Disease Management
- ☐ Care Plan(s) and Assessment(s)
- ☐ Health Ed. and Disease Mgmt. Notes

Long-Term Services and Supports (LTSS)
- ☐ Assessment(s) and Authorization(s)
- ☐ Case Management Notes

Multipurpose Senior Services Program (MSSP)
- ☐ Assessment; Care Plan; Progress Notes; Referral and Application Form

Records noted with an asterisk (*) are maintained by CalOptima Health PACE and are also considered part of the DRS.

Delivery method requested (select one):

☐ "Personal" pickup at CalOptima Health PACE (identification required at the time of pickup)

☐ Mail: _____ *Street/Unit* _____ *City* _____ *State* _____ *ZIP Code*

☐ Fax (Upon approval): (____) _____ ☐ Email: _____

Identifying information is required (select one):

☐ Copy of ID attached (e.g. valid driver license, benefits ID card, etc.)

☐ If no ID is attached, your signature must be notarized.

Notarized By: _____

Notary Public Number: _____

Date: _____

Unofficial Unless Stamped by Notary Public

Signature Block:

(I understand that to process my request, a copy of valid, government-issued identification (ID), a copy of documentation of legal authority, or a notarized signature must be included with my request form.)

By signing below, I state that I have read this form and know what it means.

_____ _____

Signature of Member/Personal Representative Date

Personal Representatives — Please attach legal documentation to verify that you are the conservator, executor of a decedent's will or have medical decision-making authority for the individual. CalOptima Health reserves the right to request legal documentation (e.g. court order, etc.) from the Personal Representative signing on behalf of a member.

Submit the completed and signed request form and copy of ID to CalOptima Health, either in person, by mail or by fax.

CalOptima Health PACE
13300 Garden Grove Blvd
Garden Grove, CA, 92843
OR
Fax to 1-714-468-1071

For CalOptima Health Use:

Date received by CalOptima Health PACE: _____

Staff Name: _____

Member Request to Amend Protected Health Information (PHI)

Date of Request: _____

Member Name: _____ Date of Birth: _____

Member CIN: _____ Telephone Number: _____

Please tell us what Protected Health Information (PHI) or record you would like CalOptima Health to change:

_____

_____

_____

Please tell us why you would like this change. You must give a reason:

_____

_____

NOTIFICATION:

CalOptima Health must notify you within 60 calendar days if the changes were made as you requested or tell you that more time is needed (up to 30 calendar extra days) to decide. Please tell us where to send you a letter:

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

If CalOptima Health decides to change the record as you requested, the change will be sent to any person who received the information before it was changed. Please tell us if there are any such persons who need the changed information.

☐ No
☐ Yes Please list the person's names and addresses:

_____ _____

_____ _____

_____ _____

We will also send the change to other persons that we know received the information before it was changed if they relied, or might in the future rely, on the information. Do you agree to this?

☐ No
☐ Yes

Continued on page 2

RESTRICTIONS:

CalOptima Health does not have to change your record if:

- CalOptima Health did not create the information.
- The information in the record is accurate and complete.
- You do not have the legal right to access the Protected Health Information (PHI) you want changed.
- The Protected Health Information (PHI) you want changed is not part of the information kept by CalOptima Health (Member Designated Record Set; this includes enrollment information, billing records and records containing your Protected Health Information (PHI) that are used by us to make decisions about you.).

YOUR RIGHTS:

To learn more about your privacy rights, please refer to your copy of the CalOptima Health Notice of Privacy Practices. It is also be found on our website: www.caloptima.org, or you can call the CalOptima Health's Customer Service Department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD/TTY line at **1-714-246-8523** or toll-free at **1-800-735-2929**. We have staff who can speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima Health by calling **1-714-246-8500.**

CalOptima Health cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights.

SIGNATURE:

Member Signature: _____

If Authorized Representative (please include appropriate documentation):

Print Name:_____Relationship to Member: _____

SUBMIT TO CALOPTIMA HEALTH:

Return this completed form to:

CalOptima Health Privacy Officer
505 City Parkway West
Orange CA 92868

Fax: 714-338-3166

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Approve Updates to the CalOptima Health Provider Dispute Resolution Process effective January 1, 2024, and Impacted Policies MA.9006, MA.9009, HH.1101, FF.2001 and MA.3101

Contacts

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

Recommended Actions

1. Approve the transition to a one level internal provider dispute resolution process for claims payments to CalOptima Health Community Network and CalOptima Health Direct providers effective January 1, 2024.

2. Approve updates to the associated policies to reflect the changes to the internal provider dispute resolution process.
    a. Grievance and Appeals Resolution Services Policies:
        i. MA.9006 Provider Complaint Process
        ii. MA.9009 Non-Contracted Provider Payment Appeals
        iii. HH.1101 CalOptima Health Provider Complaint
    b. Claims Administration Policies:
        i. FF.2001 Claims Processing for Covered Services for which CalOptima Health is Financially Responsible
        ii. MA.3101 Claims Processing

Background

A provider in CalOptima Health Community Network (CHCN) or CalOptima Health Direct (CHD) who disagrees with a claim payment has the right to a provider dispute process. The provider may submit an initial written request for review to CalOptima Health's Claims Administration department explaining the reason for the dispute. If after review of the information submitted by the provider, the CalOptima Health Claims Administration department upholds the original payment, the provider may submit a second review request through the CalOptima Health Grievance and Appeals Resolution Services (GARS) department. This existing 2-level process was designed by CalOptima Health to mirror the health network process for provider disputes and is not one that is required by contract or regulation.

Discussion

Effective January 1, 2024, staff recommend the transition to a single internal review process for CHCN and CHD networks through the GARS department. The one level internal review process recommendation is based on provider feedback for a more concise process and consistency with industry practice, such as the Department of Managed Health Care (DMHC) requirement of initial handling of dispute at the plan level. This also streamlines the process by providing a fast, fair, and cost-effective

Back to Agenda

dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes and reduces the timeframe for the provider to receive a final decision by CalOptima Health.

This change does not impact CalOptima Health's contracted health networks' provider dispute rights or processes. For disputes related to a contracted health network's claim payment, a provider must submit the dispute through the appropriate health network for resolution. If the provider is not satisfied with the decision by the health network, the provider may submit a request for a second level review by CalOptima Health's GARS department.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation
To ensure CalOptima Health's alignment with industry standards and its continued commitment to conducting operations in compliance with all applicable state and federal laws and regulations, CalOptima Health staff recommends that the Board of Directors approve and adopt the provider dispute resolution process change as presented and the updates to the applicable CalOptima Health policies and procedures.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. MA.9006 Provider Complaint Process
2. MA.9009 Non-contracted Provider Payment Appeals
3. HH.1101 CalOptima Health Provider Complaint
4. FF.2001 Claims Processing for Covered Services for which CalOptima Health is Financially Responsible
5. MA.3101 Claims Processing

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

Policy:	MA.9006
Title:	**Contracted Provider Complaint Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima Health, a Health Network, and a Third Party Administrator (TPA) shall address and resolve ~~contracted~~Contracted Provider Complaints, which ~~include~~includes, but ~~are~~is not limited to, Provider ~~disputes or appeals for claims payment, utilization management decisions,~~Dispute Resolution (PDR), Appeals and ~~other non-payment related issues.~~Grievances.

II. POLICY

A. CalOptima Health, Health Networks, and TPAs shall maintain a fast, fair, and cost-effective ~~grievance~~ system to process and resolve ~~contracted~~Contracted Provider Complaints, in accordance with applicable statutory, regulatory, and contractual requirements.

B. Non-~~Contract~~Contracted Provider ~~claims disputes~~Complaints shall be processed under CalOptima Health Policy MA.9009: Non-~~Contract~~Contracted Provider ~~Payment Appeals~~Complaint Process.

C. ~~Provider~~Contracted Providers shall utilize the Health Network and TPA ~~grievance~~Grievance systems prior to filing a ~~Complaint~~complaint directly with CalOptima Health, in accordance with this policy.

D. CalOptima Health, Health Networks, and TPAs shall promptly review and investigate Complaints and resolve them, in accordance with the timeframes set forth herein.

E. CalOptima Health, Health Networks, and TPAs shall not discriminate or retaliate against any ~~Provider~~Contracted Provider including, but not limited to, terminating the ~~Provider~~Contracted Provider's contract on grounds that such ~~Provider~~Contracted Provider filed a ~~Complaint~~complaint.

F. CalOptima Health, Health Networks, and TPAs shall designate a Principal Officer to be primarily responsible for the maintenance, oversight, and analysis of trends and preparation of reports related to ~~Provider~~ Complaints as required by this policy and applicable regulations.

Back to Item

Back to Agenda

G. CalOptima Health, Health Networks, and TPAs shall train assigned staff to process ~~provider complaints~~Complaints expeditiously in accordance with this policy.

H. CalOptima Health, Health Networks, and TPAs shall not impose a deadline for receipt of a ~~Provider~~ Complaint for an individual claim, billing dispute, or other dispute that is less than three hundred sixty-five (365) calendar days after the date of an action or, in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired. If the dispute relates to a demonstrable and unfair payment pattern by CalOptima Health, or CalOptima Health Contracted ~~capitated~~ Provider, neither CalOptima Health nor the ~~capitated~~ Contracted Provider shall impose a deadline for the receipt of a dispute that is less than three hundred sixty-five (365) calendar days from CalOptima Health or the Contracted ~~capitated~~ Provider's most recent action, or in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the most recent time for contesting or denying claims has expired.

I. CalOptima Health, Health Networks, and TPAs shall not charge a ~~Provider~~Contracted Provider for the cost of processing a ~~Provider~~ Complaint. Notwithstanding the foregoing, CalOptima Health, Health Networks, and TPAs shall have no obligation to reimburse a ~~Provider~~Contracted Provider for any costs incurred in connection with utilizing the ~~Provider~~ Complaint process.

J. CalOptima Health shall have the right to extend, or stay, or require a Health Network or TPA to delay, or stay, the implementation of a decision in order to allow the affected ~~Provider~~Contracted Provider an opportunity to file a ~~Complaint~~complaint under this policy.

K. A ~~Provider~~Contracted Provider who seeks to contest any decision made by CalOptima Health pursuant to this policy is required to comply with CalOptima Health Policy AA.1217: Legal Claims and Judicial Review, if applicable.

III. PROCEDURE

A. Submission of a Complaint

1. A Complaint shall contain the following:

a. Provider Dispute Resolution (PDR) ~~Form~~form, Appeal, Grievance or ~~Dispute Letter~~dispute letter and supporting documentation

b. ~~Provider~~Contracted Provider name and Provider Identification Number (PIN);

c. Contact information;

d. Claim number assigned the original claim, if applicable;

e. Clear description of the disputed item;

f. Date of service;

g. Clear explanation of the basis upon which the ~~Provider~~Contracted Provider believes the action is incorrect;

h. If the Complaint involves a bundled group of substantially similar multiple claims, identification of the original claim number; and

i. If the Complaint involves a dispute involving a Member, or group of Members; the name(s), identification number(s), claim numbers (if applicable) of the Member(s), a clear explanation of the disputed item(s) including the date(s) of service, and the ~~Provider~~Contracted Provider's position on the issue(s).

2. A ~~Provider~~Contracted Provider may submit an amended ~~Provider~~ Complaint within thirty (30) business days after the date of receipt of a returned ~~Provider~~ Complaint that is missing required information.

3. A ~~Provider~~Contracted Provider that (i) has furnished Covered Services to a Member for which a Health Network is financially responsible, or (ii) is dissatisfied with any aspect of CalOptima Health's program shall file a Complaint with that Health Network prior to filing a Complaint with CalOptima Health within three hundred sixty-five (365) calendar days after the Health Network's action, or in the case of inaction, within three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired.

4. A ~~Provider~~Contracted Provider that (i) has furnished Covered Services to a Member or (ii) is dissatisfied with any aspect of a TPA's program, shall file a Complaint with that TPA prior to filing a Complaint with CalOptima Health within three hundred sixty-five (365) calendar days after the TPA's action, or in the case of inaction, three hundred sixty-five (365) calendar days after the time for contesting, or denying, claims has expired.

5. A ~~Provider~~Contracted Provider may file a Complaint with CalOptima Health as follows:

a. The ~~Provider~~Contracted Provider has provided Covered Services to a Member for which CalOptima Health is financially responsible, or is dissatisfied with any aspect of CalOptima Health;

b. The ~~Provider~~Contracted Provider has provided Covered Services to a Member for which a Health Network, or TPA, is financially responsible, is dissatisfied with a Complaint Resolution Letter received from the Health Network, or TPA, as set forth in this policy, and files within the following timeframes:

i. Sixty (60) calendar days after the date of the Health Network's, or TPA's, Complaint Resolution Letter for Complaints related to Medical Necessity; or

ii. One hundred eighty (180) calendar days after the date of the Health Network's, or TPA's, Complaint Resolution Letter for all other types of Complaints.

B. CalOptima Health, Health Network, or TPA Complaint Receipt and Resolution

1. Record of Complaint

a. CalOptima Health, or a Health Network, shall enter into its ~~Complaint~~complaint tracking system each Complaint (whether or not complete) received and create an electronic, or hard copy, ~~grievance~~Grievance file.

i. The Complaint tracking system shall include the original claim number assigned to each claim being disputed.

b. A TPA will track and maintain records of each ~~complaint~~Complaint (whether or not complete) it receives.

2. Acknowledgement of a Complaint

a. CalOptima Health, a Health Network, or TPA shall acknowledge the receipt of a Complaint in paper form (whether or not complete) within fifteen (15) business days after the date of receipt by the office, or department, designated to receive Complaints.

b. CalOptima Health, a Health Network, or TPA shall acknowledge the receipt of a Complaint in electronic form (whether or not complete) within two (2) business days after the date of receipt by the office or department designated to receive Complaints.

3. Incomplete Complaints

a. CalOptima Health, a Health Network, or TPA may return to a ~~Provider~~Contracted Provider any Complaint lacking reasonably relevant information, or information necessary to determine payer liability, that is in the possession of the ~~Provider~~Contracted Provider and not readily accessible to CalOptima Health, Health Network, or TPA.

b. The returned Complaint shall clearly identify, in writing, the missing reasonably relevant information, or information necessary to determine payer liability. In no event shall CalOptima Health, Health Network, or TPA request the ~~Provider~~Contracted Provider to resubmit claim information that the ~~Provider~~Contracted Provider previously and appropriately submitted to CalOptima Health, Health Network, or TPA as part of the claims adjudication process, except in those cases in which the claim documentation was returned to the ~~Provider~~Contracted Provider.

4. Investigation and Resolution of Complaints

a. Investigation

i. CalOptima Health, Health Network, or TPA shall promptly investigate a Complaint by consulting, as appropriate, with the appropriate department(s) at CalOptima Health, Health Network, or TPA responsible for the services, or operations that are the subject of the Complaint (e.g., Utilization Management, Claims).

ii. The applicable CalOptima Health, Health Network, or TPA department(s) shall investigate the factual matters that are the subject of the Complaint and shall report factual findings and a proposed resolution to the CalOptima Health, or Health Network, ~~grievance~~Grievance staff within ten (10) business days after the date of the initial receipt of the Complaint.

iii. The applicable CalOptima Health, Health Network, or TPA department shall use the Complaint Referral and Investigation Request ~~Form~~form, or a similar form, to report findings and proposed resolutions to the CalOptima Health, or Health Network, ~~grievance~~Grievance staff as set forth in this ~~policy~~Policy.

iv. CalOptima Health may request that the ~~Provider~~Contracted Provider submit any written materials relevant to the ~~Provider~~Contracted Provider's Complaint.

v. If the ~~Provider~~Contracted Provider is appealing a Health Network, or TPA, Complaint Resolution Letter, CalOptima Health shall review the Health Network's, or TPA's, Complaint file.

b. Resolution

i. CalOptima Health, the Health Network, or TPA shall resolve and issue a Complaint Resolution Letter for each Complaint it receives within forty-five (45) business days after the date of receipt of the Complaint or amended Complaint, in accordance with applicable laws, including those regulatory provisions identified in Title 28, California Code of Regulations, Section 1300.71.38(f).

ii. The Complaint Resolution Letter shall describe the pertinent facts of the Complaint, the reasons for the Health Networks' determination, and applicable ~~Provider~~Contracted Provider Appeal rights including the following:

a) For claims Complaints related to Medical Necessity, the right to Appeal the determination to CalOptima Health Grievance and Appeals Resolution Services (GARS) staff within sixty (60) calendar days after the date of the Health Network's, or TPA's, Complaint Resolution Letter; or

b) For other Complaints, the right to Appeal the determination to CalOptima Health GARS staff within one hundred eighty (180) calendar days after the date of the Health Network, or TPA's, Complaint Resolution Letter.

c. Implementation of Complaint Resolution

i. CalOptima Health and its Health Networks, or TPA, shall take immediate action to implement the determinations set forth in a Complaint Resolution Letter.

ii. If the Complaint, or amended Complaint, is determined in whole, or in part, in favor of the ~~Provider~~Contracted Provider, the Health Network shall pay:

a) Any outstanding monies that it determines to be due; and

b) All interest and penalties required within five (5) business days after the date of the Complaint Resolution Letter.

iii. Accrual of interest and penalties for the payment of any resolved Complaints shall commence on the day following the expiration of the time for reimbursement.

d. Resolution of complaints submitted by ~~Provider~~Contracted Provider to CalOptima Health in accordance with this policy.

i. CalOptima Health GARS staff shall review the factual findings, proposed resolution, and any other relevant information and shall issue a decision with respect to the Complaint, or amended Complaint.

ii. Within forty-five (45) business days after receipt of the Complaint, or amended Complaint, CalOptima Health GARS staff shall send a Complaint Resolution Letter to the ~~Provider~~Contracted Provider and copy the Health Network, or TPA, as appropriate.

e. Implementation of Resolution by CalOptima Health

i. CalOptima Health may take immediate action or, as appropriate, require that a Health Network, or TPA, take immediate action to implement the decision set forth in CalOptima Health's Complaint Resolution Letter.

ii. If the Complaint is a payment related issue and CalOptima Health determines that a Health Network is financially responsible, the Health Network shall make payment in the amount specified by CalOptima Health to the ~~Provider~~Contracted Provider within five (5) business days after the date of CalOptima Health' Complaint Resolution Letter. The Health Network shall send proof of payment by facsimile, or email, to the CalOptima Health GARS Manager, or his or her designee.

iii. If the Health Network does not pay the claim as required by this policy, CalOptima Health shall pay the claim on behalf of the Health Network and shall deduct from the Health Network's capitation payment the amount paid on behalf of the Health Network plus the greater of a two hundred fifty dollars ($250.00) administrative fee, or ten percent (10%) of the amount paid.

iv. If the Complaint is a payment-related issue and CalOptima Health determines that a TPA is financially responsible, the TPA shall make payment in the amount specified by CalOptima Health to the ~~Provider~~Contracted Provider within five (5) business days after the date of CalOptima Health's Complaint Resolution Latter. The TPA shall send proof of payment by facsimile, or email, to the CalOptima Health GARS Manager, or his or her designee.

C. CalOptima Health Responsible Staff

1. CalOptima Health GARS Director shall have primary responsibility for the maintenance of the Provider Complaint process.

2. A CalOptima Health Executive Officer shall have primary responsibility for the oversight and review of operations and for identifying any emergent patterns of Complaints to improve administrative capacity, Provider relations, claims payment procedures, and Member care.

D. CalOptima Health Monitoring

1. CalOptima Health shall assess on no less than an annual basis the ~~Providers,~~ Contracted Providers, subcontractors, and downstream subcontractors that regularly utilize the Provider Complaint process to identify trends and systemic~~system~~ issues.

~~1.~~2. If CalOptima Health determines that a ~~Provider~~Contracted Provider or Health Network has failed to comply with any requirements of this policy, CalOptima Health may take appropriate action, including, but not limited to, imposing corrective action plans, or sanctions, against the Health Network under CalOptima Health Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions.

~~2.~~3. CalOptima Health shall monitor a TPA.

E. Notices, Records, and Reports

1. Notice to ~~Provider~~Contracted Providers of the Complaint ~~Procedure~~Process

a. A Health Network shall include a reference to this policy in each ~~Provider~~Contracted Provider contract.

~~b. A Health Network shall notify non-contracted Providers of the availability of a Provider Complaint process. This notification may be satisfied through the Health Networks' routine Provider communication processes including, but not limited to, newsletters, bulletins, policy and procedure manuals, remittance advice notices, and websites.~~

2. Records

a. CalOptima Health, Health Networks, and TPAs shall maintain written records of each Complaint including at least the following information:

i. Date of receipt;

ii. Names of staff who is designated as the contact person;

iii. Description of the Complaint; and

iv. Disposition.

b. A Health Network and TPA shall retain written records of each Complaint, including copies of all Complaints and responses thereto, including all notes, documents, and other information upon which CalOptima Health, the Health Network, or TPA relied upon to reach its decision for a period of five (5) years following the termination of their contracts with CalOptima Health. ~~-~~A Health Network and TPA shall make records for the last two (2) years available on-site.

c. A Health Network and TPA shall make available warehoused, or stored, records within five (5) business days after a request for such records by CalOptima Health, or the department.

3. Reporting ~~Provider~~Contracted Provider Complaint Activity

a. A Health Network shall submit to CalOptima Health on a quarterly basis, within thirty (30) calendar days after the end of each quarter, aggregate Complaint data in the format required by CalOptima Health.

b. Each claim within a Complaint that has bundled substantially similar claims disputes must be listed separately as individual Complaints (including original claim numbers) on the report.

c. A Principal Officer shall sign the report certifying that the report is true and correct to the best of his or her knowledge and belief.

F. Other ~~Provider~~Contracted Provider Rights

1. In addition to any rights set forth in this policy and allowed by law, a ~~Provider~~Contracted Provider also has the following rights:

2. Claim Resubmission.

a. Prior to filing a Complaint related to payment of a claim, a ~~Provider~~Contracted Provider may resubmit the claim to the Health Network, or TPA, as appropriate, in accordance with the applicable Health Network, or TPA, claim resubmission policy.

3. ~~Provider~~Contracted Provider's Right to Hearing

a. Request for Hearing

i. A ~~Provider~~Contracted Provider that disputes recoupment of funds based upon audit findings of overpayments; the imposition of sanctions or penalties; or suspension or termination of the ~~Provider~~Contracted Provider's participation in CalOptima Health, or a Health Network, may request a hearing before the Provider Grievance Review Panel if:

a) The ~~Provider~~Contracted Provider has received a Complaint Resolution Letter from CalOptima Health; or

b) The ~~Provider~~Contracted Provider has received a Complaint Resolution Letter from a Health Network, or TPA, and pursues a hearing in lieu of filing a written Complaint to CalOptima Health under Section III.A. of this policy.

ii. No other hearings are provided under this policy.

iii. A ~~Provider~~Contracted Provider may submit to CalOptima Health GARS staff a written request for hearing within fifteen (15) calendar days after CalOptima Health, a Health Network's, or TPA's issuance of a Complaint Resolution Letter. The written request shall set forth with specificity the reasons for the hearing, including if the ~~Provider~~Contracted Provider challenges:

a) The factual basis of the decision, and if so, which facts in particular;

b) The legal basis for the decision; or

c) The rationale for the decision, sanctions, or penalties imposed.

b. Acknowledgment of Request for Hearing

i. Upon receipt of a request for hearing, CalOptima Health shall set a hearing date to be held within thirty (30) calendar days after receipt of the request.

ii. CalOptima Health shall send to the ~~Provider~~Contracted Provider a Hearing Acknowledgment Letter within five (5) calendar days after the ~~Provider~~Contracted Provider's request for a hearing, setting forth the date, time, and location of the hearing.

c. Hearing

i. The purpose of the hearing is to afford the ~~Provider~~Contracted Provider an opportunity to contest the factual, or legal, basis of the decision, or the rationale for the decision.

ii. The hearing is intended to be informal in nature. Formal rules of evidence and discovery do not apply. There shall be no cross-examination of witnesses. The ~~Provider~~Contracted Provider, CalOptima Health, Health Network, and TPA, as

appropriate, shall have the opportunity to present oral testimony and documentary evidence.

iii. The Provider Grievance Review Panel shall select a hearing officer to preside at the hearing. The hearing officer may, from time to time, establish hearing guidelines governing the hearing procedure. The hearing officer may ask questions to any party at the hearing, and shall ensure proper decorum at the hearing.

iv. The hearing officer may cause a recording of the hearing to be made either by tape recording, or providing a court reporter service.

v. After the conclusion of the hearing, the Provider Grievance Review Panel may adopt, reject, or modify, in whole or in part, the actions addressed at the hearing. The hearing officer shall send the Provider Grievance Review Panel's written decision to the ~~Provider~~Contracted Provider, Health Network, and TPA, as appropriate, within forty-five (45) calendar days after the close of the hearing. The decision shall be effective on the date issued by the hearing officer.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. California Health and Safety Code, §1367(h)
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~C. CalOptima Health PACE Program Agreement~~
~~D.~~C. CalOptima Health Policy AA.1217: Legal Claims and Judicial Review
~~E.~~D. CalOptima Health Policy HH.2002: Sanctions
~~F.~~E. CalOptima Health Policy HH.2005: Corrective Action Plan
~~G.~~F. CalOptima Health Policy MA.9009: Non-~~Contract~~Contracted Provider ~~Payment Appeals~~Complaint Process
~~H.~~G. Title 28, California Code of Regulations (C.C.R.), §§1300.71.38 and 1300.85.1.
~~I.~~H. CalOptima Health Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2005	MA.9006	Provider Complaint Process	OneCare
Revised	05/01/2010	MA.9006	Provider Complaint Process	OneCare
Revised	10/01/2012	MA.9006	Provider Complaint Process	OneCare

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	02/01/2015	MA.9006	Provider Complaint Process	OneCare OneCare Connect PACE
Revised	12/01/2016	MA.9006	Provider Complaint Process	OneCare OneCare Connect PACE
Revised	12/01/2022	MA.9006	Provider Complaint Process	OneCare OneCare Connect
Revised	TBD	MA.9006	Provider Complaint Process	OneCare OneCare Connect

1

IX. GLOSSARY

Term	Definition
Appeal	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima Health on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima Health requesting review of CalOptima Health's denial, reduction or termination of benefits or services, from CalOptima Health. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals and 42 CFR sections 422.629 through 422.634, 438.210, 438.400, and 438.402. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima Health of an Adverse Benefit Determination.
Complaint	The general term used to identify all provider-filed requests for review and expressions of dissatisfaction with any aspect of CalOptima Health or its Health Networks. This includes Appeals, disputes and Grievances.
Contracted Provider	A Provider who is obligated by a written contract to provide Covered Services to Members on behalf of CalOptima Health, or its contracted Health Networks.
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under CalOptima Health's contract with the Centers of Medicare & Medicaid Services (CMS).
Dispute	A dispute of payment regarding an amount that is less than the expected contracted amount or the amount that would be paid by Medicare.
Executive Officer	For the purposes of this policy, refers to the Chief Operating Officer or their~~his/her~~ designee.
Grievance	Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima Health's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint."
Health Network~~:~~	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as

	a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medically Necessary/Medical Necessity	~~An individual~~OneCare: The services, supplies, or ~~entity~~drugs that ~~has~~are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. OneCare Connect: Services must be provided in a ~~written agreement with CalOptima Health~~way that provides all protections to ~~perform certain functions and tasks relating to,~~the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary ~~for, the delivery of~~ Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Non-Contracted Provider (NCP)	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Organization Determination	Any determination made by CalOptima Health with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima Health; ~~1.~~4. Reduction or premature discontinuation, of a previously authorized ongoing course of treatment; or Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.
Resolution Letter	Written notification of the CalOptima Health's resolution of the complaint.
Third Party Administrator (TPA)	An individual or entity that has a written agreement with CalOptima Health to perform certain functions and tasks relating to, and necessary for, the delivery of Covered Services.

1

Policy:	MA.9006
Title:	**Contracted Provider Complaint Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima Health, a Health Network, and a Third Party Administrator (TPA) shall address and resolve Contracted Provider Complaints, which includes, but is not limited to, Provider Dispute Resolution (PDR), Appeals and Grievances.

II. POLICY

A. CalOptima Health, Health Networks, and TPAs shall maintain a fast, fair, and cost-effective system to process and resolve Contracted Provider Complaints, in accordance with applicable statutory, regulatory, and contractual requirements.

B. Non-Contracted Provider Complaints shall be processed under CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process.

C. Contracted Providers shall utilize the Health Network and TPA Grievance systems prior to filing a complaint directly with CalOptima Health, in accordance with this policy.

D. CalOptima Health, Health Networks, and TPAs shall promptly review and investigate Complaints and resolve them, in accordance with the timeframes set forth herein.

E. CalOptima Health, Health Networks, and TPAs shall not discriminate or retaliate against any Contracted Provider including, but not limited to, terminating the Contracted Provider's contract on grounds that such Contracted Provider filed a complaint.

F. CalOptima Health, Health Networks, and TPAs shall designate a Principal Officer to be primarily responsible for the maintenance, oversight, and analysis of trends and preparation of reports related to Complaints as required by this policy and applicable regulations.

G. CalOptima Health, Health Networks, and TPAs shall train assigned staff to process Complaints expeditiously in accordance with this policy.

Back to Item

Back to Agenda

H. CalOptima Health, Health Networks, and TPAs shall not impose a deadline for receipt of a Complaint for an individual claim, billing dispute, or other dispute that is less than three hundred sixty-five (365) calendar days after the date of an action or, in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired. If the dispute relates to a demonstrable and unfair payment pattern by CalOptima Health, or CalOptima Health Contracted Provider, neither CalOptima Health nor the Contracted Provider shall impose a deadline for the receipt of a dispute that is less than three hundred sixty-five (365) calendar days from CalOptima Health or the Contracted Provider's most recent action, or in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the most recent time for contesting or denying claims has expired.

I. CalOptima Health, Health Networks, and TPAs shall not charge a Contracted Provider for the cost of processing a Complaint. Notwithstanding the foregoing, CalOptima Health, Health Networks, and TPAs shall have no obligation to reimburse a Contracted Provider for any costs incurred in connection with utilizing the Complaint process.

J. CalOptima Health shall have the right to extend, or stay, or require a Health Network or TPA to delay, or stay, the implementation of a decision in order to allow the affected Contracted Provider an opportunity to file a complaint under this policy.

K. A Contracted Provider who seeks to contest any decision made by CalOptima Health pursuant to this policy is required to comply with CalOptima Health Policy AA.1217: Legal Claims and Judicial Review, if applicable.

III. PROCEDURE

A. Submission of a Complaint

1. A Complaint shall contain the following:

a. Provider Dispute Resolution (PDR) form, Appeal, Grievance or dispute letter and supporting documentation

b. Contracted Provider name and Provider Identification Number (PIN);

c. Contact information;

d. Claim number assigned the original claim, if applicable;

e. Clear description of the disputed item;

f. Date of service;

g. Clear explanation of the basis upon which the Contracted Provider believes the action is incorrect;

h. If the Complaint involves a bundled group of substantially similar multiple claims, identification of the original claim number; and

i. If the Complaint involves a dispute involving a Member, or group of Members; the name(s), identification number(s), claim numbers (if applicable) of the Member(s), a clear

explanation of the disputed item(s) including the date(s) of service, and the Contracted Provider's position on the issue(s).

2. A Contracted Provider may submit an amended Complaint within thirty (30) business days after the date of receipt of a returned Complaint that is missing required information.

3. A Contracted Provider that (i) has furnished Covered Services to a Member for which a Health Network is financially responsible, or (ii) is dissatisfied with any aspect of CalOptima Health's program shall file a Complaint with that Health Network prior to filing a Complaint with CalOptima Health within three hundred sixty-five (365) calendar days after the Health Network's action, or in the case of inaction, within three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired.

4. A Contracted Provider that (i) has furnished Covered Services to a Member or (ii) is dissatisfied with any aspect of a TPA's program, shall file a Complaint with that TPA prior to filing a Complaint with CalOptima Health within three hundred sixty-five (365) calendar days after the TPA's action, or in the case of inaction, three hundred sixty-five (365) calendar days after the time for contesting, or denying, claims has expired.

5. A Contracted Provider may file a Complaint with CalOptima Health as follows:

   a. The Contracted Provider has provided Covered Services to a Member for which CalOptima Health is financially responsible, or is dissatisfied with any aspect of CalOptima Health;

   b. The Contracted Provider has provided Covered Services to a Member for which a Health Network, or TPA, is financially responsible, is dissatisfied with a Complaint Resolution Letter received from the Health Network, or TPA, as set forth in this policy, and files within the following timeframes:

      i. Sixty (60) calendar days after the date of the Health Network's, or TPA's, Complaint Resolution Letter for Complaints related to Medical Necessity; or

      ii. One hundred eighty (180) calendar days after the date of the Health Network's, or TPA's, Complaint Resolution Letter for all other types of Complaints.

B. CalOptima Health, Health Network, or TPA Complaint Receipt and Resolution

1. Record of Complaint

   a. CalOptima Health, or a Health Network, shall enter into its complaint tracking system each Complaint (whether or not complete) received and create an electronic, or hard copy, Grievance file.

      i. The Complaint tracking system shall include the original claim number assigned to each claim being disputed.

   b. A TPA will track and maintain records of each Complaint (whether or not complete) it receives.

2. Acknowledgement of a Complaint

a. CalOptima Health, a Health Network, or TPA shall acknowledge the receipt of a Complaint in paper form (whether or not complete) within fifteen (15) business days after the date of receipt by the office, or department, designated to receive Complaints.

b. CalOptima Health, a Health Network, or TPA shall acknowledge the receipt of a Complaint in electronic form (whether or not complete) within two (2) business days after the date of receipt by the office or department designated to receive Complaints.

3. Incomplete Complaints

a. CalOptima Health, a Health Network, or TPA may return to a Contracted Provider any Complaint lacking reasonably relevant information, or information necessary to determine payer liability, that is in the possession of the Contracted Provider and not readily accessible to CalOptima Health, Health Network, or TPA.

b. The returned Complaint shall clearly identify, in writing, the missing reasonably relevant information, or information necessary to determine payer liability. In no event shall CalOptima Health, Health Network, or TPA request the Contracted Provider to resubmit claim information that the Contracted Provider previously and appropriately submitted to CalOptima Health, Health Network, or TPA as part of the claims adjudication process, except in those cases in which the claim documentation was returned to the Contracted Provider.

4. Investigation and Resolution of Complaints

a. Investigation

i. CalOptima Health, Health Network, or TPA shall promptly investigate a Complaint by consulting, as appropriate, with the appropriate department(s) at CalOptima Health, Health Network, or TPA responsible for the services, or operations that are the subject of the Complaint (e.g., Utilization Management, Claims).

ii. The applicable CalOptima Health, Health Network, or TPA department(s) shall investigate the factual matters that are the subject of the Complaint and shall report factual findings and a proposed resolution to the CalOptima Health, or Health Network, Grievance staff within ten (10) business days after the date of the initial receipt of the Complaint.

iii. The applicable CalOptima Health, Health Network, or TPA department shall use the Complaint Referral and Investigation Request form, or a similar form, to report findings and proposed resolutions to the CalOptima Health, or Health Network, Grievance staff as set forth in this Policy.

iv. CalOptima Health may request that the Contracted Provider submit any written materials relevant to the Contracted Provider's Complaint.

v. If the Contracted Provider is appealing a Health Network, or TPA, Complaint Resolution Letter, CalOptima Health shall review the Health Network's, or TPA's, Complaint file.

b. Resolution

i. CalOptima Health, the Health Network, or TPA shall resolve and issue a Complaint Resolution Letter for each Complaint it receives within forty-five (45) business days after the date of receipt of the Complaint or amended Complaint, in accordance with applicable laws, including those regulatory provisions identified in Title 28, California Code of Regulations, Section 1300.71.38(f).

ii. The Complaint Resolution Letter shall describe the pertinent facts of the Complaint, the reasons for the Health Networks' determination, and applicable Contracted Provider Appeal rights including the following:

a) For claims Complaints related to Medical Necessity, the right to Appeal the determination to CalOptima Health Grievance and Appeals Resolution Services (GARS) staff within sixty (60) calendar days after the date of the Health Network's, or TPA's, Complaint Resolution Letter; or

b) For other Complaints, the right to Appeal the determination to CalOptima Health GARS staff within one hundred eighty (180) calendar days after the date of the Health Network, or TPA's, Complaint Resolution Letter.

c. Implementation of Complaint Resolution

i. CalOptima Health and its Health Networks, or TPA, shall take immediate action to implement the determinations set forth in a Complaint Resolution Letter.

ii. If the Complaint, or amended Complaint, is determined in whole, or in part, in favor of the Contracted Provider, the Health Network shall pay:

a) Any outstanding monies that it determines to be due; and

b) All interest and penalties required within five (5) business days after the date of the Complaint Resolution Letter.

iii. Accrual of interest and penalties for the payment of any resolved Complaints shall commence on the day following the expiration of the time for reimbursement.

d. Resolution of complaints submitted by Contracted Provider to CalOptima Health in accordance with this policy.

i. CalOptima Health GARS staff shall review the factual findings, proposed resolution, and any other relevant information and shall issue a decision with respect to the Complaint, or amended Complaint.

ii. Within forty-five (45) business days after receipt of the Complaint, or amended Complaint, CalOptima Health GARS staff shall send a Complaint Resolution Letter to the Contracted Provider and copy the Health Network, or TPA, as appropriate.

e. Implementation of Resolution by CalOptima Health

i. CalOptima Health may take immediate action or, as appropriate, require that a Health Network, or TPA, take immediate action to implement the decision set forth in CalOptima Health's Complaint Resolution Letter.

ii. If the Complaint is a payment related issue and CalOptima Health determines that a Health Network is financially responsible, the Health Network shall make payment in the amount specified by CalOptima Health to the Contracted Provider within five (5) business days after the date of CalOptima Health' Complaint Resolution Letter. The Health Network shall send proof of payment by facsimile, or email, to the CalOptima Health GARS Manager, or his or her designee.

iii. If the Health Network does not pay the claim as required by this policy, CalOptima Health shall pay the claim on behalf of the Health Network and shall deduct from the Health Network's capitation payment the amount paid on behalf of the Health Network plus the greater of a two hundred fifty dollars ($250.00) administrative fee, or ten percent (10%) of the amount paid.

iv. If the Complaint is a payment-related issue and CalOptima Health determines that a TPA is financially responsible, the TPA shall make payment in the amount specified by CalOptima Health to the Contracted Provider within five (5) business days after the date of CalOptima Health's Complaint Resolution Latter. The TPA shall send proof of payment by facsimile, or email, to the CalOptima Health GARS Manager, or his or her designee.

C. CalOptima Health Responsible Staff

1. CalOptima Health GARS Director shall have primary responsibility for the maintenance of the Provider Complaint process.

2. A CalOptima Health Executive Officer shall have primary responsibility for the oversight and review of operations and for identifying any emergent patterns of Complaints to improve administrative capacity, Provider relations, claims payment procedures, and Member care.

D. CalOptima Health Monitoring

1. CalOptima Health shall assess on no less than an annual basis the Contracted Providers, subcontractors, and downstream subcontractors that regularly utilize the Provider Complaint process to identify trends and systemic issues.

2. If CalOptima Health determines that a Contracted Provider or Health Network has failed to comply with any requirements of this policy, CalOptima Health may take appropriate action, including, but not limited to, imposing corrective action plans, or sanctions, against the Health Network under CalOptima Health Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions.

3. CalOptima Health shall monitor a TPA.

E. Notices, Records, and Reports

1. Notice to Contracted Providers of the Complaint Process

a. A Health Network shall include a reference to this policy in each Contracted Provider contract.

2. Records

a. CalOptima Health, Health Networks, and TPAs shall maintain written records of each Complaint including at least the following information:

i. Date of receipt;

ii. Names of staff who is designated as the contact person;

iii. Description of the Complaint; and

iv. Disposition.

b. A Health Network and TPA shall retain written records of each Complaint, including copies of all Complaints and responses thereto, including all notes, documents, and other information upon which CalOptima Health, the Health Network, or TPA relied upon to reach its decision for a period of five (5) years following the termination of their contracts with CalOptima Health. A Health Network and TPA shall make records for the last two (2) years available on-site.

c. A Health Network and TPA shall make available warehoused, or stored, records within five (5) business days after a request for such records by CalOptima Health, or the department.

3. Reporting Contracted Provider Complaint Activity

a. A Health Network shall submit to CalOptima Health on a quarterly basis, within thirty (30) calendar days after the end of each quarter, aggregate Complaint data in the format required by CalOptima Health.

b. Each claim within a Complaint that has bundled substantially similar claims disputes must be listed separately as individual Complaints (including original claim numbers) on the report.

c. A Principal Officer shall sign the report certifying that the report is true and correct to the best of his or her knowledge and belief.

F. Other Contracted Provider Rights

1. In addition to any rights set forth in this policy and allowed by law, a Contracted Provider also has the following rights:

2. Claim Resubmission.

a. Prior to filing a Complaint related to payment of a claim, a Contracted Provider may resubmit the claim to the Health Network, or TPA, as appropriate, in accordance with the applicable Health Network, or TPA, claim resubmission policy.

3. Contracted Provider's Right to Hearing

a. Request for Hearing

i. A Contracted Provider that disputes recoupment of funds based upon audit findings of overpayments; the imposition of sanctions or penalties; or suspension or termination of

the Contracted Provider's participation in CalOptima Health, or a Health Network, may request a hearing before the Provider Grievance Review Panel if:

a) The Contracted Provider has received a Complaint Resolution Letter from CalOptima Health; or

b) The Contracted Provider has received a Complaint Resolution Letter from a Health Network, or TPA, and pursues a hearing in lieu of filing a written Complaint to CalOptima Health under Section III.A. of this policy.

ii. No other hearings are provided under this policy.

iii. A Contracted Provider may submit to CalOptima Health GARS staff a written request for hearing within fifteen (15) calendar days after CalOptima Health, a Health Network's, or TPA's issuance of a Complaint Resolution Letter. The written request shall set forth with specificity the reasons for the hearing, including if the Contracted Provider challenges:

a) The factual basis of the decision, and if so, which facts in particular;

b) The legal basis for the decision; or

c) The rationale for the decision, sanctions, or penalties imposed.

b. Acknowledgment of Request for Hearing

i. Upon receipt of a request for hearing, CalOptima Health shall set a hearing date to be held within thirty (30) calendar days after receipt of the request.

ii. CalOptima Health shall send to the Contracted Provider a Hearing Acknowledgment Letter within five (5) calendar days after the Contracted Provider's request for a hearing, setting forth the date, time, and location of the hearing.

c. Hearing

i. The purpose of the hearing is to afford the Contracted Provider an opportunity to contest the factual, or legal, basis of the decision, or the rationale for the decision.

ii. The hearing is intended to be informal in nature. Formal rules of evidence and discovery do not apply. There shall be no cross-examination of witnesses. The Contracted Provider, CalOptima Health, Health Network, and TPA, as appropriate, shall have the opportunity to present oral testimony and documentary evidence.

iii. The Provider Grievance Review Panel shall select a hearing officer to preside at the hearing. The hearing officer may, from time to time, establish hearing guidelines governing the hearing procedure. The hearing officer may ask questions to any party at the hearing, and shall ensure proper decorum at the hearing.

iv. The hearing officer may cause a recording of the hearing to be made either by tape recording, or providing a court reporter service.

v. After the conclusion of the hearing, the Provider Grievance Review Panel may adopt, reject, or modify, in whole or in part, the actions addressed at the hearing. The hearing officer shall send the Provider Grievance Review Panel's written decision to the Contracted Provider, Health Network, and TPA, as appropriate, within forty-five (45) calendar days after the close of the hearing. The decision shall be effective on the date issued by the hearing officer.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. California Health and Safety Code, §1367(h)
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Policy AA.1217: Legal Claims and Judicial Review
D. CalOptima Health Policy HH.2002: Sanctions
E. CalOptima Health Policy HH.2005: Corrective Action Plan
F. CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process
G. Title 28, California Code of Regulations (C.C.R.), §§1300.71.38 and 1300.85.1.
H. CalOptima Health Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	08/01/2005	MA.9006	Provider Complaint Process	OneCare
Revised	05/01/2010	MA.9006	Provider Complaint Process	OneCare
Revised	10/01/2012	MA.9006	Provider Complaint Process	OneCare
Revised	02/01/2015	MA.9006	Provider Complaint Process	OneCare OneCare Connect PACE
Revised	12/01/2016	MA.9006	Provider Complaint Process	OneCare OneCare Connect PACE
Revised	12/01/2022	MA.9006	Provider Complaint Process	OneCare OneCare Connect
Revised	TBD	MA.9006	Provider Complaint Process	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Appeal	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima Health on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima Health requesting review of CalOptima Health's denial, reduction or termination of benefits or services, from CalOptima Health. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals and 42 CFR sections 422.629 through 422.634, 438.210, 438.400, and 438.402. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima Health of an Adverse Benefit Determination.
Complaint	The general term used to identify all provider-filed requests for review and expressions of dissatisfaction with any aspect of CalOptima Health or its Health Networks. This includes Appeals, disputes and Grievances.
Contracted Provider	A Provider who is obligated by a written contract to provide Covered Services to Members on behalf of CalOptima Health, or its contracted Health Networks.
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under CalOptima Health's contract with the Centers of Medicare & Medicaid Services (CMS).
Dispute	A dispute of payment regarding an amount that is less than the expected contracted amount or the amount that would be paid by Medicare.
Executive Officer	For the purposes of this policy, refers to the Chief Operating Officer or their designee.
Grievance	Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima Health's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint."
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with

	CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medically Necessary/Medical Necessity	OneCare: The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Non-Contracted Provider (NCP)	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Organization Determination	Any determination made by CalOptima Health with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima Health; 4. Reduction or premature discontinuation, of a previously authorized ongoing course of treatment; or Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.
Resolution Letter	Written notification of the CalOptima Health's resolution of the complaint.
Third Party Administrator (TPA)	An individual or entity that has a written agreement with CalOptima Health to perform certain functions and tasks relating to, and necessary for, the delivery of Covered Services.

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Policy:	MA.9009
Title:	**Non-Contracted Provider ~~Payment Appeals~~Complaint Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2010
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima Health ensures that Non-Contracted Providers (~~NCP~~NCPs) have a clear and reliable ~~access to an Appeal~~ Complaint process that meets the ~~requirement~~requirements of the Centers for Medicare & Medicaid Services (CMS).

II. POLICY

A. CalOptima Health and Health Networks shall establish and maintain a process that addresses the receipt, handling, and disposition of ~~an Appeal~~Complaints for NCPs in accordance with applicable statutes, regulations, and contractual requirements~~, and the terms and conditions of this policy~~.

B. CalOptima ~~and~~ Health ~~Networks~~ shall provide all parties to ~~an Appeal~~a Complaint with a reasonable opportunity to present evidence~~, or allegations, of fact, or law,~~ related to the issue in dispute in writing. CalOptima Health shall take all relevant evidence into account when making its decision.

C. The CalOptima ~~Claims Administration~~Health Grievance and Appeal Resolution Services (GARS) Department and Health Networks shall process Provider ~~Payment~~ Dispute Resolutions (~~PDRs)~~PDR)s involving ~~payment~~ Disputes regarding payment being less than ~~that~~ what is paid by Medicare fee-for-service~~,~~ within forty-five (45) business days after receipt ~~of such PDR~~.

~~A. In the case of a PDR, CalOptima's Claims Administration Department and Health Networks shall inform the NCP in the notice of PDR decision of his or her right to file a complaint with~~ CalOptima~~, in accordance with CalOptima Policy MA.9006: Provider Complaint Process.~~

D. ~~CalOptima and the~~ Health ~~Networks~~ shall process all NCP claims payment ~~disputes as~~ Appeals, within ~~sixty (60~~thirty (30) calendar days of receipt of the Waiver of Liability

Back to Item

Back to Agenda

(WOL) form~~.~~ for all dates of service after January 1, 2023 (sixty (60) calendar days for dates of service prior to January 1, 2023). NCP claims payment ~~disputes~~ Appeals can constitute any ~~organization determination that leads to a fully or partially~~ adverse ~~determination.~~ Organization ~~determinations include,~~Determination. An adverse Organization Determination includes but ~~are~~is not limited to the following situations:

1. ~~A~~Reopening: when reopening~~, which~~ leads to ~~a fully or partially~~an adverse ~~determination~~Organization Determination;

2. Diagnosis code/DRG payment denials: An NCP submits a claim to CalOptima Health, CalOptima Health initially approves the claim, which is considered a favorable ~~organization determination~~Organization Determination (pursuant to Title 42 Code of Federal Regulations (CFR), section 422.566(b)). CalOptima Health later reopens and revises the favorable ~~organization determination~~Organization Determination and denies the DRG code on the basis that a different DRG code should have been submitted and recoups funds;

3. Downcoding: CalOptima Health approves coverage for inpatient services from a NCP, which is considered a favorable ~~organization determination~~Organization Determination (pursuant to Title 42, CFR section 422.566(b)). CalOptima Health later reopens and revises the favorable ~~organization determination~~Organization Determination (e.g., retrospective review) and determines the Member should have received outpatient services; ~~and~~

4. Bundling issues and disputed rate of payment: Pre-~~-~~and post-pay bundling and global payment determinations. For example, denial of procedure codes – as mutually exclusive to another, or due to inclusion in a previously paid global surgical package~~.~~; and

5. Level of care or rate of payment denials: Payment of a reduced fee schedule amount for a course treatment. For example, ~~a provider~~an NCP bills a procedure code for a visit, but CalOptima Health reimburses based on a lower level of care.

E. NCPs may file an Appeal with ~~the~~ CalOptima ~~Grievance and Appeal Resolution Services (~~Health's GARS~~)~~ Department ~~or the Health Network,~~ within sixty (60) calendar days from the receipt of the Remittance Advice (RA~~) for all payment disputes,~~), notwithstanding ~~PDRs~~the PDR process as described in Section II.~~D~~C. of this Policy.

F. NCP's may file a payment dispute with CalOptima ~~and the Health Networks~~ Health's GARS Department within one hundred twenty (120) calendar days from the receipt of the RA for any payment dispute as referenced in Section II.C. of this Policy.

~~F.~~G. CalOptima Health shall notify an NCP of the Appeal process:

1. In all RAs;

2. On the CalOptima Health Website at ~~www.caloptima.org~~www.caloptima.org; and

3. Upon request by the NCP.

III. PROCEDURE

Back to Item

Back to Agenda

A. Submission of ~~an Appeal request involving Claims payment dispute~~a Complaint:

1. An NCP shall submit the initial ~~payment dispute~~Complaint, in writing, within the required timeframe using the Provider Complaint Resolution Request form located on the CalOptima Health website, or a letter and shall include, at a minimum:

   a. The Member's name;

   b. Medicare Beneficiary Identifier (MBI) (formally known as Medicare Health Insurance Claim (HIC) number) or Client Index Number (CIN);

   c. The specific service(s) and/or items(s) for which the ~~Appeal~~Complaint ~~requested~~filed;

   d. The specific date(s) of the service;

   e. Copy of the original claim or remittance notification showing the denial;

   f. The name and signature of the party or the representative of the party filing the request;

   g. A Waiver of Liability Form; and

   h. Any additional information that supports the request, including, but not limited to, Medical Records.

2. CalOptima ~~or a~~ Health ~~Network~~ shall notify the ~~Provider~~NCP if any required information, as stated in Section III.A.1~~.~~ of this Policy, is missing. ~~If the information is not submitted within the required timeframe,~~ CalOptima Health shall ~~process the Appeal in accordance~~allow the NCP thirty (30) days to resubmit the request with ~~Sections III.B., and III.C. of this Policy~~the missing information. If not received, the request is invalidated.

B. For a PDR handled by a Health Network or CalOptima ~~Claims Administration~~Health GARS Department:

1. For disputes for a payment less than that paid by Medicare fee-for-service, the NCP shall file the dispute with the payer as identified on the RA, either the Health Network or CalOptima ~~Claims Administration~~Health's GARS Department.

   a. Contact information for Health Networks is available on the CalOptima Health website at ~~www.caloptima.org~~www.caloptima.org, or by contacting ~~CalOptima's~~CalOptima Health's Health Network Relations Department at 714-246-8600.

   b. Claims processed by the CalOptima Health Claims Administration Department, mail to:

      CalOptima ~~Claims~~Health Grievance and Appeal Resolution Services (GARS) Department ~~– Provider Dispute Unit~~

Back to Item

Back to Agenda

~~P.O. Box 57015~~
~~Irvine~~505 City Parkway West
Orange CA ~~92619~~92868

C. ~~CalOptima's Claims Administration~~CalOptima Health's GARS Department and the Health Network shall issue a ~~PDR notice~~ Resolution Letter to the NCP within ~~thirty (30) calendar days of~~the timeframe shown below, following the receipt of the request.

~~1. An NCP may file a complaint with CalOptima, in accordance with CalOptima Policy MA.9006: Provider Complaint Process:~~

~~a. If the NCP is not satisfied with the decision issued by the Health Network or CalOptima Claims Administration Department; or~~

~~b. A decision is not issued by the Health Network or CalOptima Claims Administration Department within the one hundred and eighty (180) calendar day time limit.~~

1. Thirty (30) calendar days for services rendered on or after January 1, 2023.

2. Sixty (60) calendar days for services rendered on or before December 31, 2022.

D. For an Appeal handled by CalOptima ~~GARS or a Health Network, such Appeals are payment disputes from NCP Medicare providers, that are not PDRs:~~Health

1. File the request, in writing, within sixty (60) calendar days from the notice of denial with CalOptima ~~GARS or the~~ Health ~~Network~~GARS, based on the payer on the RA.

2. The NCP may request an extension to this timeframe for good cause by submitting a written request for such an extension that includes the reason the NCP cannot meet the timeframe, in accordance with Title 20 CFR, ~~section~~Section 404.911.

3. Upon verification that the request meets criteria for processing as an NCP Appeal, CalOptima ~~GARS or the~~ Health's ~~Network~~GARS Department shall send ~~the~~an NCP an acknowledgement letter and a WOL form, if not already included with the NCP Appeal request, after receipt of the NCP Appeal request.

4. If the NCP fails to submit a signed WOL form after three (3) attempts (written and verbal requests) by CalOptima ~~GARS or the~~ Health ~~Network~~GARS, the GARS Department ~~or the Health Network~~ shall notify the NCP that the request shall be dismissed due to lack of the WOL, no sooner than sixty (60) calendar days from the receipt of the request. The Notice of Dismissal of Appeal Request shall inform the NCP of the process and the right to request a review of the dismissal by the Independent Review Entity (IRE).

5. CalOptima ~~GARS or the~~ Health ~~Network~~GARS Department shall commence review of the NCP Appeal upon receipt of the signed WOL form or letter of good cause, as applicable, and the review shall be completed within sixty (60) calendar days of that the receipt date.

6. Upon completion of review of the NCP Appeal, GARS ~~or the Health Network~~ shall send

Back to Item

Back to Agenda

a ~~resolution letter~~ Resolution Letter to the NCP informing the NCP of the review decision within sixty (60) calendar days of receipt of the signed WOL form.

7. Failure of the CalOptima ~~GARS or the~~ Health ~~Network~~GARS Department to provide the NCP with a decision within the sixty (60) calendar day period constitutes an adverse decision and ~~GARS or the~~CalOptima Health ~~Network~~GARS shall forward the NCP Appeal to the IRE for review.

8. An Appeal decision which upholds in whole, or in part, the initial denial shall be forwarded to the IRE for review.

E. ~~Appeal~~Complaint Review

1. CalOptima ~~or the~~ Health ~~Network~~ shall designate an individual other than the person involved in making the initial adverse Organization Determination to review a request for ~~Appeal~~NCP Complaint.

   a. If the original denial is based on a lack of Medical Necessity, a physician with expertise in the field of medicine that is appropriate for the requested service shall review the request for ~~Appeal.~~NCP Complaint. The reviewing physician shall possess the appropriate level of training and expertise to evaluate the necessity of the service, but need not have the same specialty, or subspecialty, as the treating physician.

   b. If the request for ~~Appeal~~NCP Complaint involves Emergency Services, CalOptima Health shall apply the Prudent Layperson Standard when reviewing the Appeal.

2. GARS staff ~~or the Health Network~~ shall present the ~~Appeal~~NCP Complaint request to the appropriate reviewer for a decision.

3. CalOptima ~~GARS or the~~ Health ~~Network~~GARS shall document the decision made by the reviewer, the rationale for the decision, and include the name of the staff member who reviewed the case in a ~~Provider resolution letter.~~ Resolution Letter.

4. If, upon the ~~Appeal~~NCP Complaint review, CalOptima ~~or the~~ Health ~~Network~~ completely reverses its adverse Organization Determination, GARS staff ~~or the Health Network~~ shall:

   a. Notify the ~~Provider~~NCP of the decision, in writing;

   b. Notify and request claim payment from CalOptima Health or the Health Network Claims Department;

   c. Verify that CalOptima Health or the Health Network made payment through the claims system and/or that a retro-authorization was issued;

   d. Ensure that CalOptima Health or the Health Network adjusts claims for payment within sixty (60) calendar days after the date of receipt of the request for ~~Appeal~~NCP Complaint;

   e. Ensure that the NCP's case file includes documentation of payment and retro-

Back to Item

Back to Agenda

authorization, if required; and

f. Note the ~~Appeal~~NCP Complaint as "closed" in the ~~Appeals~~Complaint database.

5. If, upon NCP Appeal review, CalOptima ~~or the~~ Health ~~Network~~ affirms, in whole~~,~~ or in part, the adverse Organization Determination, CalOptima ~~or the~~ Health ~~Network~~ shall take the following actions:

a. Notify the NCP who requested the ~~Appeal~~NCP Complaint no later than sixty (60) calendar days after receipt of the signed WOL, including notice that CalOptima ~~or the~~ Health ~~Network~~ forwarded the Appeal to the IRE.

b. Forward a copy of the case file, and the Reconsideration Background Data Form and Case Narrative Form to the IRE, no later than sixty (60) calendar days of receipt of the signed WOL. ~~The Health Network should notify CalOptima of submission to the IRE simultaneously with submission.~~

F. IRE Determination

1. The IRE shall ~~make a decision~~decide on an Appeal in accordance with its CMS contracted timeframe.

2. The IRE may request additional information from CalOptima ~~or the~~ Health ~~Network~~ within a specified timeframe using the IRE Request for Additional Information Form. Upon receipt of such request, CalOptima Health GARS staff ~~or the Health Network~~ shall make every effort to provide the requested information within the specified timeframe using the Request for Information Response Letter to IRE. ~~The Health Network should notify CalOptima of any additional submissions to the IRE at the time of submission to the IRE.~~

3. If the IRE upholds ~~CalOptima's or the Health Network's~~CalOptima Health's adverse Organization Determination, it shall notify CalOptima ~~or the~~ Health ~~Network~~ and the NCP of such decision, in writing. ~~-~~Upon receipt of such notice, GARS staff ~~or the Health Network~~ shall place the notice in the NCP's Appeal file. ~~The Health Network should notify CalOptima of the final decision by the IRE within five (5) calendar days of notification.~~

4. If the IRE reverses or partially reverses ~~CalOptima's or the Health Network's~~CalOptima Health's adverse Organization Determination, CalOptima Health GARS ~~or the Health Network~~ shall:

a. Coordinate with the CalOptima Health Claims Administration Department to arrange for the payment or adjustment of the Appealed claim no later than thirty (30) calendar days after notice from the IRE;

b. Coordinate with the Health Network's Claims Administration Department to arrange for the payment or adjustment of the Appealed claim no later than twenty (20) calendar days after notice from the IRE;

c. Notify the NCP of the IRE's decision and compliance with IRE decision;

d. Send a notification of compliance letter to the IRE; and

e. Document all activities in the Appeal tracking system.

5. The Health Network shall notify CalOptima Health of the final decision by the IRE, with proof of effectuation within twenty (20) calendar days of notification.

G. Administrative Law Judge (ALJ) Hearing

1. An NCP that provided Covered Services to a Member has the right to a hearing before an ALJ if the projected value of the disputed service meets the threshold amount specified in the Medicare Managed Care Manual, as determined by Medicare regulations and the ALJ.

2. An NCP shall request an ALJ hearing by submitting such request:

a. In writing to CalOptima Health, or the IRE; and

b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. The NCP may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the NCP cannot meet the timeframe in accordance with Title 20 CFR, section 40 4.911.

3. If CalOptima Health receives a request for an ALJ hearing from an NCP, CalOptima Health GARS staff shall forward the ~~Provider~~ NCP request for ALJ hearing to the IRE. The IRE shall compile and forward the NCP's file to the ALJ.

4. If the Health Network receives a request for an ALJ hearing from an NCP, the Health Network shall forward the ~~Provider~~ NCP request for ALJ hearing to the IRE with a Carbon Copy to CalOptima~~.~~ Health. The IRE shall compile and forward the NCP's file to the ALJ.

5. CalOptima Health or the Health Network shall not have the right to request an ALJ hearing but may remain a party to the hearing.

6. If the ALJ reverses ~~CalOptima's~~CalOptima Health's or the Health Network's initial adverse Organization Determination in whole, or in part, CalOptima Health shall:

a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the ALJ reversing the adverse Organization Determination unless it requests Medicare Appeals Council (MAC) review of the ALJ decision in accordance with Section III.H. of this Policy~~.~~; or

b. Request a MAC Hearing of the ALJ decision; and

c. Wait for the MAC's decision before it authorizes, or provides, the disputed service; and

d. Inform the IRE when it effectuates the decision.

H. Medicare Appeals Council (MAC) Review

Back to Item

Back to Agenda

1. Any party that is dissatisfied with the ALJ hearing decision, including CalOptima Health, may request a MAC Hearing of the ALJ decision, or dismissal.

2. A party requesting a MAC Hearing shall submit such request:

   a. In writing, directly to the MAC; and

   b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision, or dismissal. The MAC may grant an extension if the requesting party demonstrates good cause.

3. If CalOptima Health receives an NCP's request for a MAC Hearing, it shall forward a copy of the NCP request for MAC Hearing, the NCP's complete case file, and a cover letter to the MAC.

4. If the Health Network receives an NCP's request for a MAC Hearing~~, it~~ the Health Network shall forward a copy of the NCP request for MAC Hearing, the NCP's complete case file, and a cover letter to CalOptima Health within five (5) days of receipt.

5. If CalOptima Health requests a MAC Hearing, it shall:

   a. Submit a CalOptima Health Request for MAC Hearing and a complete case file to the MAC;

   b. Concurrently notify the NCP of ~~CalOptima's~~CalOptima Health's request by sending the ~~Provider~~ NCP a copy of the request and all information submitted to the MAC; and

   c. Notify the IRE of ~~CalOptima's~~CalOptima Health's request.

6. The MAC may initiate a review on its motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC shall notify all parties, in writing, of its decision to initiate such a review.

7. If the MAC reverses ~~CalOptima's~~CalOptima Health's or the Health Networks' initial adverse Organization Determination in whole, or in part, CalOptima Health or the Health Network shall:

   a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the MAC reversing the initial adverse Organization Determination; and

   b. Inform the IRE when it effectuates the decision.

I. Judicial Review

1. Any party, including CalOptima Health, may request a judicial review of an ALJ decision if:

   a. The MAC denied the party's request for review; and

Back to Item

Back to Agenda

b. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

2. Any party, including CalOptima Health, may request a judicial review of a MAC decision if:

a. The MAC denied the party's request for review; or

b. It is the final decision of CMS; and

c. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

3. A party may not obtain a judicial review unless the MAC has acted on the case.

4. In order to obtain ~~a~~ judicial review, a party shall file a civil action in a district court of the United States in accordance with Section 205(g) of the Social Security Act.

5. CalOptima Health shall notify all other parties to an Appeal prior to requesting a judicial review.

6. If the judicial review reverses ~~CalOptima's~~CalOptima Health's or the Health Network's initial adverse Organization Determination in whole, or in part, CalOptima Health or a Health Network shall:

a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the judicial review reversing the adverse Organization Determination; and

b. Inform the IRE when it effectuates the decision.

J. Documentation of Data

1. ~~CalOptima's~~CalOptima Health's GARS ~~and Claims Administration Departments and Health Networks~~Department shall document all actions taken related to ~~an~~a ~~Non-Contracted Provider~~ NCP Appeal request in its tracking system and/or hard copy including, but not limited to:

a. Provider's name;

b. Date received;

c. Name of staff that received the ~~complaint~~Complaint at CalOptima Health;

d. Designated contact person;

e. Description of the ~~complaint~~Complaint;

f. Date; and

g. Disposition.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Three-Way Contract with the Department of Health Care Services (DHCS) and the Centers for Medicaid and Medicare Services (CMS) for Cal MediConnect
C. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
D. CalOptima Health Policy MA.9015: Standard Integrated Appeals
~~D.~~E. Centers for Medicare & Medicaid Services Letter, Provider Payment Dispute Resolution for Non-Contracted Providers, January 4, 2010
~~E.~~F. "Part C Dismissals Procedure," Health Plan Management System (HPMS) Memorandum, Issued September 10, 2013
~~F.~~G. "Model Dismissal Notice," Health Plan Management System (HPMS) Memorandum, Issued October 30, 2013
~~G.~~H. MA Payment Guide for Out of Network Payments, Revised April 15, 2015
~~H.~~I. MAXIMUS Medicare Health Plan Reconsideration Process Manual, Revised January 2020
~~I.~~J. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Revised January 2020
~~J.~~K. "Non-Contract Provider Access to Medicare Administrative Appeals Process," Health Plan Management System (HPMS) Memorandum, Issued September 23, 2020
~~K.~~L. Social Security Act, §§1852(k) and 1894(b)(3)
~~L.~~M. Title 20, Code of Federal Regulations (C.F.R.), § 404.911.
~~M.~~N. Title 20, California Code of Regulations (C.C.R.), §§ 1300.71 and 1300.71.38.
~~N.~~O. Title 42, Code of Federal Regulations (C.F.R.), §§417.588, 422.214, 422.520, 422.560, 422.566(b) et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting	Action
05/05/2022	Regular Meeting of the CalOptima Board of Directors	Ratified Post-CEO Approval

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	03/01/2012	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	01/01/2014	MA.9009	Non-Contracted Provider Payment Disputes	OneCare

Back to Item

Back to Agenda

Action	Date	Policy	Policy Title	Program(s)
Revised	03/01/2014	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	01/01/2015	MA.9009	Non-Contracted Provider Payment Disputes	OneCare OneCare Connect
Revised	01/01/2017	MA.9009	Non-Contracted Provider Payment Disputes	OneCare OneCare Connect
Revised	04/01/2022	MA.9009	Non-Contracted Provider Payment Appeals	OneCare OneCare Connect
Revised	TBD	MA.9009	Non-Contracted Provider Complaint Process	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Appeal(s)	OneCare: Any of the procedures that deal with the review of an adverse ~~initial determination~~Organization Determination made by CalOptima Health on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima Health requesting review of ~~CalOptima's~~CalOptima Health's denial, reduction or termination of benefits or services, from CalOptima Health. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals~~.~~ and 42 CFR sections 422.629 through 422.634, 438.210, 438.400, and 438.402. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima Health of an Adverse Benefit Determination.
Complaint	The general term used to identify all provider-filed requests for review and expressions of dissatisfaction with any aspect of CalOptima Health or its Health Networks. This includes Appeals, disputes and Grievances.
Contracted Provider	A Provider who is obligated by a written contract to provide Covered Services to Members on behalf of CalOptima Health, or its contracted Health Networks.
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under CalOptima's contract with the Centers of Medicare & Medicaid Services (CMS~~) Contract.~~).
Dispute	A dispute of payment regarding an amount that is less than the expected contracted amount or the amount that would be paid by Medicare.
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish Emergency Services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Independent Review Entity (IRE)	An independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review denial of Coverage Determinations.

Term	Definition
Medical Record	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.
Medically Necessary/Medical Necessity	OneCare: The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Non-Contracted Provider (NCP)	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Organization Determination	Any determination made by CalOptima Health~~OneCare Connect~~ with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider ~~other than OneCare Connect~~ that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by ~~OneCare Connect~~CalOptima Health. 3. ~~OneCare Connect's refusal to~~Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by ~~OneCare Connect~~CalOptima Health; ~~3. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and~~ 4. ~~OneCare Connect's failure~~Reduction or premature discontinuation, of a previously authorized ongoing course of treatment; or ~~4.~~5. Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the ~~Member's~~ health of the Member.

Term	Definition
Prudent Layperson Standard	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person ~~might anticipate~~could reasonably expect serious impairment to his or her health in an emergency situation.
Remittance Advice (RA)	A summary report, by claim, that supports the detail payment, denial, or adjustment made by check.
Reopening	A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.
Resolution Letter	Written notification of the CalOptima Health's resolution of the complaint.
Waiver of Liability	The Waiver of Liability statement ensures the Non-Contracted Provider shall hold the Member harmless regardless of the outcome of the Appeal.

1

Policy:	MA.9009
Title:	**Non-Contracted Provider Complaint Process**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2010
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima Health ensures that Non-Contracted Providers (NCPs) have a clear and reliable Complaint process that meets the requirements of the Centers for Medicare & Medicaid Services (CMS).

II. POLICY

A. CalOptima Health and Health Networks shall establish and maintain a process that addresses the receipt, handling, and disposition of Complaints for NCPs in accordance with applicable statutes, regulations, and contractual requirements.

B. CalOptima Health shall provide all parties to a Complaint with a reasonable opportunity to present evidence related to the issue in dispute in writing. CalOptima Health shall take all relevant evidence into account when making its decision.

C. The CalOptima Health Grievance and Appeal Resolution Services (GARS) Department and Health Networks shall process Provider Dispute Resolutions (PDR)s involving Disputes regarding payment being less than what is paid by Medicare fee-for-service, within forty-five (45) business days after receipt.

D. CalOptima Health shall process all NCP claims payment Appeals, within thirty (30) calendar days of receipt of the Waiver of Liability (WOL) form for all dates of service after January 1, 2023 (sixty (60) calendar days for dates of service prior to January 1, 2023). NCP claims payment Appeals can constitute any adverse Organization Determination. An adverse Organization Determination includes but is not limited to the following situations:

1. Reopening: when reopening leads to an adverse Organization Determination;

2. Diagnosis code/DRG payment denials: An NCP submits a claim to CalOptima Health.

Back to Item

Back to Agenda

CalOptima Health initially approves the claim, which is considered a favorable Organization Determination (pursuant to Title 42 Code of Federal Regulations (CFR), section 422.566(b)). CalOptima Health later reopens and revises the favorable Organization Determination and denies the DRG code on the basis that a different DRG code should have been submitted and recoups funds;

3. Downcoding: CalOptima Health approves coverage for inpatient services from a NCP, which is considered a favorable Organization Determination (pursuant to Title 42, CFR section 422.566(b)). CalOptima Health later reopens and revises the favorable Organization Determination (e.g., retrospective review) and determines the Member should have received outpatient services;

4. Bundling issues and disputed rate of payment: Pre-and post-pay bundling and global payment determinations. For example, denial of procedure codes – as mutually exclusive to another, or due to inclusion in a previously paid global surgical package; and

5. Level of care or rate of payment denials: Payment of a reduced fee schedule amount for a course treatment. For example, an NCP bills a procedure code for a visit, but CalOptima Health reimburses based on a lower level of care.

E. NCPs may file an Appeal with CalOptima Health's GARS Department within sixty (60) calendar days from the receipt of the Remittance Advice (RA), notwithstanding the PDR process as described in Section II.C. of this Policy.

F. NCP's may file a payment dispute with CalOptima Health's GARS Department within one hundred twenty (120) calendar days from the receipt of the RA for any payment dispute as referenced in Section II.C. of this Policy.

G. CalOptima Health shall notify an NCP of the Appeal process:

1. In all RAs;

2. On the CalOptima Health Website at www.caloptima.org; and

3. Upon request by the NCP.

III. PROCEDURE

A. Submission of a Complaint:

1. An NCP shall submit the initial Complaint, in writing, within the required timeframe using the Provider Complaint Resolution Request form located on the CalOptima Health website, or a letter and shall include, at a minimum:

a. The Member's name;

b. Medicare Beneficiary Identifier (MBI) (formally known as Medicare Health Insurance Claim (HIC) number) or Client Index Number (CIN);

c. The specific service(s) and/or items(s) for which the Complaint is being filed;

Back to Item

Back to Agenda

d. The specific date(s) of the service;

e. Copy of the original claim or remittance notification showing the denial;

f. The name and signature of the party or the representative of the party filing the request;

g. A Waiver of Liability Form; and

h. Any additional information that supports the request, including, but not limited to, Medical Records.

2. CalOptima Health shall notify the NCP if any required information, as stated in Section III.A.1 of this Policy, is missing. CalOptima Health shall allow the NCP thirty (30) days to resubmit the request with the missing information. If not received, the request is invalidated.

B. For a PDR handled by a Health Network or CalOptima Health GARS Department:

1. For disputes for a payment less than that paid by Medicare fee-for-service, the NCP shall file the dispute with the payer as identified on the RA, either the Health Network or CalOptima Health's GARS Department.

a. Contact information for Health Networks is available on the CalOptima Health website at www.caloptima.org, or by contacting CalOptima Health's Health Network Relations Department at 714-246-8600.

b. Claims processed by the CalOptima Health Claims Administration Department, mail to:

CalOptima Health Grievance and Appeal Resolution Services
(GARS) Department
505 City Parkway West
Orange CA 92868

C. CalOptima Health's GARS Department and the Health Network shall issue a Resolution Letter to the NCP within the timeframe shown below, following the receipt of the request.

1. Thirty (30) calendar days for services rendered on or after January 1, 2023.

2. Sixty (60) calendar days for services rendered on or before December 31, 2022.

D. For an Appeal handled by CalOptima Health

1. File the request, in writing, within sixty (60) calendar days from the notice of denial with CalOptima Health GARS, based on the payer on the RA.

2. The NCP may request an extension to this timeframe for good cause by submitting a written request for such an extension that includes the reason the NCP cannot meet the timeframe, in accordance with Title 20 CFR, Section 404.911.

Back to Item

Back to Agenda

3. Upon verification that the request meets criteria for processing as an NCP Appeal, CalOptima Health's GARS Department shall send the NCP an acknowledgement letter and a WOL form, if not already included with the NCP Appeal request, after receipt of the NCP Appeal request.

4. If the NCP fails to submit a signed WOL form after three (3) attempts (written and verbal requests) by CalOptima Health GARS, the GARS Department shall notify the NCP that the request shall be dismissed due to lack of the WOL, no sooner than sixty (60) calendar days from the receipt of the request. The Notice of Dismissal of Appeal Request shall inform the NCP of the process and the right to request a review of the dismissal by the Independent Review Entity (IRE).

5. CalOptima Health GARS Department shall commence review of the NCP Appeal upon receipt of the signed WOL form or letter of good cause, as applicable, and the review shall be completed within sixty (60) calendar days of that the receipt date.

6. Upon completion of review of the NCP Appeal, GARS shall send a Resolution Letter to the NCP informing the NCP of the review decision within sixty (60) calendar days of receipt of the signed WOL form.

7. Failure of the CalOptima Health GARS Department to provide the NCP with a decision within the sixty (60) calendar day period constitutes an adverse decision and CalOptima Health GARS shall forward the NCP Appeal to the IRE for review.

8. An Appeal decision which upholds in whole, or in part, the initial denial shall be forwarded to the IRE for review.

E. Complaint Review

1. CalOptima Health shall designate an individual other than the person involved in making the initial adverse Organization Determination to review a request for NCP Complaint.

   a. If the original denial is based on a lack of Medical Necessity, a physician with expertise in the field of medicine that is appropriate for the requested service shall review the request for NCP Complaint. The reviewing physician shall possess the appropriate level of training and expertise to evaluate the necessity of the service, but need not have the same specialty, or subspecialty, as the treating physician.

   b. If the request for NCP Complaint involves Emergency Services, CalOptima Health shall apply the Prudent Layperson Standard when reviewing the Appeal.

2. GARS staff shall present the NCP Complaint request to the appropriate reviewer for a decision.

3. CalOptima Health GARS shall document the decision made by the reviewer, the rationale for the decision, and include the name of the staff member who reviewed the case in a Resolution Letter.

4. If, upon the NCP Complaint review, CalOptima Health completely reverses its adverse Organization Determination, GARS staff shall:

Back to Item

Back to Agenda

a. Notify the NCP of the decision, in writing;

b. Notify and request claim payment from CalOptima Health or the Health Network Claims Department;

c. Verify that CalOptima Health or the Health Network made payment through the claims system and/or that a retro-authorization was issued;

d. Ensure that CalOptima Health or the Health Network adjusts claims for payment within sixty (60) calendar days after the date of receipt of the request for NCP Complaint;

e. Ensure that the NCP's case file includes documentation of payment and retro-authorization, if required; and

f. Note the NCP Complaint as "closed" in the Complaint database.

5. If, upon NCP Appeal review, CalOptima Health affirms, in whole or in part, the adverse Organization Determination, CalOptima Health shall take the following actions:

a. Notify the NCP who requested the NCP Complaint no later than sixty (60) calendar days after receipt of the signed WOL, including notice that CalOptima Health forwarded the Appeal to the IRE.

b. Forward a copy of the case file, and the Reconsideration Background Data Form and Case Narrative Form to the IRE, no later than sixty (60) calendar days of receipt of the signed WOL.

F. IRE Determination

1. The IRE shall decide on an Appeal in accordance with its CMS contracted timeframe.

2. The IRE may request additional information from CalOptima Health within a specified timeframe using the IRE Request for Additional Information Form. Upon receipt of such request, CalOptima Health GARS staff shall make every effort to provide the requested information within the specified timeframe using the Request for Information Response Letter to IRE.

3. If the IRE upholds CalOptima Health's adverse Organization Determination, it shall notify CalOptima Health and the NCP of such decision, in writing. Upon receipt of such notice, GARS staff shall place the notice in the NCP's Appeal file.

4. If the IRE reverses or partially reverses CalOptima Health's adverse Organization Determination, CalOptima Health GARS shall:

a. Coordinate with the CalOptima Health Claims Administration Department to arrange for the payment or adjustment of the Appealed claim no later than thirty (30) calendar days after notice from the IRE;

b. Coordinate with the Health Network's Claims Administration Department to arrange for the payment or adjustment of the Appealed claim no later than twenty (20)

Back to Item

Back to Agenda

calendar days after notice from the IRE;

c. Notify the NCP of the IRE's decision and compliance with IRE decision;

d. Send a notification of compliance letter to the IRE; and

e. Document all activities in the Appeal tracking system.

5. The Health Network shall notify CalOptima Health of the final decision by the IRE, with proof of effectuation within twenty (20) calendar days of notification.

G. Administrative Law Judge (ALJ) Hearing

1. An NCP that provided Covered Services to a Member has the right to a hearing before an ALJ if the projected value of the disputed service meets the threshold amount specified in the Medicare Managed Care Manual, as determined by Medicare regulations and the ALJ.

2. An NCP shall request an ALJ hearing by submitting such request:

a. In writing to CalOptima Health, or the IRE; and

b. Within sixty (60) calendar days after the notice from the IRE of its Appeal decision. The NCP may request an extension to this timeframe for good cause by submitting a written request for such extension that includes the reason the NCP cannot meet the timeframe in accordance with Title 20 CFR, section 40 4.911.

3. If CalOptima Health receives a request for an ALJ hearing from an NCP, CalOptima Health GARS staff shall forward the NCP request for ALJ hearing to the IRE. The IRE shall compile and forward the NCP's file to the ALJ.

4. If the Health Network receives a request for an ALJ hearing from an NCP, the Health Network shall forward the NCP request for ALJ hearing to the IRE with a Carbon Copy to CalOptima Health. The IRE shall compile and forward the NCP's file to the ALJ.

5. CalOptima Health or the Health Network shall not have the right to request an ALJ hearing but may remain a party to the hearing.

6. If the ALJ reverses CalOptima Health's or the Health Network's initial adverse Organization Determination in whole, or in part, CalOptima Health shall:

a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the ALJ reversing the adverse Organization Determination unless it requests Medicare Appeals Council (MAC) review of the ALJ decision in accordance with Section III.H. of this Policy; or

b. Request a MAC Hearing of the ALJ decision; and

c. Wait for the MAC's decision before it authorizes, or provides, the disputed service; and

d. Inform the IRE when it effectuates the decision.

Back to Item

Back to Agenda

H. Medicare Appeals Council (MAC) Review

1. Any party that is dissatisfied with the ALJ hearing decision, including CalOptima Health, may request a MAC Hearing of the ALJ decision, or dismissal.

2. A party requesting a MAC Hearing shall submit such request:

   a. In writing, directly to the MAC; and

   b. Within sixty (60) calendar days after the date of receipt of the ALJ hearing decision, or dismissal. The MAC may grant an extension if the requesting party demonstrates good cause.

3. If CalOptima Health receives an NCP's request for a MAC Hearing, it shall forward a copy of the NCP request for MAC Hearing, the NCP's complete case file, and a cover letter to the MAC.

4. If the Health Network receives an NCP's request for a MAC Hearing the Health Network shall forward a copy of the NCP request for MAC Hearing, the NCP's complete case file, and a cover letter to CalOptima Health within five (5) days of receipt.

5. If CalOptima Health requests a MAC Hearing, it shall:

   a. Submit a CalOptima Health Request for MAC Hearing and a complete case file to the MAC;

   b. Concurrently notify the NCP of CalOptima Health's request by sending the NCP a copy of the request and all information submitted to the MAC; and

   c. Notify the IRE of CalOptima Health's request.

6. The MAC may initiate a review on its motion within sixty (60) calendar days after the date of an ALJ hearing decision, or dismissal. The MAC shall notify all parties, in writing, of its decision to initiate such a review.

7. If the MAC reverses CalOptima Health's or the Health Networks' initial adverse Organization Determination in whole, or in part, CalOptima Health or the Health Network shall:

   a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the MAC reversing the initial adverse Organization Determination; and

   b. Inform the IRE when it effectuates the decision.

I. Judicial Review

1. Any party, including CalOptima Health, may request a judicial review of an ALJ decision if:

   a. The MAC denied the party's request for review; and

b. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

2. Any party, including CalOptima Health, may request a judicial review of a MAC decision if:

a. The MAC denied the party's request for review; or

b. It is the final decision of CMS; and

c. The amount in controversy meets the threshold amount specified in the Medicare Managed Care Manual.

3. A party may not obtain a judicial review unless the MAC has acted on the case.

4. In order to obtain judicial review, a party shall file a civil action in a district court of the United States in accordance with Section 205(g) of the Social Security Act.

5. CalOptima Health shall notify all other parties to an Appeal prior to requesting a judicial review.

6. If the judicial review reverses CalOptima Health's or the Health Network's initial adverse Organization Determination in whole, or in part, CalOptima Health or a Health Network shall:

a. Pay the disputed claim within sixty (60) calendar days after the date it receives notice from the judicial review reversing the adverse Organization Determination; and

b. Inform the IRE when it effectuates the decision.

J. Documentation of Data

1. CalOptima Health's GARS Department shall document all actions taken related to a NCP Appeal request in its tracking system and/or hard copy including, but not limited to:

a. Provider's name;

b. Date received;

c. Name of staff that received the Complaint at CalOptima Health;

d. Designated contact person;

e. Description of the Complaint;

f. Date; and

g. Disposition.

Back to Item

Back to Agenda

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Three-Way Contract with the Department of Health Care Services (DHCS) and the Centers for Medicaid and Medicare Services (CMS) for Cal MediConnect
C. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
D. CalOptima Health Policy MA.9015: Standard Integrated Appeals
E. Centers for Medicare & Medicaid Services Letter, Provider Payment Dispute Resolution for Non-Contracted Providers, January 4, 2010
F. "Part C Dismissals Procedure," Health Plan Management System (HPMS) Memorandum, Issued September 10, 2013
G. "Model Dismissal Notice," Health Plan Management System (HPMS) Memorandum, Issued October 30, 2013
H. MA Payment Guide for Out of Network Payments, Revised April 15, 2015
I. MAXIMUS Medicare Health Plan Reconsideration Process Manual, Revised January 2020
J. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Revised January 2020
K. "Non-Contract Provider Access to Medicare Administrative Appeals Process," Health Plan Management System (HPMS) Memorandum, Issued September 23, 2020
L. Social Security Act, §§1852(k) and 1894(b)(3)
M. Title 20, Code of Federal Regulations (C.F.R.), § 404.911.
N. Title 20, California Code of Regulations (C.C.R.), §§ 1300.71 and 1300.71.38.
O. Title 42, Code of Federal Regulations (C.F.R.), §§417.588, 422.214, 422.520, 422.560, 422.566(b) et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting	Action
05/05/2022	Regular Meeting of the CalOptima Board of Directors	Ratified Post-CEO Approval

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	03/01/2012	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	01/01/2014	MA.9009	Non-Contracted Provider Payment Disputes	OneCare
Revised	03/01/2014	MA.9009	Non-Contracted Provider Payment Disputes	OneCare

Back to Item

Back to Agenda

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2015	MA.9009	Non-Contracted Provider Payment Disputes	OneCare OneCare Connect
Revised	01/01/2017	MA.9009	Non-Contracted Provider Payment Disputes	OneCare OneCare Connect
Revised	04/01/2022	MA.9009	Non-Contracted Provider Payment Appeals	OneCare OneCare Connect
Revised	TBD	MA.9009	Non-Contracted Provider Complaint Process	OneCare OneCare Connect

1

Back to Item

Back to Agenda

IX. GLOSSARY

Term	Definition
Appeal(s)	OneCare: Any of the procedures that deal with the review of an adverse Organization Determination made by CalOptima Health on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima Health requesting review of CalOptima Health's denial, reduction or termination of benefits or services, from CalOptima Health. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals and 42 CFR sections 422.629 through 422.634, 438.210, 438.400, and 438.402. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima Health of an Adverse Benefit Determination.
Complaint	The general term used to identify all provider-filed requests for review and expressions of dissatisfaction with any aspect of CalOptima Health or its Health Networks. This includes Appeals, disputes and Grievances.
Contracted Provider	A Provider who is obligated by a written contract to provide Covered Services to Members on behalf of CalOptima Health, or its contracted Health Networks.
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under CalOptima's contract with the Centers of Medicare & Medicaid Services (CMS).
Dispute	A dispute of payment regarding an amount that is less than the expected contracted amount or the amount that would be paid by Medicare.
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish Emergency Services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Independent Review Entity (IRE)	An independent entity contracted by the Centers for Medicare & Medicaid Services (CMS) to review denial of Coverage Determinations.

Back to Item

Back to Agenda

Term	Definition
Medical Record	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.
Medically Necessary/Medical Necessity	OneCare: The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Non-Contracted Provider (NCP)	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Organization Determination	Any determination made by CalOptima Health with respect to any of the following: 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima Health; 4. Reduction or premature discontinuation, of a previously authorized ongoing course of treatment; or 5. Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.
Prudent Layperson Standard	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person could reasonably expect serious impairment to his or her health in an emergency situation.

Term	Definition
Remittance Advice (RA)	A summary report, by claim, that supports the detail payment, denial, or adjustment made by check.
Reopening	A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.
Resolution Letter	Written notification of the CalOptima Health's resolution of the complaint.
Waiver of Liability	The Waiver of Liability statement ensures the Non-Contracted Provider shall hold the Member harmless regardless of the outcome of the Appeal.

1

Back to Item

Back to Agenda

Policy:	HH.1101
Title:	**CalOptima Health Provider Complaint**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	03/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima Health, Health Networks, and Third-Party Administrators (TPA) address and resolve contracted Provider Complaints, which include, but are not limited to, Provider ~~Grievances or disputes or Appeals for claims payment, utilization management decisions, and other non-payment related issues~~Disputes, Appeals, and Grievances~~.~~.

II. POLICY

A. CalOptima Health, Health Networks, and TPAs shall maintain a fast, fair, and cost-effective ~~Grievance~~ system to process and resolve contracted Provider Complaints, in accordance with applicable statutory, regulatory, and contractual requirements.

B. Providers shall utilize the Health Network and TPA grievance systems prior to filing a Complaint directly with CalOptima Health, in accordance with this Policy.

C. Multipurpose Senior Services Program (MSSP) Providers shall submit issues arising out of or related to the contract between CalOptima Health and a MSSP Provider, including but not limited to ~~disputes~~Disputes, claims, protests of awards or other contractual issues to the CalOptima Health Grievance and Appeals Resolution Services (GARS). ~~CalOptima Health's~~ GARS Department shall process the Complaints in accordance with the CalOptima Health MSSP-Department of Aging contract.

D. Complaints related to Appeals of Medical Necessity will be processed in accordance with CalOptima Health Policy HH.1102: Member Grievance

E. CalOptima Health, Health Networks, and TPAs shall promptly review and investigate Complaints and resolve them, in accordance with the timeframes set forth herein.

F. CalOptima Health, Health Networks, and TPAs shall not discriminate or retaliate against any Provider (including, but not limited to, terminating the Provider's contract) on grounds that such Provider filed a Complaint, in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations.

Back to Item

Back to Agenda

G. CalOptima Health, Health Networks, and TPAs shall designate a principal officer to be primarily responsible for the maintenance, oversight, and analysis of trends and preparation of reports related to Provider Complaints as required by this Policy and applicable regulations.

H. CalOptima Health, Health Networks, and TPAs shall not impose a deadline for receipt of a Provider Complaint for a claims payment ~~dispute~~Dispute that is less than three hundred sixty-five (365) calendar days after the date of an action or, in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the time for contesting or denying the claim has expired.

I. If the ~~dispute~~Dispute relates to a demonstrable and unfair payment pattern by CalOptima Health, or CalOptima Health's Capitated Provider, neither CalOptima Health nor the Capitated Provider shall impose a deadline for the receipt of a ~~dispute~~Dispute that is less than three hundred sixty-five (365) calendar days from CalOptima Health's or the capitated Provider's most recent action, or in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the most recent time for contesting or denying claims has expired.

J. CalOptima Health, Health Networks, and TPAs shall not charge a Provider for the cost of processing a Provider Complaint. ~~-~~Notwithstanding the foregoing, CalOptima Health, Health Networks, and TPAs shall have no obligation to reimburse a Provider for any costs incurred in connection with utilizing the Provider Complaint process.

K. A Health Network and TPA shall make available to CalOptima Health and the Department of Health Care Services (DHCS) all records, notes, and documents regarding its Provider Complaint Resolution mechanism(s) and the Resolution of Provider Complaints.

L. CalOptima Health shall submit an annual report to DHCS that includes but is not limited to the total number of Providers who have utilized the ~~dispute~~Dispute mechanism, delineated by Providers, Network Providers, Subcontractors, and Downstream Subcontractors and a summary of the disposition of those ~~disputes~~Disputes.

M. CalOptima Health shall have the right to extend or stay the implementation of a decision or require a Health Network or TPA to delay or stay~~, the implementation of~~ such a decision, in order to allow the affected Provider an opportunity to file a Complaint under this Policy.

N. A Provider who seeks to contest any decision made by CalOptima Health pursuant to this Policy is required to comply with CalOptima Health Policy AA.1217: Legal Claims and Judicial Review, if applicable.

III. PROCEDURE

A. Submission of a Complaint

1. A Complaint shall contain the following:

   a. Provider Dispute Resolution (PDR) Form, Appeal, or Dispute Letter and supporting documents.

   b. Provider name and Provider Identification Number (PIN);

   c. Contact information;

   d. Claim number assigned to the original claim, if applicable;

e. Clear description of the ~~disputed item;~~Dispute;

f. Date of service;

g. Clear explanation of the basis upon which the Provider believes the action is incorrect;

h. If the Complaint involves a bundled group of multiple claims that are substantially similar, identification of the original claim number; and

i. If the Complaint involves a ~~dispute~~Dispute involving a Member or group of Members, the name(s) and identification number(s) and Claim numbers (if applicable) of the Member(s), a clear explanation of the ~~disputed~~Disputed item(s), includes the date(s) of service, and the Provider's position on the issue(s).

2. A Provider may submit an amended Provider Complaint within thirty (30) business days after the date of receipt of a returned Provider Complaint that is missing required information.

3. A Provider that has furnished Covered Services to a Member for which a Health Network is financially responsible, or is dissatisfied with any aspect of a Health Network's program, shall file a Complaint with that Health Network prior to filing a Complaint with CalOptima Health within three hundred sixty-five (365) calendar days after the Health Network's action, or in the case of inaction, within three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired.

4. A Provider that has furnished Covered Services to a Member is dissatisfied with any aspect of a TPA's program, shall file a Complaint with that TPA prior to filing a Complaint with CalOptima Health within three hundred sixty-five (365) calendar days after the TPA's action, or in the case of inaction, within three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired.

5. A Provider may file a Complaint with CalOptima Health as follows:

a. The Provider has provided Covered Services to a Member for which CalOptima Health is financially responsible, or is dissatisfied with any aspect of CalOptima Health;

b. The Provider has provided Covered Services to a Member for which a Health Network or TPA is financially responsible, is dissatisfied with a Complaint Resolution Letter received from the Health Network or TPA, as set forth in this Policy, and files within the following timeframes:

i. Sixty (60) calendar days after the date of the Health Network's or TPA's Complaint Resolution Letter for Complaints related to Medical Necessity; or

ii. One hundred eighty (180) calendar days after the date of the Health Network's Complaint Resolution Letter for all other types of Complaints.

6. A Provider may request additional time but must show good cause for an extension and provide supporting good cause documentation at the time of the request.

B. CalOptima Health, a Health Network or TPA Complaint Receipt and Resolution

1. Record of Complaint

a. CalOptima Health or Health Network shall enter into its Complaint tracking system each Complaint (whether or not complete) received and create an electronic or hard copy file.

b. A TPA shall track and maintain records of each Complaint (whether or not complete) it receives.

2. Acknowledgement of Complaint

a. CalOptima Health, Health Network or TPA shall acknowledge the receipt of a Complaint in paper form (whether or not complete) within fifteen (15) business days after the date of receipt by the office or department designated to receive Complaints.

b. CalOptima Health, Health Network or TPA shall acknowledge the receipt of a Complaint in electronic form (whether or not complete) within two (2) business days after the date of receipt by the office or department designated to receive Complaints.

3. Incomplete Complaints

a. CalOptima Health, a Health Network or TPA may return to a Provider any Complaint lacking the required information or information necessary to determine payer liability that is in the possession of the Provider and not readily accessible to CalOptima Health, Health Network or TPA.

b. The returned Complaint shall clearly identify, in writing, the missing reasonably relevant information or information necessary to determine payer liability. In no event shall CalOptima Health, a Health Network or TPA request the Provider to resubmit claim information that the Provider previously and appropriately submitted to CalOptima Health, the Health Network or TPA as part of the claims adjudication process, except in those cases in which the claim documentation was returned to the Provider.

4. Investigation and Resolution of Complaints

a. Investigation

i. CalOptima Health, a Health Network or TPA shall promptly investigate a Complaint by consulting, as applicable, with the appropriate departments at CalOptima Health, the Health Network department(s), or TPA responsible for the services or operations that are the subject of the Complaint (e.g., Contracting, Utilization Management, Claims).

ii. The applicable CalOptima Health, Health Network or TPA department(s) shall investigate the factual matters that are the subject of the Complaint and shall report factual findings and a proposed resolution to CalOptima Health or Health Network Grievance staff within ten (10) business days after initial receipt of the Complaint.

iii. The applicable CalOptima Health, Health Network or TPA department shall use the Complaint Referral and Investigation Request Form, or a similar form, to report findings and proposed resolutions to the CalOptima Health or Health Network Grievance staff, as set forth in this Policy.

iv. CalOptima Health may request that the Provider submit any written materials relevant to the Provider's Complaint.

v. If the Provider is appealing a Health Network or TPA Complaint Resolution Letter, CalOptima Health shall review the Health Network or TPA Complaint file.

b. Resolution

i. CalOptima Health, a Health Network or TPA shall resolve and issue a Complaint Resolution Letter for each Complaint it receives within forty-five (45) business days after the date of receipt of the Complaint or amended Complaint, in accordance with applicable laws, including those regulatory provisions identified in Title 28, California Code of Regulations, §1300.71.38(f).

ii. The Complaint Resolution Letter shall describe the pertinent facts of the Complaint, the reasons for a CalOptima Health, Health Network or TPA determination, and applicable Provider Appeal rights, including the following:

a) For Complaints related to Medical Necessity, the right to Appeal the determination to ~~CalOptima Health's~~the GARS Department within sixty (60) calendar days after the date of ~~CalOptima Health,~~ the Health Network or TPA Complaint Resolution Letter; or

b) For other Complaints, the right to ~~Appeal the determination~~request a Legal Claim pursuant to CalOptima ~~Health's GARS Department within one hundred eighty (180) calendar days after the date of CalOptima~~ Health~~, the Health Network or TPA Complaint Resolution Letter.~~ CalOptima Health Policy AA.1217: Legal Claims and Judicial Review.

c. Implementation of Complaint Resolution

i. CalOptima Health and its Health Networks or TPA shall take immediate action to implement the determinations set forth in a Complaint Resolution Letter.

ii. If the Complaint or amended Complaint is determined in whole or in part in favor of the Provider, the Health Network shall pay:

a) Any outstanding monies that it determines to be due; and

b) All interest and penalties required within five (5) business days after the date of the Complaint Resolution Letter, pursuant to CalOptima Health Policy HH.2015: Health Networks Claims Processing.

iii. Accrual of interest and penalties for the payment of any resolved Complaints shall commence on the day following the expiration of the time for reimbursement.

a. Resolution of Complaints submitted by Provider to CalOptima Health

i. ~~CalOptima Health's~~ GARS staff shall review the factual findings, proposed Resolution, and any other relevant information, and shall issue a decision with respect to the Complaint or amended Complaint, in accordance with CalOptima Health Policy HH.1109: Complaints Decision Matrix.

ii. Within forty-five (45) business days after receipt of the Complaint or amended Complaint, ~~CalOptima Health's~~ GARS staff shall send a Complaint Resolution Letter to the Provider.

b. Implementation of Resolution by CalOptima Health

i. CalOptima Health may take immediate action, or, as appropriate, require that a Health Network or TPA take immediate action to implement the decision set forth in CalOptima Health's Complaint Resolution Letter.

ii. If the Complaint is a payment-related issue, and CalOptima Health determines that a Health Network is financially responsible, the Health Network shall make payment in the amount specified by CalOptima Health to the Provider within five (5) business days after the date of CalOptima Health's Complaint Resolution Letter. The Health Network shall send written proof of payment to ~~the CalOptima Health~~ GARS staff.

iii. If the Health Network does not pay the claim as required by this Policy, CalOptima Health shall pay the claim on behalf of the Health Network and shall deduct from the Health Network's capitation payment the amount paid on behalf of the Health Network plus the greater of a two hundred fifty-dollar ($250.00) administrative fee or ten percent (10%) of the amount paid.

iv. If the Complaint is a payment-related issue, and CalOptima Health determines that a TPA is financially responsible, the TPA shall make payment in the amount specified by CalOptima Health to the Provider within five (5) business days after the date of CalOptima Health's Complaint Resolution Letter. The TPA shall send written proof of payment to ~~the CalOptima Health~~ GARS staff.

C. CalOptima Health Responsible Staff

1. The ~~CalOptima Health~~ GARS Director shall have primary responsibility for the maintenance of the Provider Complaint process.

2. The CalOptima Health Chief Operations Officer shall have primary responsibility for the oversight and review of operations, and for identifying any emergent patterns of Complaints to improve administrative capacity, provider relations, claims payment procedures, and Member care.

D. CalOptima Health Monitoring

1. CalOptima Health, Health Networks and TPAs shall continuously monitor for trends and systemic issues. If any trends are identified, a performance or corrective action plan shall be developed to address the trend. CalOptima Health shall monitor for performance improvement.

2. On an annual basis, CalOptima Health shall assess all ~~disputes~~Disputes received to identify any overall trends or systemic issues and identify the root cause. Based on this annual assessment, CalOptima Health shall develop a plan to address each trend or system issue identified. This report shall be submitted annually to DHCS.

3. If CalOptima Health determines that a Health Network has failed to comply with any requirements of this Policy, CalOptima Health may take appropriate action, including, but not limited to, imposing Corrective Action Plans or Sanctions against the Health Network under CalOptima Health Policies HH.2005: Corrective Action Plan, and HH.2002: Sanctions.

4. CalOptima Health shall monitor a TPA in accordance with CalOptima Health policy.

E. Notices, Records, and Reports

1. Notice to Providers of Complaint Procedure

   a. CalOptima Health and Health Networks shall include a reference to this Policy in each Provider contract.

   b. CalOptima Health and Health Networks shall notify Non-Contracted Providers of the availability of a Provider Complaint process. This notification may be satisfied through the Health Network's routine Provider communication processes, including, but not limited to, newsletters, bulletins, policy and procedure manuals, remittance advice notices, and Websites.

2. Records

   a. CalOptima Health, Health Networks, and TPAs shall maintain written records of each Complaint, including at least the following information: date of receipt, Provider's name; name(s) of staff who received the Complaint and is designated as the contact person, description of the Complaint, medical records, documents, evidence of coverage and other relevant information upon which CalOptima Health, Health Networks, and TPAs relied on in reaching its decision and disposition for ten (10) years.

   b. CalOptima Health, Health Networks and TPAs shall retain written records of each Complaint, including copies of all Complaints and responses thereto, including all notes, documents, and other information upon which CalOptima Health, the Health Network, or TPA relied upon to reach its decision for a period of ten (10) years following the termination of their contracts with CalOptima Health. A Health Network and TPA shall make records for the last two (2) years available on-site.

   c. A Health Network and TPA shall make available warehoused or stored records within five (5) business days after a request for such records by CalOptima Health or DHCS.

3. Reporting Provider Complaint Activity

   a. At a maximum, on a monthly basis, a Health Network shall submit to the CalOptima Health Audit & Oversight Department.

   b. Each claim within a Complaint that has bundled substantially similar claims ~~disputes~~Disputes must be listed separately as individual Complaints (including original claim numbers) on the report.

   c. A Principal Officer shall sign the report certifying that the report is true and correct, to the best of their knowledge and belief.

F. Other Provider Rights. ~~-~~In addition to any rights set forth in this Policy and allowed by law, a Provider also has the following rights:

1. Claim Resubmission. Prior to filing a Complaint related to payment of a claim, a Provider may resubmit the claim to the Health Network or TPA, as appropriate, in accordance with the applicable Health Network, or TPA, claim resubmission policy.

2. Provider's Right to Hearing

a. Request for Hearing

i. A Provider that ~~disputes~~Disputes recoupment of funds based upon audit findings of overpayments, the imposition of Sanctions or penalties, or suspension or termination of the Provider's participation in CalOptima Health, a Health Network or TPA, may request a hearing before the Provider Grievance Review Panel if:

a) The Provider has received a Complaint Resolution Letter from CalOptima Health; or

b) The Provider has received a Complaint Resolution Letter from a Health Network or TPA and pursues a hearing in lieu of filing a written Complaint to CalOptima Health under Section III.A of this Policy.

ii. No other hearings are provided under this Policy.

iii. A Provider may submit to ~~CalOptima Health's~~ CARS staff a written request for hearing within fifteen (15) calendar days after CalOptima Health's, a Health Network's or TPA's issuance of a Complaint Resolution Letter. The written request shall set forth with specificity the reasons for the hearing, including if the Provider challenges:

a) The factual basis of the decision, and if so, which facts in particular;

b) The legal basis for the decision; or

c) The reasonableness of the decision, Sanctions, or penalties imposed.

b. Acknowledgment of Request for Hearing

i. Upon receipt of a request for hearing, CalOptima Health shall set a hearing date to be held within thirty (30) calendar days after receipt of the request.

ii. CalOptima Health shall send to the Provider a Hearing Acknowledgment Letter within five (5) calendar days after the Provider's request for a hearing, setting forth the date, time, and location of the hearing.

c. Hearing

i. The purpose of the hearing is to afford the Provider an opportunity to contest the factual or legal basis of the decision, or the reasonableness of the decision.

ii. The hearing is intended to be informal in nature. Formal rules of evidence and discovery do not apply. There shall be no cross-examination of witnesses. The Provider, CalOptima Health, Health Network, and TPA, as appropriate, shall have the opportunity to present oral testimony and documentary evidence.

iii. The Provider Grievance Review Panel shall select a hearing officer to preside at the hearing. ~~-~~The hearing officer may, from time to time, establish hearing guidelines governing the hearing procedure. The hearing officer may ask questions to any party at the hearing and shall ensure proper decorum at the hearing.

iv. The hearing officer may cause a recording of the hearing to be made, either by tape recording or providing a court reporter service.

v. After the conclusion of the hearing, the Provider Grievance Review Panel may adopt, reject, or modify, in whole or in part, the actions addressed at the hearing. The hearing officer shall send the Provider Grievance Review Panel's written decision to the Provider, Health Network, and TPA, as appropriate, within forty-five (45) calendar days after the close of the hearing. The decision shall be effective on the date issued by the hearing officer.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services
B. CalOptima Health Contract with the California Department of Aging (CDA)
C. CalOptima Health Contract for Health Care Services
D. California Health and Safety Code, § 1367(h)
E. California Welfare and Institutions Code § 14094.15(d)
F. Title 28, California Code of Regulations (C.C.R.), §1300.71.38
G. CalOptima Health Policy AA.1217: Legal Claims and Judicial Review
H. CalOptima Health Policy FF.1001: Capitation Payments
I. CalOptima Health Policy HH.1102: Member Grievance
J. CalOptima Health Policy HH.1109: Compliant Decision Matrix
K. CalOptima Health Policy HH.2002: Sanctions
L. CalOptima Health Policy HH.2005: Corrective Action Plan
M. CalOptima Health Policy HH.2015: Health Networks Claims Processing
N. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted
04/30/2014	Department of Health Care Services (DHCS)	Approved as Submitted
03/11/2019	Department of Health Care Services (DHCS)	Approved as Submitted
11/09/2022	Department of Health Care Services (DHCS)	File and Use
01/27/2023	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
09/23/1997	Regular Meeting of the CalOptima Board of Directors
02/01/2005	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/1996	EE.1113	CalOptima Contractor Grievance Policy and Procedure	Medi-Cal
Revised	09/01/1998	EE.1113	CalOptima Provider Complaint	Medi-Cal
Revised	11/01/2000	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	08/01/2001	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	01/01/2003	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	01/01/2004	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	02/01/2005	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	01/01/2010	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	01/01/2013	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	09/01/2013	HH.1101	CalOptima Provider Complaint	Medi-Cal
Reviewed	09/01/2014	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	07/01/2016	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	08/01/2018	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	10/01/2019	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	10/01/2022	HH.1101	CalOptima Health Provider Complaint	Medi-Cal
Revised	01/01/2023	HH.1101	CalOptima Health Provider Complaint	Medi-Cal
Revised	TBD	HH.1101	CalOptima Health Provider Complaint	Medi-Cal

IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Capitated Provider	Providers that are reimbursed on a capitation basis.
Complaint	A dispute from a provider, regardless of contract status, related to any action or inaction by CalOptima Health, a Health Network or any delegated entity.
Complaint Resolution Letter	A written statement explaining the disposition of an Appeal or Complaint based on a review of the facts, relevant information, and documentation.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Dispute	A claims payment dispute regarding an amount paid that is less than the expected rate.
Grievance	An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision.
Health Networks	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medically Necessary or Medical Necessity	Reasonable and necessary ~~services~~ Covered Services to protect life, to prevent significant illness or significant disability, or ~~to~~ alleviate severe pain through the diagnosis or treatment of disease, illness, or injury~~.~~, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Multipurpose Senior Services Program (MSSP)	A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 or older with disabilities as an alternative to nursing facility placement.
Network Provider	A Provider that subcontracts with CalOptima Health for the delivery of Medi-Cal Covered Services.
Non-Contracted Provider	A Provider who is not obligated by written contract to provide Covered Services to a Member.
Principal Officer	Means a president, vice-president, secretary, treasurer, or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

Term	Definition
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.
Provider ~~Appeal~~Complaint	~~A request by a Provider to reconsider a decision whether administrative or medical in nature.~~The general term used to identify all provider filed request for review, and expressions of, dissatisfaction with any aspect of CalOptima Health or its Health Networks or TPAs. This includes Appeals, Disputes, and Grievances.
Provider Grievance Review Panel	A committee consisting of management level subject matter experts who will review and reach a determination for all requested hearings. The individuals on this panel will vary by case review.
Resolution	The appeal or complaint has reached a final conclusion with respect to the Provider's submitted appeal or complaint.
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.
Subcontractor	An individual or entity who has a Subcontract with CalOptima Health that relates directly or indirectly to the performance of CalOptima Health's obligations under contract with DHCS.
Third Party Administrator (TPA)	An individual or entity that has a written agreement with CalOptima Health to perform certain functions and tasks relating to, and necessary for, the delivery of Covered Services.

Policy:	HH.1101
Title:	**CalOptima Health Provider Complaint**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	03/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima Health, Health Networks, and Third-Party Administrators (TPA) address and resolve contracted Provider Complaints, which include, but are not limited to, Provider Disputes, Appeals, and Grievances.

II. POLICY

A. CalOptima Health, Health Networks, and TPAs shall maintain a fast, fair, and cost-effective system to process and resolve contracted Provider Complaints, in accordance with applicable statutory, regulatory, and contractual requirements.

B. Providers shall utilize the Health Network and TPA grievance systems prior to filing a Complaint directly with CalOptima Health, in accordance with this Policy.

C. Multipurpose Senior Services Program (MSSP) Providers shall submit issues arising out of or related to the contract between CalOptima Health and a MSSP Provider, including but not limited to Disputes, claims, protests of awards or other contractual issues to the CalOptima Health Grievance and Appeals Resolution Services (GARS). GARS Department shall process the Complaints in accordance with the CalOptima Health MSSP-Department of Aging contract.

D. Complaints related to Appeals of Medical Necessity will be processed in accordance with CalOptima Health Policy HH.1102: Member Grievance

E. CalOptima Health, Health Networks, and TPAs shall promptly review and investigate Complaints and resolve them, in accordance with the timeframes set forth herein.

F. CalOptima Health, Health Networks, and TPAs shall not discriminate or retaliate against any Provider (including, but not limited to, terminating the Provider's contract) on grounds that such Provider filed a Complaint, in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations.

Back to Item

Back to Agenda

G. CalOptima Health, Health Networks, and TPAs shall designate a principal officer to be primarily responsible for the maintenance, oversight, and analysis of trends and preparation of reports related to Provider Complaints as required by this Policy and applicable regulations.

H. CalOptima Health, Health Networks, and TPAs shall not impose a deadline for receipt of a Provider Complaint for a claims payment Dispute that is less than three hundred sixty-five (365) calendar days after the date of an action or, in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the time for contesting or denying the claim has expired.

I. If the Dispute relates to a demonstrable and unfair payment pattern by CalOptima Health, or CalOptima Health's Capitated Provider, neither CalOptima Health nor the Capitated Provider shall impose a deadline for the receipt of a Dispute that is less than three hundred sixty-five (365) calendar days from CalOptima Health's or the capitated Provider's most recent action, or in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the most recent time for contesting or denying claims has expired.

J. CalOptima Health, Health Networks, and TPAs shall not charge a Provider for the cost of processing a Provider Complaint. Notwithstanding the foregoing, CalOptima Health, Health Networks, and TPAs shall have no obligation to reimburse a Provider for any costs incurred in connection with utilizing the Provider Complaint process.

K. A Health Network and TPA shall make available to CalOptima Health and the Department of Health Care Services (DHCS) all records, notes, and documents regarding its Provider Complaint Resolution mechanism(s) and the Resolution of Provider Complaints.

L. CalOptima Health shall submit an annual report to DHCS that includes but is not limited to the total number of Providers who have utilized the Dispute mechanism, delineated by Providers, Network Providers, Subcontractors, and Downstream Subcontractors and a summary of the disposition of those Disputes.

M. CalOptima Health shall have the right to extend or stay the implementation of a decision or require a Health Network or TPA to delay or stay such a decision, in order to allow the affected Provider an opportunity to file a Complaint under this Policy.

N. A Provider who seeks to contest any decision made by CalOptima Health pursuant to this Policy is required to comply with CalOptima Health Policy AA.1217: Legal Claims and Judicial Review, if applicable.

III. PROCEDURE

A. Submission of a Complaint

1. A Complaint shall contain the following:

   a. Provider Dispute Resolution (PDR) Form, Appeal, or Dispute Letter and supporting documents.

   b. Provider name and Provider Identification Number (PIN);

   c. Contact information;

   d. Claim number assigned to the original claim, if applicable;

e. Clear description of the Dispute;

f. Date of service;

g. Clear explanation of the basis upon which the Provider believes the action is incorrect;

h. If the Complaint involves a bundled group of multiple claims that are substantially similar, identification of the original claim number; and

i. If the Complaint involves a Dispute involving a Member or group of Members, the name(s) and identification number(s) and Claim numbers (if applicable) of the Member(s), a clear explanation of the Disputed item(s), includes the date(s) of service, and the Provider's position on the issue(s).

2. A Provider may submit an amended Provider Complaint within thirty (30) business days after the date of receipt of a returned Provider Complaint that is missing required information.

3. A Provider that has furnished Covered Services to a Member for which a Health Network is financially responsible, or is dissatisfied with any aspect of a Health Network's program, shall file a Complaint with that Health Network prior to filing a Complaint with CalOptima Health within three hundred sixty-five (365) calendar days after the Health Network's action, or in the case of inaction, within three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired.

4. A Provider that has furnished Covered Services to a Member is dissatisfied with any aspect of a TPA's program, shall file a Complaint with that TPA prior to filing a Complaint with CalOptima Health within three hundred sixty-five (365) calendar days after the TPA's action, or in the case of inaction, within three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired.

5. A Provider may file a Complaint with CalOptima Health as follows:

a. The Provider has provided Covered Services to a Member for which CalOptima Health is financially responsible, or is dissatisfied with any aspect of CalOptima Health;

b. The Provider has provided Covered Services to a Member for which a Health Network or TPA is financially responsible, is dissatisfied with a Complaint Resolution Letter received from the Health Network or TPA, as set forth in this Policy, and files within the following timeframes:

i. Sixty (60) calendar days after the date of the Health Network's or TPA's Complaint Resolution Letter for Complaints related to Medical Necessity; or

ii. One hundred eighty (180) calendar days after the date of the Health Network's Complaint Resolution Letter for all other types of Complaints.

6. A Provider may request additional time but must show good cause for an extension and provide supporting good cause documentation at the time of the request.

B. CalOptima Health, a Health Network or TPA Complaint Receipt and Resolution

1. Record of Complaint

a. CalOptima Health or Health Network shall enter into its Complaint tracking system each Complaint (whether or not complete) received and create an electronic or hard copy file.

b. A TPA shall track and maintain records of each Complaint (whether or not complete) it receives.

2. Acknowledgement of Complaint

a. CalOptima Health, Health Network or TPA shall acknowledge the receipt of a Complaint in paper form (whether or not complete) within fifteen (15) business days after the date of receipt by the office or department designated to receive Complaints.

b. CalOptima Health, Health Network or TPA shall acknowledge the receipt of a Complaint in electronic form (whether or not complete) within two (2) business days after the date of receipt by the office or department designated to receive Complaints.

3. Incomplete Complaints

a. CalOptima Health, a Health Network or TPA may return to a Provider any Complaint lacking the required information or information necessary to determine payer liability that is in the possession of the Provider and not readily accessible to CalOptima Health, Health Network or TPA.

b. The returned Complaint shall clearly identify, in writing, the missing reasonably relevant information or information necessary to determine payer liability. In no event shall CalOptima Health, a Health Network or TPA request the Provider to resubmit claim information that the Provider previously and appropriately submitted to CalOptima Health, the Health Network or TPA as part of the claims adjudication process, except in those cases in which the claim documentation was returned to the Provider.

4. Investigation and Resolution of Complaints

a. Investigation

i. CalOptima Health, a Health Network or TPA shall promptly investigate a Complaint by consulting, as applicable, with the appropriate departments at CalOptima Health, the Health Network department(s), or TPA responsible for the services or operations that are the subject of the Complaint (e.g., Contracting, Utilization Management, Claims).

ii. The applicable CalOptima Health, Health Network or TPA department(s) shall investigate the factual matters that are the subject of the Complaint and shall report factual findings and a proposed resolution to CalOptima Health or Health Network Grievance staff within ten (10) business days after initial receipt of the Complaint.

iii. The applicable CalOptima Health, Health Network or TPA department shall use the Complaint Referral and Investigation Request Form, or a similar form, to report findings and proposed resolutions to the CalOptima Health or Health Network Grievance staff, as set forth in this Policy.

iv. CalOptima Health may request that the Provider submit any written materials relevant to the Provider's Complaint.

v. If the Provider is appealing a Health Network or TPA Complaint Resolution Letter, CalOptima Health shall review the Health Network or TPA Complaint file.

b. Resolution

i. CalOptima Health, a Health Network or TPA shall resolve and issue a Complaint Resolution Letter for each Complaint it receives within forty-five (45) business days after the date of receipt of the Complaint or amended Complaint, in accordance with applicable laws, including those regulatory provisions identified in Title 28, California Code of Regulations, §1300.71.38(f).

ii. The Complaint Resolution Letter shall describe the pertinent facts of the Complaint, the reasons for a CalOptima Health, Health Network or TPA determination, and applicable Provider Appeal rights, including the following:

a) For Complaints related to Medical Necessity, the right to Appeal the determination to the GARS Department within sixty (60) calendar days after the date of the Health Network or TPA Complaint Resolution Letter; or

b) For other Complaints, the right to request a Legal Claim pursuant to CalOptima Health CalOptima Health Policy AA.1217: Legal Claims and Judicial Review.

c. Implementation of Complaint Resolution

i. CalOptima Health and its Health Networks or TPA shall take immediate action to implement the determinations set forth in a Complaint Resolution Letter.

ii. If the Complaint or amended Complaint is determined in whole or in part in favor of the Provider, the Health Network shall pay:

a) Any outstanding monies that it determines to be due; and

b) All interest and penalties required within five (5) business days after the date of the Complaint Resolution Letter, pursuant to CalOptima Health Policy HH.2015: Health Networks Claims Processing.

iii. Accrual of interest and penalties for the payment of any resolved Complaints shall commence on the day following the expiration of the time for reimbursement.

a. Resolution of Complaints submitted by Provider to CalOptima Health

i. GARS staff shall review the factual findings, proposed Resolution, and any other relevant information, and shall issue a decision with respect to the Complaint or amended Complaint, in accordance with CalOptima Health Policy HH.1109: Complaints Decision Matrix.

ii. Within forty-five (45) business days after receipt of the Complaint or amended Complaint, GARS staff shall send a Complaint Resolution Letter to the Provider.

b. Implementation of Resolution by CalOptima Health

i. CalOptima Health may take immediate action, or, as appropriate, require that a Health Network or TPA take immediate action to implement the decision set forth in CalOptima Health's Complaint Resolution Letter.

ii. If the Complaint is a payment-related issue, and CalOptima Health determines that a Health Network is financially responsible, the Health Network shall make payment in the amount specified by CalOptima Health to the Provider within five (5) business days after the date of CalOptima Health's Complaint Resolution Letter. The Health Network shall send written proof of payment to GARS staff.

iii. If the Health Network does not pay the claim as required by this Policy, CalOptima Health shall pay the claim on behalf of the Health Network and shall deduct from the Health Network's capitation payment the amount paid on behalf of the Health Network plus the greater of a two hundred fifty-dollar ($250.00) administrative fee or ten percent (10%) of the amount paid.

iv. If the Complaint is a payment-related issue, and CalOptima Health determines that a TPA is financially responsible, the TPA shall make payment in the amount specified by CalOptima Health to the Provider within five (5) business days after the date of CalOptima Health's Complaint Resolution Letter. The TPA shall send written proof of payment to GARS staff.

C. CalOptima Health Responsible Staff

1. The GARS Director shall have primary responsibility for the maintenance of the Provider Complaint process.

2. The CalOptima Health Chief Operations Officer shall have primary responsibility for the oversight and review of operations, and for identifying any emergent patterns of Complaints to improve administrative capacity, provider relations, claims payment procedures, and Member care.

D. CalOptima Health Monitoring

1. CalOptima Health, Health Networks and TPAs shall continuously monitor for trends and systemic issues. If any trends are identified, a performance or corrective action plan shall be developed to address the trend. CalOptima Health shall monitor for performance improvement.

2. On an annual basis, CalOptima Health shall assess all Disputes received to identify any overall trends or systemic issues and identify the root cause. Based on this annual assessment, CalOptima Health shall develop a plan to address each trend or system issue identified. This report shall be submitted annually to DHCS.

3. If CalOptima Health determines that a Health Network has failed to comply with any requirements of this Policy, CalOptima Health may take appropriate action, including, but not limited to, imposing Corrective Action Plans or Sanctions against the Health Network under CalOptima Health Policies HH.2005: Corrective Action Plan, and HH.2002: Sanctions.

4. CalOptima Health shall monitor a TPA in accordance with CalOptima Health policy.

E. Notices, Records, and Reports

1. Notice to Providers of Complaint Procedure

a. CalOptima Health and Health Networks shall include a reference to this Policy in each Provider contract.

b. CalOptima Health and Health Networks shall notify Non-Contracted Providers of the availability of a Provider Complaint process. This notification may be satisfied through the Health Network's routine Provider communication processes, including, but not limited to, newsletters, bulletins, policy and procedure manuals, remittance advice notices, and Websites.

2. Records

a. CalOptima Health, Health Networks, and TPAs shall maintain written records of each Complaint, including at least the following information: date of receipt, Provider's name; name(s) of staff who received the Complaint and is designated as the contact person, description of the Complaint, medical records, documents, evidence of coverage and other relevant information upon which CalOptima Health, Health Networks, and TPAs relied on in reaching its decision and disposition for ten (10) years.

b. CalOptima Health, Health Networks and TPAs shall retain written records of each Complaint, including copies of all Complaints and responses thereto, including all notes, documents, and other information upon which CalOptima Health, the Health Network, or TPA relied upon to reach its decision for a period of ten (10) years following the termination of their contracts with CalOptima Health. A Health Network and TPA shall make records for the last two (2) years available on-site.

c. A Health Network and TPA shall make available warehoused or stored records within five (5) business days after a request for such records by CalOptima Health or DHCS.

3. Reporting Provider Complaint Activity

a. At a maximum, on a monthly basis, a Health Network shall submit to the CalOptima Health Audit & Oversight Department.

b. Each claim within a Complaint that has bundled substantially similar claims Disputes must be listed separately as individual Complaints (including original claim numbers) on the report.

c. A Principal Officer shall sign the report certifying that the report is true and correct, to the best of their knowledge and belief.

F. Other Provider Rights. In addition to any rights set forth in this Policy and allowed by law, a Provider also has the following rights:

1. Claim Resubmission. Prior to filing a Complaint related to payment of a claim, a Provider may resubmit the claim to the Health Network or TPA, as appropriate, in accordance with the applicable Health Network, or TPA, claim resubmission policy.

2. Provider's Right to Hearing

a. Request for Hearing

i. A Provider that Disputes recoupment of funds based upon audit findings of overpayments, the imposition of Sanctions or penalties, or suspension or termination of the Provider's participation in CalOptima Health, a Health Network or TPA, may request a hearing before the Provider Grievance Review Panel if:

a) The Provider has received a Complaint Resolution Letter from CalOptima Health; or

b) The Provider has received a Complaint Resolution Letter from a Health Network or TPA and pursues a hearing in lieu of filing a written Complaint to CalOptima Health under Section III.A of this Policy.

ii. No other hearings are provided under this Policy.

iii. A Provider may submit to GARS staff a written request for hearing within fifteen (15) calendar days after CalOptima Health's, a Health Network's or TPA's issuance of a Complaint Resolution Letter. The written request shall set forth with specificity the reasons for the hearing, including if the Provider challenges:

a) The factual basis of the decision, and if so, which facts in particular;

b) The legal basis for the decision; or

c) The reasonableness of the decision, Sanctions, or penalties imposed.

b. Acknowledgment of Request for Hearing

i. Upon receipt of a request for hearing, CalOptima Health shall set a hearing date to be held within thirty (30) calendar days after receipt of the request.

ii. CalOptima Health shall send to the Provider a Hearing Acknowledgment Letter within five (5) calendar days after the Provider's request for a hearing, setting forth the date, time, and location of the hearing.

c. Hearing

i. The purpose of the hearing is to afford the Provider an opportunity to contest the factual or legal basis of the decision, or the reasonableness of the decision.

ii. The hearing is intended to be informal in nature. Formal rules of evidence and discovery do not apply. There shall be no cross-examination of witnesses. The Provider, CalOptima Health, Health Network, and TPA, as appropriate, shall have the opportunity to present oral testimony and documentary evidence.

iii. The Provider Grievance Review Panel shall select a hearing officer to preside at the hearing. The hearing officer may, from time to time, establish hearing guidelines governing the hearing procedure. The hearing officer may ask questions to any party at the hearing and shall ensure proper decorum at the hearing.

iv. The hearing officer may cause a recording of the hearing to be made, either by tape recording or providing a court reporter service.

v. After the conclusion of the hearing, the Provider Grievance Review Panel may adopt, reject, or modify, in whole or in part, the actions addressed at the hearing. The hearing officer shall send the Provider Grievance Review Panel's written decision to the Provider, Health Network, and TPA, as appropriate, within forty-five (45) calendar days after the close of the hearing. The decision shall be effective on the date issued by the hearing officer.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services
B. CalOptima Health Contract with the California Department of Aging (CDA)
C. CalOptima Health Contract for Health Care Services
D. California Health and Safety Code, § 1367(h)
E. California Welfare and Institutions Code § 14094.15(d)
F. Title 28, California Code of Regulations (C.C.R.), §1300.71.38
G. CalOptima Health Policy AA.1217: Legal Claims and Judicial Review
H. CalOptima Health Policy FF.1001: Capitation Payments
I. CalOptima Health Policy HH.1102: Member Grievance
J. CalOptima Health Policy HH.1109: Compliant Decision Matrix
K. CalOptima Health Policy HH.2002: Sanctions
L. CalOptima Health Policy HH.2005: Corrective Action Plan
M. CalOptima Health Policy HH.2015: Health Networks Claims Processing
N. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted
04/30/2014	Department of Health Care Services (DHCS)	Approved as Submitted
03/11/2019	Department of Health Care Services (DHCS)	Approved as Submitted
11/09/2022	Department of Health Care Services (DHCS)	File and Use
01/27/2023	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
09/23/1997	Regular Meeting of the CalOptima Board of Directors
02/01/2005	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/1996	EE.1113	CalOptima Contractor Grievance Policy and Procedure	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/1998	EE.1113	CalOptima Provider Complaint	Medi-Cal
Revised	11/01/2000	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	08/01/2001	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	01/01/2003	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	01/01/2004	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	02/01/2005	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	01/01/2010	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	01/01/2013	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	09/01/2013	HH.1101	CalOptima Provider Complaint	Medi-Cal
Reviewed	09/01/2014	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	07/01/2016	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	08/01/2018	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	10/01/2019	HH.1101	CalOptima Provider Complaint	Medi-Cal
Revised	10/01/2022	HH.1101	CalOptima Health Provider Complaint	Medi-Cal
Revised	01/01/2023	HH.1101	CalOptima Health Provider Complaint	Medi-Cal
Revised	TBD	HH.1101	CalOptima Health Provider Complaint	Medi-Cal

1

IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Capitated Provider	Providers that are reimbursed on a capitation basis.
Complaint	A dispute from a provider, regardless of contract status, related to any action or inaction by CalOptima Health, a Health Network or any delegated entity.
Complaint Resolution Letter	A written statement explaining the disposition of an Appeal or Complaint based on a review of the facts, relevant information, and documentation.
Corrective Action Plan	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Service	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Dispute	A claims payment dispute regarding an amount paid that is less than the expected rate.
Grievance	An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision.
Health Networks	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Multipurpose Senior Services Program (MSSP)	A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 or older with disabilities as an alternative to nursing facility placement.
Network Provider	A Provider that subcontracts with CalOptima Health for the delivery of Medi-Cal Covered Services.
Non-Contracted Provider	A Provider who is not obligated by written contract to provide Covered Services to a Member.
Principal Officer	Means a president, vice-president, secretary, treasurer, or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

Term	Definition
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.
Provider Complaint	The general term used to identify all provider filed request for review, and expressions of, dissatisfaction with any aspect of CalOptima Health or its Health Networks or TPAs. This includes Appeals, Disputes, and Grievances.
Provider Grievance Review Panel	A committee consisting of management level subject matter experts who will review and reach a determination for all requested hearings. The individuals on this panel will vary by case review.
Resolution	The appeal or complaint has reached a final conclusion with respect to the Provider's submitted appeal or complaint.
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.
Subcontractor	An individual or entity who has a Subcontract with CalOptima Health that relates directly or indirectly to the performance of CalOptima Health's obligations under contract with DHCS.
Third Party Administrator (TPA)	An individual or entity that has a written agreement with CalOptima Health to perform certain functions and tasks relating to, and necessary for, the delivery of Covered Services.

1

Policy:	FF.2001
Title:	**Claims Processing for Covered Services for which CalOptima Health is Financially Responsible**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which CalOptima Health ensures timely and accurate processing of claims for Covered Services for which CalOptima Health is financially responsible.

II. POLICY

A. CalOptima Health shall process claims in compliance with Title 42, United States Code (U.S.C.), Section 1396a(a)(37), and Health and Safety Code Sections 1371 through 1371.39.

B. CalOptima Health shall establish and maintain administrative processes, or contract with a claims processing organization, to accept and adjudicate claims for health care services provided to Members, in accordance with the provisions of this Policy and the California Code of Regulations.

C. CalOptima Health shall ensure timely compliance with claims payment obligations and claims settlement practices.

D. CalOptima Health shall not impose a deadline for the receipt of a claim that is less than ninety (90) calendar days for a participating Provider or one hundred and eighty (180) calendar days for a non-participating Provider, after the date of service, except as required by state or federal law or regulation.

E. CalOptima Health shall identify and acknowledge the receipt of each claim, whether or not it is a Complete Claim, and disclose the recorded date of receipt. CalOptima Health may provide an electronic method of notification, by which the Provider may readily confirm CalOptima Health's receipt of the claim and the recorded date of receipt within fifteen (15) business days of receipt of the claim.

F. CalOptima Health may review a claim for National Correct Coding Initiative (NCCI) edits and may contest or deny a claim based on improper coding. CalOptima Health may subcontract with a third-party vendor to review claims for NCCI edits and improper billing practices.

G. Claims Processing Timelines

Back to Item

Back to Agenda

1. CalOptima Health shall process and adjudicate ninety percent (90%) of Clean Claims for Covered Services within thirty (30) calendar days after CalOptima Health's receipt of such Clean Claims.

2. CalOptima Health shall process and adjudicate ninety-nine (99%) of claims for Covered Services within ninety (90) calendar days after CalOptima Health's receipt of such claim.

3. CalOptima Health shall notify a Provider of an Unclean Claim for Covered Services, within forty-five (45) business days after receipt of such claim If CalOptima Health fails to notify the Provider of the Unclean Claim, CalOptima Health shall consider the claim a Clean Claim, and shall pay, in accordance with the timelines for Clean Claims as set forth in this Policy.

H. CalOptima Health shall reimburse a Provider claim for Covered Services for which CalOptima Health is responsible, in accordance with CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Health Direct, or a Member Enrolled in a Shared Risk Group. Covered Services shall include payment for Emergency and Family Planning Services which do not require authorization.

I. CalOptima Health shall have a process to recoup Overpayments made to Providers and suppliers when claims payments exceed the allowed amount.

1. CalOptima Health may recoup Overpayments for a look-back period not to exceed six (6) years from current calendar year.

2. The six (6) year time limit shall not apply if the Overpayment was caused in whole, or in part, by ~~fraud~~Fraud, or misrepresentation, on the part of the Provider.

3. Failure to timely repay Overpayments will result in the addition of interest charges.

J. CalOptima Health shall not request reimbursement for the Overpayment of a claim, including requests made pursuant to Health and Safety Code, Section 1371.1, unless CalOptima Health sends a written request for reimbursement to the Provider within six (6) years from the date the Overpayment was made.

K. CalOptima Health shall pay interest and applicable penalties on all uncontested claims not paid within forty-five (45) business days, in accordance with Section III.G. of this Policy. The interest is determined by Health and Safety Code, Section 1371 or 1371.35, whichever is applicable.

L. CalOptima Health shall not improperly deny, adjust, or contest a claim, and shall provide a clear and accurate written explanation of the specific reasons for the action taken.

M. CalOptima Health may contest or deny a claim, or portion thereof, by notifying the Provider, in writing, that the claim is contested or denied, within forty-five (45) business days after the date of receipt of the claim by CalOptima Health.

~~N. CalOptima Health shall establish and maintain a fair, fast, and cost-effective Provider dispute process. CalOptima Health shall annually make available to the Department of Health Care Services (DHCS) all records, notes, and documents regarding its Provider dispute resolution mechanism(s) and the resolution of its Provider disputes.~~

~~O.~~N. CalOptima Health shall not engage in any practices, policies, or procedures that may constitute a basis for a finding of a demonstrable and unjust payment pattern or unfair payment pattern that

results in repeated delays in the adjudication and correct reimbursement of a Provider claim.

~~P.~~O. CalOptima Health shall submit all required reports and documents regarding claims payment practices and claims settlement practices to ~~DHCS.~~Department of Health Care Services (DHCS).

~~Q.~~P. CalOptima Health shall identify and process Overpayment recoveries in accordance with applicable statutory, regulatory and contractual requirements, as well as regulatory guidance, CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination, and Section III.I. of this Policy.

~~R.~~Q. CalOptima Health shall maintain procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, Members, and Covered Services for which payment is claimed.

~~S.~~R. CalOptima Health shall maintain sufficient claims processing, tracking and payment systems capability to comply with applicable State and Federal laws, regulations, and Contract requirements, to determine status of received claims and to estimate incurred and unreported claims amounts.

~~T.~~S. DHCS may impose Corrective Action Plans (CAPs) as well as administrative and/or monetary sanctions for non-compliance with any of the following outlined procedures in this policy.

T. CalOptima Health shall establish and maintain a fair, fast, and cost-effective Provider Dispute process. CalOptima Health shall annually make available to DHCS all records, notes, and documents regarding its Provider Dispute resolution mechanisms and the resolution of its Provider Disputes.

U. CalOptima Health's Claims Administration Department shall inform a Provider in the remittance advice of their right to file a Complaint with CalOptima Health's Grievance and Appeals Resolution Services (GARS) Department, in accordance with CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

III. PROCEDURE

A. A Provider shall verify a Member's eligibility to receive Covered Services, in accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification.

B. For Members assigned to CalOptima Health Direct Administrative (COD-A) or CalOptima Health Community Network (CCN), a Provider shall obtain authorization for Covered Services, in accordance with CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, and GG.1508: Authorization and Processing of Referrals.

C. Members with Other Health Coverage or Medicare

1. If a Member has Other Health Coverage (OHC) or Medicare, a Provider shall submit a claim for Covered Services provided to the Member to the Other Health Coverage or Medicare prior to submitting the claim to CalOptima Health, in accordance with CalOptima Health Policy FF.2003: Coordination of Benefits.

2. CalOptima Health processes Crossover Claims for Members with secondary benefits under Medi-Cal. A Provider may submit Crossover Claims to CalOptima Health, in accordance with

the Medi-Cal Provider Manual guidelines for Crossover Claims.

3. If a claim is received and is lacking the required OHC documentation, the claim shall be returned to the Provider and handled as a corrected claim once the documentation is received.

D. Claims Submission

1. A Provider shall utilize the following standard forms for submitting claims for Covered Services:

   a. A Provider shall use the CMS-1500 (Attachment A) when submitting a claim for professional services and supplies;

   b. A Provider shall use the UB-04 Form (Attachment B) when submitting a claim for hospital inpatient or outpatient services;

   c. An Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF) shall use the LTC-25-1 Claim Form (Attachment C) when submitting a claim for long-term care services; and

   d. For Child Health and Disability Prevention Program (CHDP) services, a Provider shall use the appropriate CMS-1500 (Attachment A) or UB-04 Claim Form (Attachment B) and standard CPT and HCPCS codes when submitting a claim for Pediatric Preventive Services. Claims for COD-A or CCN Members shall continue to be submitted to CalOptima Health, while claims for delegated Health Network Members shall be submitted to the appropriate Health Network.

2. A Provider shall submit a claim on the appropriate form with supporting documentation, including required prior authorizations and proof of Medicare or Other Health Coverage payment or denial.

3. A Provider may submit invoices, electronic or paper claims to CalOptima Health for Covered Services.

   a. A Provider may elect to submit electronic claims to CalOptima Health utilizing the process outlined in the CalOptima Health Provider Manual, Section H3: Electronic Claim Submissions~~, in the~~: CalOptima Health ~~Provider Manual,~~Direct, Shared risk and OneCare (HMO D-SNP) Claims. This is located on the Provider section of the CalOptima Health website.

   b. A Provider who submits a paper claim shall submit the original claim form and retain a copy for the Provider's files. CalOptima Health shall not accept carbon copies, photocopies, computer generated copies, or facsimiles of paper claims.

   c. A Provider may submit paper claims to CalOptima Health by mail, or in person, at the following addresses:

      i. By mail:
      Attn: Claims Department
      CalOptima Health
      Post Office Box 11037
      Orange CA 92856

      ii. In person:

Attn: Claims Department
CalOptima Health
505 City Parkway West
Orange CA 92868

4. A Provider shall bill accordingly for services rendered based on bill type and specialty. Claims elements include but are not limited to the following:

   a. Member Information;

   b. Provider of Service;

   c. Date of Service;

   d. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS);

   e. Applicable Revenue code (Institutional only);

   f. Applicable modifier (information and/or financial when required);

   g. Place of Service;

   h. Service Units; and

   i. Billed Charges.

E. Claim Filing Deadlines

1. A Provider shall submit a claim for Covered Services within three hundred sixty-five (365) calendar days after the month of the date of service.

2. If CalOptima Health is not the primary payer under coordination of benefits, CalOptima Health shall not impose a deadline for submitting supplemental or coordination of benefits claims to CalOptima Health that is less than ninety (90) calendar days from the date of payment or date of contest, date of denial, or notice from the primary payer.

F. Misdirected Claims

1. For a Provider claim involving Emergency Services or Family Planning Services that is incorrectly sent to CalOptima Health, CalOptima Health shall forward the claim to the appropriate Health Network within ten (10) business days after receipt of the claim.

2. For a Provider Claim that does not involve Emergency Services or Family Planning Services that is incorrectly sent to CalOptima Health, and the Provider that filed the claim is a participating Provider, CalOptima Health shall either:

   a. Send the Provider a notice of denial via a remittance advice, within forty-five (45) business days, with instructions to bill the Health Network; or

   b. Forward the claim to the appropriate Health Network, within ten (10) business days of the receipt of the claim.

3. In all other cases, for claims incorrectly sent to CalOptima Health, CalOptima Health shall forward the claim to the appropriate Health Network within ten (10) business days of the receipt of the claim.

G. Interest on Late Claims

1. Interest shall begin to accrue on the forty-sixth (46th) business day following receipt of the claim and is calculated based on calendar days.

2. CalOptima Health shall automatically include for late payment on a Complete Claim for Emergency Services 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 annum for the period of time that the payment is late.

3. CalOptima Health shall automatically include for late payments on all other claims other than Complete Claims for Emergency Services, interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

4. If the interest due on an individual claim is less than two dollars ($2), CalOptima Health may wait until the close of the calendar month and make a lump interest payment for all late claim payments during that time period. CalOptima Health shall make lump interest payments within ten (10) calendar days of the calendar month's end.

5. If CalOptima Health fails to automatically include the interest due on a late claim payment, CalOptima Health shall pay the Provider a ten dollar ($10) penalty for that late claim, in addition to any interest amount due.

H. Denying, Adjusting, or Contesting a Claim

1. In the event that CalOptima Health requests reasonably relevant information from a Provider; in addition to information that the Provider submits with a claim, CalOptima Health shall provide a clear, accurate, and written explanation of the necessity for the request.

2. If CalOptima Health fails to provide the Provider with timely written notice that a claim has been contested or denied ~~pursuant to Section III.K. of this Policy within the allowable time period~~, or requests information ~~from the Provider~~ that is not reasonably ~~relevant information, or requests information from a third party that is in excess of the information~~ necessary to determine payer liability, but ultimately pays the claim in whole or in part, CalOptima Health shall compute the interest or impose a penalty, pursuant to Section III.G. of this Policy.

3. A request for information necessary to determine payer liability from a third party shall not extend the time for reimbursement or the time for contesting or denying claims. CalOptima Health shall either contest or deny, in writing and within the time frames set forth in Section III.G. of this Policy, incomplete claims and claims for which information necessary to determine payer liability that has been requested, which are held or pended awaiting receipt of additional information. CalOptima Health shall identify in the denied or contested claim, the individual or entity that was requested to submit information, the specific documents requested, and the reason(s) why the information is necessary to determine payer liability.

4. If CalOptima Health subsequently denies the claim based on the Provider's failure to provide the requested medical records or other information, any ~~dispute~~Provider Dispute arising from the

denial of such claim shall be handled ~~as a Provider dispute,~~ in accordance with Title 28, California Code of Regulations, Section 1300.71.38.

5. Any claim submitted by a Provider that is flagged as "Do Not Pay" in the Provider Data Systems database will be denied.

   a. A "Do Not Pay" flag is entered into the Provider Data System for:

      i. Excluded Network Providers or Subcontractors for services provided after the effective date of the suspension or exclusion.

      ii. Decertified or suspended LTC Facilities for all services provided after the effective date of the suspension or exclusion.

      iii. Network Providers or Subcontractors for services on payment suspensions until payment suspension or exclusion has been lifted.

I. Reimbursement for the Overpayment of Claims

1. Overpayment Identified by Providers

   a. A Provider shall report to CalOptima Health when it has identified an Overpayment and return such Overpayment to CalOptima Health within sixty (60) calendar days after the date on which the Overpayment was identified. The Provider shall notify the CalOptima Health Claims Administration Department, in writing, of the reason for the Overpayment and the Claims Administration Department shall coordinate with the Provider on the process to return the Overpayment to CalOptima Health.

2. Overpayment Identified by CalOptima Health

   a. If CalOptima Health determines that it has overpaid a claim, it shall notify the Provider, in writing, through a separate notice clearly identifying the claim, the name of the patient, the date of service and include a clear explanation of the basis upon which CalOptima Health believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

      If the Provider contests CalOptima Health's notice of reimbursement of the Overpayment of a claim, the Provider, within sixty (60) calendar days of the receipt of the notice of Overpayment of a claim, shall send written notice to CalOptima ~~Health~~Health's GARS Department stating the basis upon which the Provider believes that CalOptima Health's notice was in error. CalOptima Health shall receive and process the contested notice of Overpayment of a claim as a Provider ~~dispute, pursuant to Title 28, California Code of Regulations, Section 1300.71.38 and~~Dispute, in accordance with CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

   b. If the Provider does not contest CalOptima Health's notice of reimbursement of the Overpayment of a claim, the Provider shall reimburse CalOptima Health within sixty (60) calendar days of the receipt, by the Provider, of the notice of Overpayment of a claim.

   c. If the Provider does not reimburse CalOptima Health for the Overpayment of a claim within sixty (60) calendar days after receipt of CalOptima Health's notice, interest shall accrue at the rate of ten percent (10%) per annum, beginning with the first (1^{st}) calendar day after the

sixty (60) calendar day period.

d. CalOptima Health may only offset an uncontested notice of reimbursement of the Overpayment of a claim against a Provider's current claim submission when:

i. The Provider fails to reimburse CalOptima Health within the time frame in set forth in Section III.I.2. of this Policy; or

ii. The Provider has entered into a written contract specifically authorizing CalOptima Health to offset an uncontested notice of Overpayment of a claim from the current claim submissions.
~~offset an uncontested notice of Overpayment of a claim from the current claim submissions.~~

e. In the event that an Overpayment of a claim or claims is offset against a Provider's current claim or claims pursuant to this section, CalOptima Health shall provide the Provider a detailed written explanation identifying the specific Overpayment or payments that have been offset against the specific current claim or claims.

3. CalOptima Health shall investigate any identified Overpayments that are suspected to be the result of inappropriate and/or inaccurate billing activity and shall promptly refer such identified suspected Overpayment to CalOptima Health's Special Investigations Unit (SIU) and/or DHCS as outlined in CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination.

4. CalOptima Health shall provide effective training and education for its compliance officer and all employees. This training shall include reporting to DHCS when Overpayments are identified or recovered, specifying which Overpayments are due to potential Fraud.

a. CalOptima Health shall notify DHCS within ten (10) days of identifying Overpayment, regardless of the amount as referenced in Title 42, Code of Federal Regulations (CFR~~)~~), Section 438.608(a)(2).

5. Retention and Reporting of Overpayment

a. CalOptima Health shall retain all Overpayment less than twenty-five million dollars ($25,000,000).

b. CalOptima Health shall document all Overpayments retained by CalOptima Health and review reports bi-annually for accuracy.

i. On a monthly basis, the Claims Administration Department shall submit a report to the Accounting Department documenting the Overpayment recovery activities for the prior month.

c. On an annual basis, CalOptima Health shall submit a report to DHCS on the recoveries of Overpayments, including those made to a Provider that was otherwise excluded from participation in the Medicaid program, and those made to a Provider due to ~~fraud, waste~~Fraud, Waste or ~~abuse~~Abuse. CalOptima Health shall submit the report through the rate setting process and in a manner specified by DHCS.

d. Upon identification of an Overpayment to a Provider of twenty-five million dollars

($25,000,000) or more in a single instance, CalOptima Health shall share the recovery amount with DHCS equally.

~~i.~~ CalOptima Health shall report such Overpayment to the DHCS Contract Manager within sixty

~~ii.~~i. (60) calendar days after ~~that~~ the Overpayment was identified.

~~iii.~~ii. CalOptima Health shall submit the Overpayment amount that was recovered, the reason for Overpayment, the services the Overpayment related to, the Provider's information, and steps taken to correct future occurrences to the DHCS Contract Manager.

6. CalOptima Health shall submit documentation including retention policies, process, time frames, and documentation required for reporting the recovery of all Overpayments, upon request by DHCS.

~~J. Provider Claims Dispute Resolution~~

~~1. A Provider may request reconsideration of a claim that has been denied, adjusted, or contested. A Provider may request, in writing, a Provider Dispute Resolution (PDR) within three hundred sixty-five (365) calendar days after the date of the original Remittance Advice Detail (RAD) containing the adjudicated claim to CalOptima Health's Claims Department. The Provider shall submit a PDR form (Attachment D) including, at minimum, the following information:~~

~~a. Provider's name;~~

~~b. Provider's identification number;~~

~~c. Provider's contact information; and~~

~~d. A clear identification of the disputed item, including:~~

~~i. Member's identification;~~

~~ii. Date of service;~~

~~iii. Original claim identification number;~~

~~iv. A clear explanation of the dispute; and~~

~~v. Any relevant material to support the dispute.~~

~~2. A Provider shall submit a PDR form (Attachment D), and any required attachments, to the address provided in Section III.D.3.c. of this Policy.~~

~~3. A Provider may obtain a copy of the PDR form (Attachment D) on the CalOptima Health Website at www.caloptima.org.~~

~~4. CalOptima Health shall respond to each PDR individually.~~

~~5. Acknowledgement of Provider claims dispute resolution:~~

a. CalOptima Health's Claims Department shall send the Provider a PDR Acknowledgement Letter within fifteen (15) business days after receipt of a complete PDR, indicating receipt of the PDR, and identifying a Claims staff Member whom the Provider may contact regarding the Provider claims dispute.

b. If the PDR is lacking information that is not readily accessible to CalOptima Health, CalOptima Health's Claims Department shall return the PDR to the Provider, and clearly identify the missing information necessary to resolve the PDR. A Provider may submit an amended PDR within thirty (30) business days after receipt of a returned PDR setting forth the missing information.

6. PDR processing

a. Upon receipt of a complete PDR from a Provider, CalOptima Health's Claims Department shall:

i. Review the initial claims decision, and all documents related to the determination of the original adjudicated claim; and

ii. Prepare the case file for review by CalOptima Health's Claims PDR Unit.

b. CalOptima Health shall utilize specialist consultants, as appropriate.

7. PDR resolution

a. CalOptima Health's Claims PDR Unit shall resolve each Provider dispute, or amended Provider dispute, within applicable state and federal laws, regulations, and statutes within forty-five (45) business days after receipt of the PDR request.

i. The Claims PDR unit shall send a written PDR Determination Letter to the Provider, as appropriate. Such written notice shall include information regarding a Provider's right to file a Provider Complaint, in accordance with CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

ii. If the Claims PDR Unit upholds the original claims adjudication, the Claims PDR Unit shall clearly specify the provisions for such determination.

iii. If the Claims PDR Unit overturns, in whole or in part, the original claims adjudication, the Claims PDR Unit shall pay any outstanding monies determined to be due, and all interest and penalties, if applicable, within five (5) business days of sending a PDR Determination Letter.

8. A Provider may submit disputed claims involving Emergency Services and/or Post Stabilization Care Services for resolution at the following address:

a. Department of Health Care Services
Office of Administrative Hearing and Appeals
3831 N Freeway BLVD STE 200
Sacramento CA 95834

b. Upon receipt of determination, CalOptima Health shall reimburse the provider within thirty (30) calendar days of the effective date of decision for payment of a claim and must provide

~~proof of reimbursement in such forms as DHCS directs.~~

~~9. CalOptima Health shall retain copies of Provider disputes and determinations for at least ten (10) years, including all notes, documents, and any other pertinent information upon which CalOptima Health PDR unit relied to resolve the Provider dispute.~~

~~K.~~J. CalOptima Health shall retain claims information data for a period of at least ten (10) years after the termination of its contract with the ~~Department of Health Care Services (DHCS)~~DHCS and shall not remove or transfer such records and data from its offices, except in accordance with applicable laws.

~~L.~~K. CalOptima Health shall hold harmless and indemnify Members for CalOptima Health's debt to Providers for ~~services~~Covered Services rendered and billed to Members.

~~M.~~L. CalOptima Health shall maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and contract requirements, to determine the status of received claims and to estimate Incurred But Not Reported (IBNR) claims.

IV. ATTACHMENT(S)

A. CMS-1500
B. UB-04 Form
C. LTC-25-1 Claim Form
D. Provider Claims Dispute Resolution Request Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
D. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to CalOptima Health Direct Members or Members Enrolled in a Shared Risk Group
E. CalOptima Health Policy FF.2003: Coordination of Benefits
F. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
G. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
H. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
I. CalOptima Health Policy MA.9009: Non-Contracted Provider Payment Appeals and Provider Dispute Resolution
J. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
~~I.~~K. CalOptima Health Policy HH.2022: Record Retention and Access
~~J.~~L. CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination
~~K.~~M. CalOptima Health Provider Manual
~~L.~~N. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations
~~M.~~O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-014: Electronic Visit Verification Implementation Requirements
~~N.~~P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-011: Treatment for Recoveries Made by the Managed Care Health Plan of Overpayment Providers (Supersedes APL 17-003)
~~O.~~Q. Health and Safety Code, §§1371 through 1371.39
~~P.~~R. Medi-Cal Provider Manual
~~Q.~~S. Title 22, California Code of Regulations, §§ 53220 and 53222

~~R.~~T. Title 28, California Code of Regulations, §§ 1300.71 and 1300.71.38
~~S.~~U. Title 42, United States Code, § 1396a(a)(37)
~~T.~~V. Title 42, Code of Federal Regulations (CFR), § 438.608(a)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/09/2017	Department of Health Care Services (DHCS)	Approved as Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved as Submitted
01/27/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/05/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2023	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2006	CC.1202	CalOptima Direct Claims Processing	Medi-Cal
Revised	01/01/2007	FF.2001	CalOptima Direct Claims Processing	Medi-Cal
Revised	08/01/2008	FF.2001	CalOptima Direct Claims Processing	Medi-Cal
Revised	01/01/2009	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	03/01/2012	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	01/01/2013	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	12/01/2014	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	03/01/2015	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2017	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	07/01/2017	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	06/07/2018	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal
Revised	05/01/2019	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal
Revised	01/01/2022	FF.2001	Claims Processing for Covered Services for which CalOptima is Financially Responsible	Medi-Cal
Revised	01/01/2023	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	06/01/2023	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	08/01/2023	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	TBD	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in unnecessary costs to a CalOptima Health Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the Provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
CalOptima Health Community Network (CCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
CalOptima Health Direct Administrative (COD- A)	The managed Fee-For-Service health care program operated by CalOptima Health that provides services to Members as described in CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for persons eligible for Medi-Cal. For CalOptima Health Members, the CHDP Program is incorporated into CalOptima Health's Pediatric Preventive Services Program.
Clean Claim	A claim that can be processed without obtaining additional information from the provider of the service or from a third party.
Complete Claim	A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides~~:~~ reasonably relevant information and information necessary to determine payer liability as defined in Title 28, California Code of Regulations section 1300.71 (a)(10) and (a)(11).

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Crossover Claims	A claim submitted for payment for a Medi-~~Medi~~Cal Member for which Medicare has primary responsibility and Medi-Cal is the secondary payer.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Dispute	A claims payment dispute regarding an amount paid that is less than the expected rate.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.

Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures.
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	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Incurred But Not Reported (IBNR)	An estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Network Provider	A Provider that subcontracts with CalOptima Health for the delivery of Medi-Cal Covered Services.
Other Health Coverage	The responsibility of an individual or entity, other than CalOptima Health or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.

Term	Definition
Pediatric Preventive Services (PPS)	Regular preventive health assessments, as recommended by the American Academy of Pediatrics or the Child Health and Disability Prevention (CHDP) Program. These include, but are not limited to, health and developmental history, physical examination, nutritional assessment, immunizations, vision testing, hearing testing, selected laboratory tests, health education, and anticipatory guidance.
Overpayment	Any payment made by CalOptima Health to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act
Provider	For the purposes of this policy, a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, physician group, Health Network, or other person or institution that furnishes Covered Services.
~~Overpayment~~Provider Complaint	~~Any payment made by CalOptima Health to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act~~The general term used to identify all provider filed request for review, and expressions of, dissatisfaction with any aspect of CalOptima Health or its Health Networks. This includes appeals, disputes and grievances.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima Health as the responsible partner for facility services.
Subcontractor	An individual or entity who has a Subcontract with CalOptima Health that relates directly or indirectly to the performance of CalOptima Health's obligations under contract with DHCS.
Unclean Claim	A claim from a Provider that does not have all the required data elements, documentation, or information necessary to process the claim or make a final disposition. Unclean claim shall have the same meaning as incomplete claim submission.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy:	FF.2001
Title:	**Claims Processing for Covered Services for which CalOptima Health is Financially Responsible**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which CalOptima Health ensures timely and accurate processing of claims for Covered Services for which CalOptima Health is financially responsible.

II. POLICY

A. CalOptima Health shall process claims in compliance with Title 42, United States Code (U.S.C.), Section 1396a(a)(37), and Health and Safety Code Sections 1371 through 1371.39.

B. CalOptima Health shall establish and maintain administrative processes, or contract with a claims processing organization, to accept and adjudicate claims for health care services provided to Members, in accordance with the provisions of this Policy and the California Code of Regulations.

C. CalOptima Health shall ensure timely compliance with claims payment obligations and claims settlement practices.

D. CalOptima Health shall not impose a deadline for the receipt of a claim that is less than ninety (90) calendar days for a participating Provider or one hundred and eighty (180) calendar days for a non-participating Provider, after the date of service, except as required by state or federal law or regulation.

E. CalOptima Health shall identify and acknowledge the receipt of each claim, whether or not it is a Complete Claim, and disclose the recorded date of receipt. CalOptima Health may provide an electronic method of notification, by which the Provider may readily confirm CalOptima Health's receipt of the claim and the recorded date of receipt within fifteen (15) business days of receipt of the claim.

F. CalOptima Health may review a claim for National Correct Coding Initiative (NCCI) edits and may contest or deny a claim based on improper coding. CalOptima Health may subcontract with a third-party vendor to review claims for NCCI edits and improper billing practices.

G. Claims Processing Timelines

Back to Item

Back to Agenda

1. CalOptima Health shall process and adjudicate ninety percent (90%) of Clean Claims for Covered Services within thirty (30) calendar days after CalOptima Health's receipt of such Clean Claims.

2. CalOptima Health shall process and adjudicate ninety-nine (99%) of claims for Covered Services within ninety (90) calendar days after CalOptima Health's receipt of such claim.

3. CalOptima Health shall notify a Provider of an Unclean Claim for Covered Services, within forty-five (45) business days after receipt of such claim If CalOptima Health fails to notify the Provider of the Unclean Claim, CalOptima Health shall consider the claim a Clean Claim, and shall pay, in accordance with the timelines for Clean Claims as set forth in this Policy.

H. CalOptima Health shall reimburse a Provider claim for Covered Services for which CalOptima Health is responsible, in accordance with CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Health Direct, or a Member Enrolled in a Shared Risk Group. Covered Services shall include payment for Emergency and Family Planning Services which do not require authorization.

I. CalOptima Health shall have a process to recoup Overpayments made to Providers and suppliers when claims payments exceed the allowed amount.

1. CalOptima Health may recoup Overpayments for a look-back period not to exceed six (6) years from current calendar year.

2. The six (6) year time limit shall not apply if the Overpayment was caused in whole, or in part, by Fraud, or misrepresentation, on the part of the Provider.

3. Failure to timely repay Overpayments will result in the addition of interest charges.

J. CalOptima Health shall not request reimbursement for the Overpayment of a claim, including requests made pursuant to Health and Safety Code, Section 1371.1, unless CalOptima Health sends a written request for reimbursement to the Provider within six (6) years from the date the Overpayment was made.

K. CalOptima Health shall pay interest and applicable penalties on all uncontested claims not paid within forty-five (45) business days, in accordance with Section III.G. of this Policy. The interest is determined by Health and Safety Code, Section 1371 or 1371.35, whichever is applicable.

L. CalOptima Health shall not improperly deny, adjust, or contest a claim, and shall provide a clear and accurate written explanation of the specific reasons for the action taken.

M. CalOptima Health may contest or deny a claim, or portion thereof, by notifying the Provider, in writing, that the claim is contested or denied, within forty-five (45) business days after the date of receipt of the claim by CalOptima Health.

N. CalOptima Health shall not engage in any practices, policies, or procedures that may constitute a basis for a finding of a demonstrable and unjust payment pattern or unfair payment pattern that results in repeated delays in the adjudication and correct reimbursement of a Provider claim.

O. CalOptima Health shall submit all required reports and documents regarding claims payment practices and claims settlement practices to Department of Health Care Services (DHCS).

P. CalOptima Health shall identify and process Overpayment recoveries in accordance with applicable statutory, regulatory and contractual requirements, as well as regulatory guidance, CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination, and Section III.I. of this Policy.

Q. CalOptima Health shall maintain procedures for pre-payment and post-payment claims review, including review of any data associated with Providers, Members, and Covered Services for which payment is claimed.

R. CalOptima Health shall maintain sufficient claims processing, tracking and payment systems capability to comply with applicable State and Federal laws, regulations, and Contract requirements, to determine status of received claims and to estimate incurred and unreported claims amounts.

S. DHCS may impose Corrective Action Plans (CAPs) as well as administrative and/or monetary sanctions for non-compliance with any of the following outlined procedures in this policy.

T. CalOptima Health shall establish and maintain a fair, fast, and cost-effective Provider Dispute process. CalOptima Health shall annually make available to DHCS all records, notes, and documents regarding its Provider Dispute resolution mechanisms and the resolution of its Provider Disputes.

U. CalOptima Health's Claims Administration Department shall inform a Provider in the remittance advice of their right to file a Complaint with CalOptima Health's Grievance and Appeals Resolution Services (GARS) Department, in accordance with CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

III. PROCEDURE

A. A Provider shall verify a Member's eligibility to receive Covered Services, in accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification.

B. For Members assigned to CalOptima Health Direct Administrative (COD-A) or CalOptima Health Community Network (CCN), a Provider shall obtain authorization for Covered Services, in accordance with CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, and GG.1508: Authorization and Processing of Referrals.

C. Members with Other Health Coverage or Medicare

1. If a Member has Other Health Coverage (OHC) or Medicare, a Provider shall submit a claim for Covered Services provided to the Member to the Other Health Coverage or Medicare prior to submitting the claim to CalOptima Health, in accordance with CalOptima Health Policy FF.2003: Coordination of Benefits.

2. CalOptima Health processes Crossover Claims for Members with secondary benefits under Medi-Cal. A Provider may submit Crossover Claims to CalOptima Health, in accordance with the Medi-Cal Provider Manual guidelines for Crossover Claims.

3. If a claim is received and is lacking the required OHC documentation, the claim shall be returned to the Provider and handled as a corrected claim once the documentation is received.

D. Claims Submission

1. A Provider shall utilize the following standard forms for submitting claims for Covered Services:

   a. A Provider shall use the CMS-1500 (Attachment A) when submitting a claim for professional services and supplies;

   b. A Provider shall use the UB-04 Form (Attachment B) when submitting a claim for hospital inpatient or outpatient services;

   c. An Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF) shall use the LTC-25-1 Claim Form (Attachment C) when submitting a claim for long-term care services; and

   d. For Child Health and Disability Prevention Program (CHDP) services, a Provider shall use the appropriate CMS-1500 (Attachment A) or UB-04 Claim Form (Attachment B) and standard CPT and HCPCS codes when submitting a claim for Pediatric Preventive Services. Claims for COD-A or CCN Members shall continue to be submitted to CalOptima Health, while claims for delegated Health Network Members shall be submitted to the appropriate Health Network.

2. A Provider shall submit a claim on the appropriate form with supporting documentation, including required prior authorizations and proof of Medicare or Other Health Coverage payment or denial.

3. A Provider may submit invoices, electronic or paper claims to CalOptima Health for Covered Services.

   a. A Provider may elect to submit electronic claims to CalOptima Health utilizing the process outlined in the CalOptima Health Provider Manual, Section H3: Electronic Claim Submissions: CalOptima Health Direct, Shared risk and OneCare (HMO D-SNP) Claims. This is located on the Provider section of the CalOptima Health website.

   b. A Provider who submits a paper claim shall submit the original claim form and retain a copy for the Provider's files. CalOptima Health shall not accept carbon copies, photocopies, computer generated copies, or facsimiles of paper claims.

   c. A Provider may submit paper claims to CalOptima Health by mail, or in person, at the following addresses:

      i. By mail:
      Attn: Claims Department
      CalOptima Health
      Post Office Box 11037
      Orange CA 92856

      ii. In person:
      Attn: Claims Department
      CalOptima Health
      505 City Parkway West
      Orange CA 92868

4. A Provider shall bill accordingly for services rendered based on bill type and specialty. Claims

elements include but are not limited to the following:

a. Member Information;

b. Provider of Service;

c. Date of Service;

d. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS);

e. Applicable Revenue code (Institutional only);

f. Applicable modifier (information and/or financial when required);

g. Place of Service;

h. Service Units; and

i. Billed Charges.

E. Claim Filing Deadlines

1. A Provider shall submit a claim for Covered Services within three hundred sixty-five (365) calendar days after the month of the date of service.

2. If CalOptima Health is not the primary payer under coordination of benefits, CalOptima Health shall not impose a deadline for submitting supplemental or coordination of benefits claims to CalOptima Health that is less than ninety (90) calendar days from the date of payment or date of contest, date of denial, or notice from the primary payer.

F. Misdirected Claims

1. For a Provider claim involving Emergency Services or Family Planning Services that is incorrectly sent to CalOptima Health, CalOptima Health shall forward the claim to the appropriate Health Network within ten (10) business days after receipt of the claim.

2. For a Provider Claim that does not involve Emergency Services or Family Planning Services that is incorrectly sent to CalOptima Health, and the Provider that filed the claim is a participating Provider, CalOptima Health shall either:

a. Send the Provider a notice of denial via a remittance advice, within forty-five (45) business days, with instructions to bill the Health Network; or

b. Forward the claim to the appropriate Health Network, within ten (10) business days of the receipt of the claim.

3. In all other cases, for claims incorrectly sent to CalOptima Health, CalOptima Health shall forward the claim to the appropriate Health Network within ten (10) business days of the receipt of the claim.

G. Interest on Late Claims

1. Interest shall begin to accrue on the forty-sixth (46th) business day following receipt of the claim and is calculated based on calendar days.

2. CalOptima Health shall automatically include for late payment on a Complete Claim for Emergency Services 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 annum for the period of time that the payment is late.

3. CalOptima Health shall automatically include for late payments on all other claims other than Complete Claims for Emergency Services, interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

4. If the interest due on an individual claim is less than two dollars ($2), CalOptima Health may wait until the close of the calendar month and make a lump interest payment for all late claim payments during that time period. CalOptima Health shall make lump interest payments within ten (10) calendar days of the calendar month's end.

5. If CalOptima Health fails to automatically include the interest due on a late claim payment, CalOptima Health shall pay the Provider a ten dollar ($10) penalty for that late claim, in addition to any interest amount due.

H. Denying, Adjusting, or Contesting a Claim

1. In the event that CalOptima Health requests reasonably relevant information from a Provider; in addition to information that the Provider submits with a claim, CalOptima Health shall provide a clear, accurate, and written explanation of the necessity for the request.

2. If CalOptima Health fails to provide the Provider with timely written notice that a claim has been contested or denied, or requests information that is not reasonably necessary to determine payer liability, but ultimately pays the claim in whole or in part, CalOptima Health shall compute the interest or impose a penalty, pursuant to Section III.G. of this Policy.

3. A request for information necessary to determine payer liability from a third party shall not extend the time for reimbursement or the time for contesting or denying claims. CalOptima Health shall either contest or deny, in writing and within the time frames set forth in Section III.G. of this Policy, incomplete claims and claims for which information necessary to determine payer liability that has been requested, which are held or pended awaiting receipt of additional information. CalOptima Health shall identify in the denied or contested claim, the individual or entity that was requested to submit information, the specific documents requested, and the reason(s) why the information is necessary to determine payer liability.

4. If CalOptima Health subsequently denies the claim based on the Provider's failure to provide the requested medical records or other information, any Provider Dispute arising from the denial of such claim shall be handled in accordance with Title 28, California Code of Regulations, Section 1300.71.38.

5. Any claim submitted by a Provider that is flagged as "Do Not Pay" in the Provider Data Systems database will be denied.

   a. A "Do Not Pay" flag is entered into the Provider Data System for:

i. Excluded Network Providers or Subcontractors for services provided after the effective date of the suspension or exclusion.

ii. Decertified or suspended LTC Facilities for all services provided after the effective date of the suspension or exclusion.

iii. Network Providers or Subcontractors for services on payment suspensions until payment suspension or exclusion has been lifted.

I. Reimbursement for the Overpayment of Claims

1. Overpayment Identified by Providers

a. A Provider shall report to CalOptima Health when it has identified an Overpayment and return such Overpayment to CalOptima Health within sixty (60) calendar days after the date on which the Overpayment was identified. The Provider shall notify the CalOptima Health Claims Administration Department, in writing, of the reason for the Overpayment and the Claims Administration Department shall coordinate with the Provider on the process to return the Overpayment to CalOptima Health.

2. Overpayment Identified by CalOptima Health

a. If CalOptima Health determines that it has overpaid a claim, it shall notify the Provider, in writing, through a separate notice clearly identifying the claim, the name of the patient, the date of service and include a clear explanation of the basis upon which CalOptima Health believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

If the Provider contests CalOptima Health's notice of reimbursement of the Overpayment of a claim, the Provider, within sixty (60) calendar days of the receipt of the notice of Overpayment of a claim, shall send written notice to CalOptima Health's GARS Department stating the basis upon which the Provider believes that CalOptima Health's notice was in error. CalOptima Health shall receive and process the contested notice of Overpayment of a claim as a Provider Dispute, in accordance with CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

b. If the Provider does not contest CalOptima Health's notice of reimbursement of the Overpayment of a claim, the Provider shall reimburse CalOptima Health within sixty (60) calendar days of the receipt, by the Provider, of the notice of Overpayment of a claim.

c. If the Provider does not reimburse CalOptima Health for the Overpayment of a claim within sixty (60) calendar days after receipt of CalOptima Health's notice, interest shall accrue at the rate of ten percent (10%) per annum, beginning with the first (1^{st}) calendar day after the sixty (60) calendar day period.

d. CalOptima Health may only offset an uncontested notice of reimbursement of the Overpayment of a claim against a Provider's current claim submission when:

i. The Provider fails to reimburse CalOptima Health within the time frame in set forth in Section III.I.2. of this Policy; or

ii. The Provider has entered into a written contract specifically authorizing CalOptima Health

to offset an uncontested notice of Overpayment of a claim from the current claim submissions.

e. In the event that an Overpayment of a claim or claims is offset against a Provider's current claim or claims pursuant to this section, CalOptima Health shall provide the Provider a detailed written explanation identifying the specific Overpayment or payments that have been offset against the specific current claim or claims.

3. CalOptima Health shall investigate any identified Overpayments that are suspected to be the result of inappropriate and/or inaccurate billing activity and shall promptly refer such identified suspected Overpayment to CalOptima Health's Special Investigations Unit (SIU) and/or DHCS as outlined in CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination.

4. CalOptima Health shall provide effective training and education for its compliance officer and all employees. This training shall include reporting to DHCS when Overpayments are identified or recovered, specifying which Overpayments are due to potential Fraud.

   a. CalOptima Health shall notify DHCS within ten (10) days of identifying Overpayment, regardless of the amount as referenced in Title 42, Code of Federal Regulations (CFR), Section 438.608(a)(2).

5. Retention and Reporting of Overpayment

   a. CalOptima Health shall retain all Overpayment less than twenty-five million dollars ($25,000,000).

   b. CalOptima Health shall document all Overpayments retained by CalOptima Health and review reports bi-annually for accuracy.

      i. On a monthly basis, the Claims Administration Department shall submit a report to the Accounting Department documenting the Overpayment recovery activities for the prior month.

   c. On an annual basis, CalOptima Health shall submit a report to DHCS on the recoveries of Overpayments, including those made to a Provider that was otherwise excluded from participation in the Medicaid program, and those made to a Provider due to Fraud, Waste or Abuse. CalOptima Health shall submit the report through the rate setting process and in a manner specified by DHCS.

   d. Upon identification of an Overpayment to a Provider of twenty-five million dollars ($25,000,000) or more in a single instance, CalOptima Health shall share the recovery amount with DHCS equally.

      i. CalOptima Health shall report such Overpayment to the DHCS Contract Manager within sixty (60) calendar days after the Overpayment was identified.

      ii. CalOptima Health shall submit the Overpayment amount that was recovered, the reason for Overpayment, the services the Overpayment related to, the Provider's information, and steps taken to correct future occurrences to the DHCS Contract Manager.

6. CalOptima Health shall submit documentation including retention policies, process, time frames, and documentation required for reporting the recovery of all Overpayments, upon request by DHCS.

J. CalOptima Health shall retain claims information data for a period of at least ten (10) years after the termination of its contract with the DHCS and shall not remove or transfer such records and data from its offices, except in accordance with applicable laws.

K. CalOptima Health shall hold harmless and indemnify Members for CalOptima Health's debt to Providers for Covered Services rendered and billed to Members.

L. CalOptima Health shall maintain sufficient claims processing, tracking, and payment systems capability to comply with applicable State and federal law, regulations, and contract requirements, to determine the status of received claims and to estimate Incurred But Not Reported (IBNR) claims.

IV. ATTACHMENT(S)

A. CMS-1500
B. UB-04 Form
C. LTC-25-1 Claim Form
D. Provider Claims Dispute Resolution Request Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
D. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to CalOptima Health Direct Members or Members Enrolled in a Shared Risk Group
E. CalOptima Health Policy FF.2003: Coordination of Benefits
F. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
G. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
H. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
I. CalOptima Health Policy MA.9009: Non-Contracted Provider Payment Appeals and Provider Dispute Resolution
J. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
K. CalOptima Health Policy HH.2022: Record Retention and Access
L. CalOptima Health Policy HH.5000: Provider Overpayment Investigation and Determination
M. CalOptima Health Provider Manual
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-014: Electronic Visit Verification Implementation Requirements
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-011: Treatment for Recoveries Made by the Managed Care Health Plan of Overpayment Providers (Supersedes APL 17-003)
Q. Health and Safety Code, §§1371 through 1371.39
R. Medi-Cal Provider Manual
S. Title 22, California Code of Regulations, §§ 53220 and 53222
T. Title 28, California Code of Regulations, §§ 1300.71 and 1300.71.38
U. Title 42, United States Code, § 1396a(a)(37)

V. Title 42, Code of Federal Regulations (CFR), § 438.608(a)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/09/2017	Department of Health Care Services (DHCS)	Approved as Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved as Submitted
01/27/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/05/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2023	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2006	CC.1202	CalOptima Direct Claims Processing	Medi-Cal
Revised	01/01/2007	FF.2001	CalOptima Direct Claims Processing	Medi-Cal
Revised	08/01/2008	FF.2001	CalOptima Direct Claims Processing	Medi-Cal
Revised	01/01/2009	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	03/01/2012	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	01/01/2013	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	12/01/2014	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	03/01/2015	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	01/01/2017	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2017	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	06/07/2018	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal
Revised	05/01/2019	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal
Revised	01/01/2022	FF.2001	Claims Processing for Covered Services for which CalOptima is Financially Responsible	Medi-Cal
Revised	01/01/2023	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	06/01/2023	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	08/01/2023	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal
Revised	TBD	FF.2001	Claims Processing for Covered Services for which CalOptima Health is Financially Responsible	Medi-Cal

1

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in unnecessary costs to a CalOptima Health Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the Provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "Abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
CalOptima Health Community Network (CCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
CalOptima Health Direct Administrative (COD- A)	The managed Fee-For-Service health care program operated by CalOptima Health that provides services to Members as described in CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for persons eligible for Medi-Cal. For CalOptima Health Members, the CHDP Program is incorporated into CalOptima Health's Pediatric Preventive Services Program.
Clean Claim	A claim that can be processed without obtaining additional information from the provider of the service or from a third party.
Complete Claim	A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides reasonably relevant information and information necessary to determine payer liability as defined in Title 28, California Code of Regulations section 1300.71 (a)(10) and (a)(11).

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Crossover Claims	A claim submitted for payment for a Medi-Cal Member for which Medicare has primary responsibility and Medi-Cal is the secondary payer.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Dispute	A claims payment dispute regarding an amount paid that is less than the expected rate.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.

Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures.
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	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Incurred But Not Reported (IBNR)	An estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Network Provider	A Provider that subcontracts with CalOptima Health for the delivery of Medi-Cal Covered Services.
Other Health Coverage	The responsibility of an individual or entity, other than CalOptima Health or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.

Term	Definition
Pediatric Preventive Services (PPS)	Regular preventive health assessments, as recommended by the American Academy of Pediatrics or the Child Health and Disability Prevention (CHDP) Program. These include, but are not limited to, health and developmental history, physical examination, nutritional assessment, immunizations, vision testing, hearing testing, selected laboratory tests, health education, and anticipatory guidance.
Overpayment	Any payment made by CalOptima Health to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act
Provider	For the purposes of this policy, a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, physician group, Health Network, or other person or institution that furnishes Covered Services.
Provider Complaint	The general term used to identify all provider filed request for review, and expressions of, dissatisfaction with any aspect of CalOptima Health or its Health Networks. This includes appeals, disputes and grievances.
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima Health as the responsible partner for facility services.
Subcontractor	An individual or entity who has a Subcontract with CalOptima Health that relates directly or indirectly to the performance of CalOptima Health's obligations under contract with DHCS.
Unclean Claim	A claim from a Provider that does not have all the required data elements, documentation, or information necessary to process the claim or make a final disposition. Unclean claim shall have the same meaning as incomplete claim submission.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

Back to Item

Back to Agenda

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
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23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS		81CC			
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76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO.

Back to Item

Back to Agenda

DO NOT STAPLE IN BAR AREA

PROVIDER'S NAME, ADDRESS, ZIP CODE

(1A)

1 CLAIM CONTROL NUMBER . FOR F.I. USE ONLY

(1)

FASTEN HERE

6

2 Provider Number

(2)

128 Zip Code

PAYMENT REQUEST FOR LONG TERM CARE

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CARE SERVICES

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM

Elite Pica — PLEASE TYPE ALL REQUIRED INFORMATION — Typewriter Alignment — Elite Pica

1

DELETE 3 (3) | 4 PATIENT NAME (4) | 5 MEDI-CAL ID. NUMBER (5) | CHECK | 6 YR. OF BIRTH (6) | 7 SEX (7) | 8 TAR CONTROL NO. (8) | 9 MEDICAL RECORD NO. (9) | 10 ATTED. M.D. PROVIDER NUMBER (10)

11 BILL'G LIMIT EXCEPTIONS (11) | 12 DATE OF SERVICE FROM (12) | 13 THRU (13) | 14 PATIENT STATUS (14) | 15 ACCOM. CODE (15) | 16 PRIM. DX CODE (16) | 17 GROSS AMOUNT $ (17) | 18 PATIENT LIABILITY/ MEDICARE DEDUCT $ (18) | MEDICARE TYPE (18A) | 19 OTHER COVERAGE $ (19) | 20 NET AMOUNT BILLED $ (20) | 21 M.D. CERT. (21)

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30 BILL'G LIMIT EXCEPTIONS | 31 DATE OF SERVICE FROM | 32 THRU | 33 PATIENT STATUS | 34 ACCOM. CODE | 35 PRIM. DX CODE | 36 GROSS AMOUNT $ | 37 PATIENT LIABILITY/ MEDICARE DEDUCT $ | MEDICARE TYPE | 38 OTHER COVERAGE $ | 39 NET AMOUNT BILLED $ | 40 M.D. CERT.

3

DELETE 41 | 42 PATIENT NAME | 43 MEDI-CAL ID. NUMBER | CHECK | 44 YR. OF BIRTH | 45 SEX | 46 TAR CONTROL NO. | 47 MEDICAL RECORD NO. | 48 ATTED. M.D. PROVIDER NUMBER

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4

DELETE 60 | 61 PATIENT NAME | 62 MEDI-CAL ID. NUMBER | CHECK | 63 YR. OF BIRTH | 64 SEX | 65 TAR CONTROL NO. | 66 MEDICAL RECORD NO. | 67 ATTED. M.D. PROVIDER NUMBER

68 BILL'G LIMIT EXCEPTIONS | 69 DATE OF SERVICE FROM | 70 THRU | 71 PATIENT STATUS | 72 ACCOM. CODE | 73 PRIM. DX CODE | 74 GROSS AMOUNT $ | 75 PATIENT LIABILITY/ MEDICARE DEDUCT $ | MEDICARE TYPE | 76 OTHER COVERAGE $ | 77 NET AMOUNT BILLED $ | 78 M.D. CERT.

5

DELETE 79 | 80 PATIENT NAME | 81 MEDI-CAL ID. NUMBER | CHECK | 82 YR. OF BIRTH | 83 SEX | 84 TAR CONTROL NO. | 85 MEDICAL RECORD NO. | 86 ATTED. M.D. PROVIDER NUMBER

87 BILL'G LIMIT EXCEPTIONS | 88 DATE OF SERVICE FROM | 89 THRU | 90 PATIENT STATUS | 91 ACCOM. CODE | 92 PRIM. DX CODE | 93 GROSS AMOUNT $ | 94 PATIENT LIABILITY/ MEDICARE DEDUCT $ | MEDICARE TYPE | 95 OTHER COVERAGE $ | 96 NET AMOUNT BILLED $ | 97 M.D. CERT.

6

DELETE 98 | 99 PATIENT NAME | 100 MEDI-CAL ID. NUMBER | CHECK | 101 YR. OF BIRTH | 102 SEX | 103 TAR CONTROL NO. | 104 MEDICAL RECORD NO. | 105 ATTED. M.D. PROVIDER NUMBER

106 BILL'G LIMIT EXCEPTIONS | 107 DATE OF SERVICE FROM | 108 THRU | 109 PATIENT STATUS | 110 ACCOM. CODE | 111 PRIM. DX CODE | 112 GROSS AMOUNT $ | 113 PATIENT LIABILITY/ MEDICARE DEDUCT $ | MEDICARE TYPE | 114 OTHER COVERAGE $ | 115 NET AMOUNT BILLED $ | 116 M.D. CERT.

117 ATTACH-MENTS (117) | 118 PROV. REF. NO. (118) | 119 DATE BILLED (119) | 120 (120) | 121 | 122 | 123 | 124 | 125 | 126 (126) | (116)

PLEASE DO NOT MARK IN SHADED AREAS — F.I. USE ONLY

EXPLANATIONS: (REFERENCE SPECIFIC AREAS)

(126A)

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

127 x (127)

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

25-1C 08/16

Back to Item

Back to Agenda

PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
- For routine follow-up regarding claims status, please contact the CalOptima Claims Provider Line: 714-246-8885
- Mail the completed form to: CalOptima Health Claims Provider Dispute
  P.O. Box 11037
  Orange, CA 92856

PRODUCT TYPE: ☐ MEDI-CAL ☐ MEDICARE ☐ COMMERCIAL

***PROVIDER NPI:**	***PROVIDER TAX ID # / Medicare ID #:**
***PROVIDER NAME:**	**CONTRACTED:** ☑ YES ☐ NO
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC
☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet) *Number of claims*:_____

*** Patient Name:**		**Date of Birth:**
*** Health Plan ID Number:**	**Patient Account Number:**	**Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	**Title**	**( ) Phone Number**
Signature	**Date**	**( ) Fax Number**

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

For Health Plan Use Only

TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

Back to Item

Back to Agenda

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
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☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**

Back to Item

Back to Agenda

Policy:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima Health or a Health Network in accordance with applicable statutory~~,~~ and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima Health or a Health Network shall reimburse a claim for Covered Services rendered to a Member in accordance with the standard allowances set by CalOptima Health Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a ~~contracted~~Contracted Provider.

B. A Provider shall submit a claim for Covered Services ~~rendered on, or after, January 1, 2010,~~ as follows:

1. A Non-Contracted Provider shall submit a claim for Covered Services rendered to a Member within one (1) calendar year after the date of service.

2. A ~~contracted~~Contracted Provider shall submit a claim for Covered Services rendered to a Member within the time frame specified in the ~~contracted~~Contracted Provider agreement. If the ~~contracted~~Contracted Provider agreement does not specify a time frame, the ~~contracted~~Contracted Provider shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima Health or a Health Network shall make timely and reasonable payment for the following Covered Services provided to a Member by a Non-Contracted Provider:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the Member's health, as provided in CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. Emergency Services~~ - Emergency medical services~~ do not require Prior Authorization. If it is determined that the Member is to be admitted and CalOptima Health or a Health Network does not have a notification of an inpatient admission from the ~~ER~~emergency department on file for the room and board charges, CalOptima Health or a Health Network must pay the emergency triage fee and request Medical Records;

3. Urgently needed services;

4. Authorized post-stabilization care services;

5. Renal dialysis services when the Member is temporarily out-of-area and cannot reasonably access a ~~contracted~~Contracted Provider for such Covered Services;

6. Denied Covered Services that are determined in the Appeal processes in CalOptima Health policies to be services the Member was entitled to have furnished, or paid for, by CalOptima Health or a Health Network; and

7. CalOptima Health or a Health Network shall provide Medically Necessary, Covered Services to a Member through an ~~out-of-network~~Non-Contracted Provider when CalOptima Health or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Health Policy EE.1141: CalOptima Provider Contracts.

D. CalOptima Health or a Health Network shall pay, or deny, a claim as follows:

1. Contracted Providers

   a. CalOptima Health or a Health Network shall pay, or deny, a claim from a ~~contracted~~Contracted Provider, or portion thereof, in accordance with the time frames, terms, and conditions of the Provider ~~Agreement~~agreement.

2. Non-Contracted Providers

   a. CalOptima Health or a Health Network shall pay, or deny, ninety-five percent (95%) of all Clean Claims from Non-Contracted Providers within thirty (30) calendar days after the date of receipt.

   b. CalOptima Health or a Health Network shall pay, or deny, all other claims from Non-Contracted Providers within sixty (60) calendar days after the date of receipt.

   c. If CalOptima Health or a Health Network fails to pay a Clean Claim from a Non-Contracted Provider within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

   d. CalOptima Health or a Health Network shall reimburse a Non-Contracted Provider at the Medicare Fee Schedule for Medicare Part B professional services.

   e. ~~For Dates of Service effective beginning January 1, 2019,~~ CalOptima Health or a Health Network shall administer the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) for Part B professional services provided by non-

contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima Health or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by CMS in the MIPS adjustment data files.

i. CalOptima Health or a Health Network shall apply positive MIPS payment adjustments, within thirty (30) calendar days of receipt of a ~~clean claim~~Clean Claim regardless of the dates of service.

E. If CalOptima Health or a Health Network denies payment of a Clean Claim, CalOptima Health or a Health Network shall notify the Member with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima Health or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

a. The specific reasons for the payment denial;

b. Inform the Member of his or her right to request an Appeal;

c. Describe the Appeals process, time frames, and other elements; and

d. Inform the Member of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program~~,~~ but is covered by and payable under a Member's Medi-Cal coverage, CalOptima Health or a Health Network shall not send the Member a Notice of Denial of Payment.

F. The CalOptima Health Claims Administration Department or a Health Network shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

G. CalOptima Health or a Health Network shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

H. CalOptima Health or a Health Network shall reopen a claim for clerical errors in accordance with this Policy.

I. Provider Dispute Resolution (PDR) and Appeal ~~and Grievance~~

1. A ~~Provider may~~Contracted provider may dispute or Appeal a claim determination in accordance with CalOptima Health ~~Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal~~Policy MA.9006: Contracted Provider Complaint Process.

2. ~~In case of a Payment Dispute Resolutions (PDR), the CalOptima Health Claim Administration Department or Health Network shall inform the~~A Non-Contracted Provider ~~in the notice of PDR decision of his right to~~may dispute or Appeal a claim determination in accordance with CalOptima Health Policy MA.9009: Non-Contracted

Provider Complaint Process.

~~2.~~3. Providers may file a ~~complaint with CalOptima Health,~~Medical Necessity Appeal in accordance with CalOptima Health Policy MA.~~9006: Provider Complaint Process~~9015: Standard Integrated Appeals.

~~3. The CalOptima Health Claims Administration Department and Health Network staff shall accept, track, report all NCP PDRs as determined by CalOptima Health's Audit & Oversight Department.~~

~~4. Non-Contracted Providers may file a PDR within one hundred and eighty (180) calendar days from the receipt of the Remittance Advice (RA) for level of payment disputes (The notice of initial determination is presumed to be received five (5) calendar days from the date of the RA unless there is evidence to the contrary.).~~

~~5. The Claims Administration Department or the Health Network shall issue a PDR notice to the NCP within thirty (30) calendar days of the receipt of the request.~~

~~6. The CalOptima Health Grievance and Appeals Resolution Service and Claims Administration Departments and Health Networks shall document all actions taken related to the PDR, or Appeal, request in its tracking system and/or hard copy including, but not limited to:~~

~~a. Provider's name;~~

~~b. Date received;~~

~~c. Name of staff that received the complaint at CalOptima Health;~~

~~d. Designated contact person;~~

~~e. Description of the complaint;~~

~~f. Date;~~

~~g. Dispositions; and~~

~~h. Appeal Review.~~

III. PROCEDURE

A. If CalOptima Health or a Health Network receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) business days after the date of receipt, as applicable.

B. Invalid/Incomplete Claims

1. If CalOptima Health or a Health Network receives an Invalid or Incomplete Claim, it shall notify the Provider no later than ten (10) business days after the date of receipt, in writing, with a request for the missing or invalid information.

2. If CalOptima Health or a Health Network does not receive the requested information within forty-

five (45) calendar days after the date of CalOptima Health's notice, or a Health Network notice, CalOptima Health or a Health Network shall review the claim with ~~(45) calendar days after the date of CalOptima Health's notice, CalOptima Health's or a Health Network notice, CalOptima Health or a Health Network shall review the claim with~~ the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima Health or a Health Network denies an Invalid/Incomplete Claim, the Provider shall have no rights to Appeal such denial.

C. Non-Clean Claims

1. If CalOptima Health or a Health Network receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima Health or a Health Network shall notify a Provider of a Non-Clean Claim no later than thirty (30) business days after the date of receipt, in writing, with a request for the missing information. If CalOptima Health or a Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, CalOptima Health or a Health Network shall provide a written explanation of the necessity for such request.

3. Contracted/Non-Contracted Providers:

   a. If CalOptima Health or a Health Network does not receive the requested information within forty- five (45) calendar days after it receives the claim, CalOptima Health or a Health Network shall send a second (2nd) letter to the ~~contracted~~Contracted/Non-Contracted Provider requesting such information.

   b. If CalOptima Health or a Health Network does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima Health or a Health Network shall review the claim with the information available and shall make a determination to pay or deny the claim.

4. CalOptima Health or a Health Network shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima Health or a Health Network denies a claim based on a Provider's failure to provide requested Medical Records or other information, it shall process any dispute arising from the denial of such claim as a ~~Provider Grievance~~PDR or Appeal, in accordance with Section II.I. of this Policy.

6. If CalOptima Health or a Health Network denies a claim based on a Provider's failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the Provider's submission of a ~~Grievance~~PDR or an Appeal in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima Health or a Health Network shall have the right to accept and adjudicate the claim.

7. CalOptima Health or a Health Network may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima Health or a Health Network may contract with a third--party vendor to review claims for NCCI edits, or improper billing practices.

D. CalOptima Health or a Health Network Reopening of Claims

1. CalOptima Health or a Health Network shall reopen a claim for clerical errors including minor errors or omissions such as human or mechanical errors on the part of CalOptima Health or a Health Network, such as:

   a. Mathematical or computational mistakes;

   b. Transposed procedure or diagnostic codes;

   c. Inaccurate data entry;

   d. Misapplication of a fee schedule;

   e. Computer errors;

   f. Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; or

   g. Incorrect data items, such as provider number, use of a modifier or date of service.

2. The following does not constitute grounds for Reopening of a claim:

   a. Failing to bill for certain items or services;

   b. Untimely filing; or

   c. Redetermination requests.

3. CalOptima Health or a Health Network, a Provider, or any other party to the determination decision may request CalOptima Health or a Health Network reopen a claim as follows:

   a. The request may be made verbally or in writing.

   b. CalOptima Health or a Health Network shall complete the claim determination within sixty (60) calendar days from the date of receipt of the party's written or verbal request to reopen.

   c. If the reopening action results in a revised claim determination or decision that results in payment to a Provider, CalOptima Health or a Health Network shall issue a revised electronic or paper remittance advice notice.

   d. If the reopening action results in an adverse revised claim determination or decision, CalOptima Health or a Health Network shall provide a written notice to the Provider that states the basis for the adverse determination and provide ~~Appeal rights.~~the applicable rights according to Section II. I. of this policy.

4. When reviewing a request to reopen a claim, CalOptima Health or a Health Network can consider new and material evidence if it meets the following:

   a. Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination;

b. Does not include evidence that was, or reasonably could have been, available to the decision-maker at the time the decision was made; and

c. May result in a conclusion different from that reached in the initial claim determination or redetermination.

5. CalOptima Health or a Health Network may reopen a claim within one (1) to four (4) years from the date of the initial claim determination, as applicable.

6. The reopening of a claim is separate and distinct from the Appeals process as provided in CalOptima Health Policies MA.9005: Payment Appeal ~~and CMC.9005: Payment Appeal~~, MA.9009: Non-Contracted Provider Complaint Process, and MA.9015: Standard Integrated Appeals.

7. The decision of CalOptima Health or a Health Network to reopen a claim determination ~~is not an initial claim determination~~constitutes a new Organization Determination and ~~is therefore not subject~~CalOptima or the Health Network must issue an Organization Determination to the provider with instructions on how to Appeal or dispute, consistent with the regulations under 42 CFR, Subpart M.

8. Revised claim determinations resulting from a reopening action will be subject to Appeal.

E. Denial to Reopen a Claim

1. CalOptima Health or a Health Network has the discretion to determine the criteria and corrections necessary to reopen a claim. CalOptima Health or a Health Network shall notify the requesting party in writing of the decision not to reopen.

F. Notifications Related to Determinations that are Reopened and Changed

1. CalOptima Health or a Health Network shall ensure the following for written notifications:

a. Are delivered to the last known address when the determination or decision is reopened and revised;

b. State the rational and basis for the reopening and revision;

c. State the specific reason for the revision or change in rationale, written in a manner that is understandable; and

d. Provide information on any ~~appeal rights.~~additional rights as provided in Section II. I of this policy.

G. Record Maintenance

1. CalOptima Health or a Health Networks shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a Clean Claim, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima Health or a Health Networks took such action, in the same manner that the Provider submitted the claim.

2. CalOptima Health or a Health Networks shall maintain all Member Medical Records and claim information data for a period of at least ten (10) years from the latest CMS contracting

period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare ~~-~~DSNP Coverage Decision Letter Integrated ~~-~~(CMS-10716~~); OMB Approval 0938-1386(Expires: 11/30/2023))~~
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Policy CMC.3103: Claims Coordination of Benefits
E. CalOptima Health Policy CMC.9005: Payment Appeal
F. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
G. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
H. CalOptima Health Policy MA.3103: Coordination of Benefits
I. CalOptima Health Policy MA.9005: Payment Appeal
J. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
K. CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process
L. CalOptima Health Policy MA.9015 Standard Integrated Appeals
~~K.~~M. Centers for Medicare and Medicaid Services (CMS): Release of 2020 MIPS Payment Adjustment Data File
~~L.~~N. Centers for Medicare and Medicaid (CMS): Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments - Update
~~M.~~O. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
~~N.~~P. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
~~O.~~Q. Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revision of Claim Determinations and Decisions
~~P.~~R. Patient Protection and Affordable Care Act, §6404
~~Q.~~S. Title 31, United States Code (U.S.C.), §3902(a)
~~R.~~T. ~~S.~~ Title 42, Code of Federal Regulations (C.F.R.), §§405.927, 405.980(a)(3), 410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
05/05/2022	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	12/03/2020	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2022	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	05/05/2022	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2023	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	TBD	MA.3101	Claims Processing	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Appeal	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima Health on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. ~~OneCare Connect: Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima Health and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.~~ OneCare Connect: In general, a Member's actions, both internal and external to CalOptima Health requesting review of CalOptima Health's denial, reduction or termination of benefits or services, from CalOptima Health. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals and 42 CFR sections 422.629 through 422.634, 438.210, 438.400, and 438.402. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima Health of an Adverse Benefit Determination. PACE: A Participant's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Term	Definition
Contracted & Contracting Provider	OneCare/OneCare Connect: A Provider who is obligated by a written contract to provide Covered Services to Members on behalf of CalOptima Health, or its contracted Health Networks. PACE: A Physician, Nurse, technician, teacher, researcher, hospital, home health agency, nursing home or any other individual or institution that contracts with CalOptima PACE to provide medical services to CalOptima PACE's plan Members.
Covered Services	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 Health 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) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.
Emergency Care	Covered Services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima Health PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive ~~prior authorization~~Prior Authorization for emergency care.
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Grievance	~~OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.~~ ~~OneCare Connect:~~ Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima Health's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication thru the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.
~~Non-Clean Claim~~	~~A claim for covered services that lacks required documentation such as medical records or authorization numbers.~~
~~Non-Contracted Provider~~	~~A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.~~
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.
Medical Record	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.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
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Term	Definition
Organization Determination	Any determination made by CalOptima Health, or its delegated entity with respect the following: 1. Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, which the Member believes should be furnished or arranged by CalOptima Health; 4. Reduction or premature discontinuation, of a previously authorized ongoing course of treatment; or 5. Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.
Prior Authorization	OneCare & OneCare Connect: A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a Participant to receive a specific service or procedure.
Provider	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. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, or other person or institution who furnishes Covered Services.

1

Policy:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima Health or a Health Network in accordance with applicable statutory and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima Health or a Health Network shall reimburse a claim for Covered Services rendered to a Member in accordance with the standard allowances set by CalOptima Health Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a Contracted Provider.

B. A Provider shall submit a claim for Covered Services as follows:

1. A Non-Contracted Provider shall submit a claim for Covered Services rendered to a Member within one (1) calendar year after the date of service.

2. A Contracted Provider shall submit a claim for Covered Services rendered to a Member within the time frame specified in the Contracted Provider agreement. If the Contracted Provider agreement does not specify a time frame, the Contracted Provider shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima Health or a Health Network shall make timely and reasonable payment for the following Covered Services provided to a Member by a Non-Contracted Provider:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the Member's health, as provided in CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. Emergency Services do not require Prior Authorization. If it is determined that the Member is to be admitted and CalOptima Health or a Health Network does not have a notification of

an inpatient admission from the emergency department on file for the room and board charges, CalOptima Health or a Health Network must pay the emergency triage fee and request Medical Records;

3. Urgently needed services;

4. Authorized post-stabilization care services;

5. Renal dialysis services when the Member is temporarily out-of-area and cannot reasonably access a Contracted Provider for such Covered Services;

6. Denied Covered Services that are determined in the Appeal processes in CalOptima Health policies to be services the Member was entitled to have furnished, or paid for, by CalOptima Health or a Health Network; and

7. CalOptima Health or a Health Network shall provide Medically Necessary, Covered Services to a Member through an Non-Contracted Provider when CalOptima Health or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Health Policy EE.1141: CalOptima Provider Contracts.

D. CalOptima Health or a Health Network shall pay, or deny, a claim as follows:

1. Contracted Providers

   a. CalOptima Health or a Health Network shall pay, or deny, a claim from a Contracted Provider, or portion thereof, in accordance with the time frames, terms, and conditions of the Provider agreement.

2. Non-Contracted Providers

   a. CalOptima Health or a Health Network shall pay, or deny, ninety-five percent (95%) of all Clean Claims from Non-Contracted Providers within thirty (30) calendar days after the date of receipt.

   b. CalOptima Health or a Health Network shall pay, or deny, all other claims from Non-Contracted Providers within sixty (60) calendar days after the date of receipt.

   c. If CalOptima Health or a Health Network fails to pay a Clean Claim from a Non-Contracted Provider within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

   d. CalOptima Health or a Health Network shall reimburse a Non-Contracted Provider at the Medicare Fee Schedule for Medicare Part B professional services.

   e. CalOptima Health or a Health Network shall administer the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) for Part B professional services provided by non- contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima Health or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by CMS in the MIPS adjustment data

files.

i. CalOptima Health or a Health Network shall apply positive MIPS payment adjustments, within thirty (30) calendar days of receipt of a Clean Claim regardless of the dates of service.

E. If CalOptima Health or a Health Network denies payment of a Clean Claim, CalOptima Health or a Health Network shall notify the Member with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima Health or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

a. The specific reasons for the payment denial;

b. Inform the Member of his or her right to request an Appeal;

c. Describe the Appeals process, time frames, and other elements; and

d. Inform the Member of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program but is covered by and payable under a Member's Medi-Cal coverage, CalOptima Health or a Health Network shall not send the Member a Notice of Denial of Payment.

F. The CalOptima Health Claims Administration Department or a Health Network shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

G. CalOptima Health or a Health Network shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

H. CalOptima Health or a Health Network shall reopen a claim for clerical errors in accordance with this Policy.

I. Provider Dispute Resolution (PDR) and Appeal

1. A Contracted provider may dispute or Appeal a claim determination in accordance with CalOptima Health Policy MA.9006: Contracted Provider Complaint Process.

2. A Non-Contracted Provider may dispute or Appeal a claim determination in accordance with CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process.

3. Providers may file a Medical Necessity Appeal in accordance with CalOptima Health Policy MA.9015: Standard Integrated Appeals.

III. PROCEDURE

A. If CalOptima Health or a Health Network receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) business days after the date of receipt, as applicable.

B. Invalid/Incomplete Claims

1. If CalOptima Health or a Health Network receives an Invalid or Incomplete Claim, it shall notify the Provider no later than ten (10) business days after the date of receipt, in writing, with a request for the missing or invalid information.

2. If CalOptima Health or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima Health's notice, or a Health Network notice, CalOptima Health or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima Health or a Health Network denies an Invalid/Incomplete Claim, the Provider shall have no rights to Appeal such denial.

C. Non-Clean Claims

1. If CalOptima Health or a Health Network receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima Health or a Health Network shall notify a Provider of a Non-Clean Claim no later than thirty (30) business days after the date of receipt, in writing, with a request for the missing information. If CalOptima Health or a Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, CalOptima Health or a Health Network shall provide a written explanation of the necessity for such request.

3. Contracted/Non-Contracted Providers:

a. If CalOptima Health or a Health Network does not receive the requested information within forty- five (45) calendar days after it receives the claim, CalOptima Health or a Health Network shall send a second (2nd) letter to the Contracted/Non-Contracted Provider requesting such information.

b. If CalOptima Health or a Health Network does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima Health or a Health Network shall review the claim with the information available and shall make a determination to pay or deny the claim.

4. CalOptima Health or a Health Network shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima Health or a Health Network denies a claim based on a Provider's failure to provide requested Medical Records or other information, it shall process any dispute arising from the denial of such claim as a PDR or Appeal, in accordance with Section II.I. of this Policy.

6. If CalOptima Health or a Health Network denies a claim based on a Provider's failure to file the

claim within the time frames set forth in Section II.B. of this Policy, upon the Provider's submission of a PDR or an Appeal in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima Health or a Health Network shall have the right to accept and adjudicate the claim.

7. CalOptima Health or a Health Network may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima Health or a Health Network may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. CalOptima Health or a Health Network Reopening of Claims

1. CalOptima Health or a Health Network shall reopen a claim for clerical errors including minor errors or omissions such as human or mechanical errors on the part of CalOptima Health or a Health Network, such as:

   a. Mathematical or computational mistakes;

   b. Transposed procedure or diagnostic codes;

   c. Inaccurate data entry;

   d. Misapplication of a fee schedule;

   e. Computer errors;

   f. Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; or

   g. Incorrect data items, such as provider number, use of a modifier or date of service.

2. The following does not constitute grounds for Reopening of a claim:

   a. Failing to bill for certain items or services;

   b. Untimely filing; or

   c. Redetermination requests.

3. CalOptima Health or a Health Network, a Provider, or any other party to the determination decision may request CalOptima Health or a Health Network reopen a claim as follows:

   a. The request may be made verbally or in writing.

   b. CalOptima Health or a Health Network shall complete the claim determination within sixty (60) calendar days from the date of receipt of the party's written or verbal request to reopen.

   c. If the reopening action results in a revised claim determination or decision that results in payment to a Provider, CalOptima Health or a Health Network shall issue a revised electronic or paper remittance advice notice.

   d. If the reopening action results in an adverse revised claim determination or decision,

CalOptima Health or a Health Network shall provide a written notice to the Provider that states the basis for the adverse determination and provide the applicable rights according to Section II. I. of this policy.

4. When reviewing a request to reopen a claim, CalOptima Health or a Health Network can consider new and material evidence if it meets the following:

   a. Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination;

   b. Does not include evidence that was, or reasonably could have been, available to the decision-maker at the time the decision was made; and

   c. May result in a conclusion different from that reached in the initial claim determination or redetermination.

5. CalOptima Health or a Health Network may reopen a claim within one (1) to four (4) years from the date of the initial claim determination, as applicable.

6. The reopening of a claim is separate and distinct from the Appeals process as provided in CalOptima Health Policies MA.9005: Payment Appeal, MA.9009: Non-Contracted Provider Complaint Process, and MA.9015: Standard Integrated Appeals.

7. The decision of CalOptima Health or a Health Network to reopen a claim determination constitutes a new Organization Determination and CalOptima or the Health Network must issue an Organization Determination to the provider with instructions on how to Appeal or dispute, consistent with the regulations under 42 CFR, Subpart M.

8. Revised claim determinations resulting from a reopening action will be subject to Appeal.

E. Denial to Reopen a Claim

1. CalOptima Health or a Health Network has the discretion to determine the criteria and corrections necessary to reopen a claim. CalOptima Health or a Health Network shall notify the requesting party in writing of the decision not to reopen.

F. Notifications Related to Determinations that are Reopened and Changed

1. CalOptima Health or a Health Network shall ensure the following for written notifications:

   a. Are delivered to the last known address when the determination or decision is reopened and revised;

   b. State the rational and basis for the reopening and revision;

   c. State the specific reason for the revision or change in rationale, written in a manner that is understandable; and

   d. Provide information on any additional rights as provided in Section II. I of this policy.

G. Record Maintenance

1. CalOptima Health or a Health Networks shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a Clean Claim, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima Health or a Health Networks took such action, in the same manner that the Provider submitted the claim.

2. CalOptima Health or a Health Networks shall maintain all Member Medical Records and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare DSNP Coverage Decision Letter Integrated (CMS-10716)
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Policy CMC.3103: Claims Coordination of Benefits
E. CalOptima Health Policy CMC.9005: Payment Appeal
F. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
G. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
H. CalOptima Health Policy MA.3103: Coordination of Benefits
I. CalOptima Health Policy MA.9005: Payment Appeal
J. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
K. CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process
L. CalOptima Health Policy MA.9015 Standard Integrated Appeals
M. Centers for Medicare and Medicaid Services (CMS): Release of 2020 MIPS Payment Adjustment Data File
N. Centers for Medicare and Medicaid (CMS): Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments - Update
O. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
P. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
Q. Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revision of Claim Determinations and Decisions
R. Patient Protection and Affordable Care Act, §6404
S. Title 31, United States Code (U.S.C.), §3902(a)
T. Title 42, Code of Federal Regulations (C.F.R.), §§405.927, 405.980(a)(3), 410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
05/05/2022	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
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Revised	01/01/2022	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	05/05/2022	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2023	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	TBD	MA.3101	Claims Processing	OneCare OneCare Connect PACE

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Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.
Medical Record	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.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Organization Determination	Any determination made by CalOptima Health, or its delegated entity with respect the following: 1. Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, which the Member believes should be furnished or arranged by CalOptima Health; 4. Reduction or premature discontinuation, of a previously authorized ongoing course of treatment; or 5. Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.

Term	Definition
Prior Authorization	OneCare & OneCare Connect: A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a Participant to receive a specific service or procedure.
Provider	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. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, or other person or institution who furnishes Covered Services.

1

Coverage Decision Letter

<**Date of Letter**>

[*Insert Member name*]
<Beneficiary's street address>
<Beneficiary's city, state, zip>

Claim number:

<Member Health Plan ID>: *[Insert Member CIN]*

Service/item this letter is about:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan is called "our plan" or "we" in this letter. We are a health plan that contracts with Medicare and Medi-Cal (Medicaid) to provide coverage for both programs. Our plan coordinates your Medicare and Medi-Cal (Medicaid) services and your doctors, hospitals, pharmacies, and other health care providers.

Our plan denied the service *or* **item listed below:**

> [*Insert description of service or item being denied, partially denied, reduced, stopped, or suspended, and include doctor or provider's name if a particular doctor or provider requested the service or item.*]

Our plan made this decision because [*Provide a specific denial reason and a concise explanation of why the service/item was denied and include state or federal law and/or Evidence of Coverage provisions to support the decision. Write rationale in plain language – see instructions for more information*].

You have the right to appeal our decision

You can appeal our plan's decision. Share this letter with your doctor or health care provider and ask about next steps. If you appeal and our plan changes its decision, we may pay for the service *or* item.

You can also call 1-877-412-2734 (TTY: 711) and ask us for a free copy of the information we used to make our decision. This may include health records, guidelines, and other documents. You should show this information to your doctor or health care provider to help you decide if you should appeal.

You must appeal by *60 calendar days from date of letter.* Our plan may give you more time if you have a good reason.

There are two kinds of appeals

Our plan has two kinds of appeals – standard appeals and fast appeals.

1. If you ask for a **standard appeal**, our plan will send you a written decision within **30 calendar days** *or a shorter timeframe if required by the state* **after we get your appeal**.

2. If you ask for a **fast appeal**, our plan will give you a decision within **72 hours** *or a shorter timeframe if required by the state* **after we get your appeal**. You can ask for a fast appeal if you or your doctor believe your health could be **seriously harmed** by waiting up to **30 calendar days** *or a shorter timeframe if required by the state* for a decision. **Note:** You can't get a fast appeal if our plan denied payment for a service you already got.

   Our plan will **automatically** give you a fast appeal if your **doctor** or **health care provider asks for one for you** or if your **doctor supports your request**. If you ask for a fast appeal without support from a doctor, our plan will decide if you can get a fast appeal. If our plan doesn't approve a fast appeal, we'll give you a decision on your appeal within **30 calendar days** *or a shorter timeframe if required by the state*.

For both standard and fast appeals, our decision might take longer if you ask for more time or if we need more information from you. Our plan will send you a letter and tell you if we need more time and why.

How to appeal

You, someone you have named in writing as your representative to act on your behalf (such as a relative, friend, or lawyer), or your doctor or health care provider can appeal. You can contact our plan to appeal in one of these ways:

- **Phone:** Call 1-877-412-2734 (TTY: 711)
- **Fax:** Send a fax to 1-714-481-6499
- **Mail:** Mail it to
  Attn: Grievance and Appeals Resolution Services
  CalOptima Health
  505 City Parkway West
  Orange CA 92868
- **In person:** Deliver it to 505 City Parkway West, Orange, CA 92868

If you appeal in writing, keep a copy. If you call, we'll send you a letter that says what you told us on the phone.

When you appeal, you must give our plan:

- Your name
- Your address or an address where we should send information about your appeal (if you don't have a current address, you can still appeal)
- Your member number with our plan
- The reason(s) you're appealing our decision
- If you want a standard or a fast appeal. (For a fast appeal, tell us why you need one.)
- Anything you want our plan to look at that shows why you need the service *or* item. For example, you can send us:
    - Medical records from your doctor or health care provider,
    - Letters from your doctor or health care provider (such as a statement from your doctor that says why you need a fast appeal), or
    - Other information that says why you need the service *or* item

To get more information on how to appeal, call Customer Service at 1-877-412-2734 (TTY: 711). You can also find more information in our plan's *Evidence of Coverage*. An up-to-date copy of the *Evidence of Coverage* is always available on our website at www.caloptimahealth.org/onecare or by calling our plan.

How to keep getting your service or item during your appeal

If you're already getting the service *or* item listed on the first page of this letter, you can ask to keep getting it during your appeal.

- **You must appeal and ask our plan to continue getting your service** *or* **item by** *<Date of Letter>:(1) 10 calendar days from date of letter (or later than 10 calendar days, if required by the state)*
- See the "How to appeal" section earlier in this letter for information about how to contact our plan.
- If you ask our plan to continue your service or item by*<10 days from Date of Letter>*, your service or item will stay the same during your appeal.
- If your doctor or health care provider is filing the appeal for you and you want to keep getting your service or item, then your doctor must include your written consent.

What happens next

After you appeal, our plan will send you an appeal decision letter to tell you if we approve or deny your appeal. If our plan still denies payment for the service *or* item listed on the first page of this Coverage Decision Letter, the appeal decision letter will tell you what happens next, such as information about a Medicare Level 2 appeal or how to ask California for a Fair Hearing.

What to do if you need help with your appeal

You can get someone to appeal for you and act on your behalf. You must first name them in writing as your "representative" by following the steps below. Your representative can be a relative, friend, lawyer, doctor, health care provider, or someone else you trust.

If you want someone to appeal for you:

- Call our plan at 1-877-412-2734 (TTY: 711) to learn how to name that person as your representative. Or, you can visit www.caloptimahealth.org/onecare.
- You and your representative must sign and date a statement that says this is what you want.
- Mail or fax the signed statement to us at:

  OneCare
  505 City Parkway West
  Orange CA 92868

  Fax: 1-714-481-6499

  Keep a copy.

Get help and more information

- OneCare **Customer Service:** Call 1-877-412-2734 (TTY: 711), <24 hours a day, 7 days a week. You can also visit www.caloptimahealth.org/onecare.
- **Medi-Cal Managed Care Office of the Ombudsman**: Call 1-888-452-8609 (TTY: 1-800-735-2929). Medi-Cal Managed Care Office of the Ombudsman can answer questions if you have a problem with your appeal. They can also help you understand what to do next. They aren't connected with our plan or with any insurance company or health plan. Their services are free.
- **Health Insurance Counseling and Advocacy Program (HICAP):** Call 1-714-560-0424 (TTY: 1-800-735-2929). HICAP counselors can help you with Medicare issues, including how to appeal. HICAP isn't connected with any insurance company or health plan. Their services are free.
- **Medicare:** Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users can call 1-877-486-2048). Or, visit Medicare.gov.

- **Medi-Cal Department of Health Care Services:** Call (800) 541-5555) (TTY: (866) 784-2595).
- **Medicare Rights Center:** Call 1-800-333-4114, or visit www.medicarerights.org.
- **Eldercare Locator**: Call 1-800-677-1116, or visit www.eldercare.acl.gov to find help in your community.
- **Office on Aging, OC Community Services**: 1-800-510-2020

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-877-412-2734 and TTY 711, 24 hours a day, 7 days a week. The call is free.

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan is a Medicare Advantage organization with a Medicare contract. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Contact OneCare Customer Service toll-free at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week.

English
ATTENTION: If you need help in your language call **1-877-412-2734** (TTY **711**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-877-412-2734** (TTY **711**). These services are free of charge.

الشعار بالعربية (Arabic)
. تتوفر أيضًا
يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل ب **1-877-412-2734**
المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير اتصل ب
1-877-412-2734 (TTY **711**). .هذه الخدمات مجانية

Հայերեն պիտակ (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1-877-412-2734** (TTY **711**): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1-877-412-2734** (TTY **711**): Այդ ծառայություններն անվճար են:

ប្តោសម្គាល់ជាភាសាខ្មែរ (Cambodian)
ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ **1-877-412-2734** (TTY **711**) ។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **1-877-412-2734** (TTY **711**) ។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 **1-877-412-2734** (TTY **711**)。 另外还提供针对残疾人士的帮助和服膜，例如文盲和需要较大字体阅读，也是方便取用的。 请致电 **1-877-412-2734** (TTY **711**)。 这些服膜都是免费的。

مطلب به زبان فارسی (Farsi)
توجه: اگر م یخواهید به زبان خود کمک دریافت کنید، با **1-877-412-2734** (TTY **711**)
تماس بگیرید.کم کها و خدمات
مخصوص افراد دارای معلولیت، مانند نسخه های خط بریل و چاپ با حروف بزرگ، نیز موجود است. ب

تماس بگیرید. این خدمات رایگان ارائه می شوند.
1-877-412-2734 (TTY **711**)

हिंदी टैगलाइनी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **1-877-412-2734** (TTY **711**) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं।: **1-877-412-2734** (TTY **711**) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1-877-412-2734** (TTY **711**). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1-877-412-2734** (TTY **711**). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での対応が必要な場合は **1-877-412-2734** (TTY **711**) へお電話ください。点字の資料や文字の拡大表示など、 障がいをお持ちの方のためのサービスも用意しています。**1-877-412-2734** (TTY **711**) へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1-877-412-2734** (TTY **711**) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **1-877-412-2734** (TTY **711**) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ **1-877-412-2734** (TTY **711**). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ **1-877-412-2734** (TTY **711**). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux: **1-877-412-2734** (TTY **711**). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx **1-877-412-2734** (TTY **711**). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **1-877-412-2734** (TTY **711**). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ **1-877-412-2734** (TTY **711**) ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский (Russian)
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1-877-412-2734** (линия 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1-877-412-2734** (телетайп 711). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al **1-877-412-2734** (TTY **711**). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1-877-412-2734** (TTY **711**). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-877-412-2734** (TTY **711**). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1-877-412-2734** (TTY **711**). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1-877-412-2734** (TTY **711**) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1-877-412-2734** (TTY **711**) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1-877-412-2734** (TTY **711**). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер **1-877-412-2734** (TTY **711**). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1-877-412-2734** (TTY **711**). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **1-877-412-2734** (TTY **711**). Các dịch vụ này đều miễn phí.

Enclosures:

- Notice of Nondiscrimination Insert [H5433_22MM006_C
- Multi-Language Insert IR23_MM002_H5433_H7501

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed toward the end under "Get help & more information." You can also see Chapter 9 of the *Member Handbook* for information about how to make an appeal.

Notice of Denial of Payment

Date:

Member number:

Claim number:

Name: <Beneficiary's full name>
<Beneficiary's street address>
<Beneficiary's city, state, zip>

Your request was denied

We've denied, the payment of medical services/items *or* Part B drug *or* Medicaid drug listed below requested by you or your doctor *or* provider

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Why did we deny your request?

We denied, the payment of medical services/items listed above because:

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask OneCare Connect to review our decision by asking us for a Level 1 Appeal (sometimes called an "internal appeal" or "plan appeal").

Level 1 Appeal with OneCare Connect: Ask OneCare Connect for a Level 1 Appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for a Level 1 Appeal with OneCare Connect" for information on how to ask for a plan level appeal.

> **How to keep your services while we review your case:** If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed. **If you want the service to continue, you must ask for an appeal within 10 calendar days** of the date of this notice or before the service is stopped or reduced, whichever is later.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: **<1-855-705-8823>** to learn how to name your representative. TTY users call **<711>**. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days**, after we get your appeal. Our decision might take longer if you ask for an extension or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a medical service/item *or* Part B drug *or* Medicaid drug you've already received, we'll give you a written decision within **60 calendar days**.

We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within **30 calendar days**.

How to ask for a Level 1 Appeal with OneCare Connect

Step 1: You, your representative, or your provider must ask for an appeal within **60 calendar days** of getting this notice.

Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing

We recommend keeping a copy of everything you send us for your records.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal or call us.

For a Standard Appeal: Mailing Address:
OneCare Connect
Attention: Grievance and Appeals Resolution Services
<505 City Parkway West
Orange, CA 92868>

Phone: <1-855-705-8823> TTY Users Call: <711>
Fax: <1-714-246-8562>

If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter confirming what you told us. The letter will tell you how to make any corrections.

What happens next?

If you ask for a Level 1 Appeal and we continue to deny your request for payment of a service, we'll send you a written decision.

If the service was originally a Medicare service or a service covered by both Medicare and Medi-Cal, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

If the service was a Medi-Cal service, you can ask for a State Hearing. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

How to ask for a State Hearing

If the service was a Medi-Cal covered service or item, you can ask for a State Hearing. You can only ask for a State Hearing after you have appealed to our health plan and received a written decision with which you disagree.

Step 1: You or your representative must ask for a State Hearing within **120 days** of the date of our notice to you that the adverse benefit determination (Level 1 appeal decision) has been upheld. Fill out the "Form to File a State Hearing" that is included with this notice. Make sure you include all of the requested information.

Step 2: Send your completed form to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
FAX: 916-651-5210 or 916-651-2789

You can also request a State Hearing by calling 1-800-952-5253 (TTY: 1-800-952-8349). If you decide to make a request by phone, you should be aware that the phone lines are very busy.

What happens next?

The State will hold a hearing. You may attend the hearing in person or by phone. You'll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision that will explain if you have additional appeal rights.

Get help & more information

- Call **OneCare Connect** at **<1-855-705-8823>**, 24 hours a day, 7 days a week. TTY users call <711>. You can also visit our website at www.caloptima.org/onecareconnect.
- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. They can talk with you about how to make an appeal and what to expect during the appeal process. The phone number is 1-855-501-3077.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Call the **Medicare Rights Center** at 1-800-333-4114.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- You can also see **Chapter 9 of the *Member Handbook*** for information about how to make an appeal.

OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **<1-855-705-8823>** (TTY **711**), 24 hours a day, 7 days a week. This call is free.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **<1-855-705-8823>** (TTY **711**), las 24 horas al día, los 7 días de la semana. Esta llamada es gratuita.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **<1-855-705-8823>** (TTY **711**). 一周7天, 一天24小時。 此通電話免費。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **<1-855-705-8823>** (TTY **711**), 24 giờ một ngày, 7 ngày một tuần. Cuộc gọi này hoàn toàn miễn phí.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **<1-855-705-8823>** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo. Libre ang tawag na ito.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 주 7 일, 하루 24 시간 운영되는 **<1-855-705-8823>** (TTY **711**) 번으로 전화해 주십시오. 통화는 무료입니다.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **<1-855-705-8823>** (TTY (հեռատիպ)՝ **711**):

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. لطفاً طی 24 ساعت شبانه روز و 7 روز هفته باشماره **<1-855-705-8823>** (TTY **711**) تماس بگیرید. این تماس رایگان است.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **<1-855-705-8823>** (линия TTY **711**), 24 часа, 7 дней в неделю. Звонок бесплатный.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**<1-855-705-8823>** (TTY **711**)まで、お電話にてご連絡ください。24 時間年中無休のフリーダイヤルです。

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل على الرقم **<1-855-705-8823>** وعلى (TTY **711**)، على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع. هذه المكالمة مجانية

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ **<1-855-705-8823>** (TTY **711**) 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਕਾਲ ਮੁਫਤ ਹੈ।

Cambodian: សំខាន់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺមានសម្រាប់អ្នក។ ទូរស័ព្ទទៅលេខ **<1-855-705-8823>** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ ការហៅទូរស័ព្ទនេះគឺឥតគិតថ្លៃ។

Hmong: LUS QHIA: Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau **<1-855-705-8823>** (TTY **711**) 24 teev tuaj ib hnub, 7 hnub tuaj ib lub lim tiam. Hu tau tus xovtooj no dawb xwb.

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। दिन के 24 घंटे, सप्ताह के सातों दिन, **<1-855-705-8823>** (TTY **711**) पर कॉल करें। यह कॉल मुफ्त है।

Thai: โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรฟรี **<1-855-705-8823>** (TTY **711**) ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์.

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣຟຣີ **<1-855-705-8823>** (TTY **711**), ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ມື້ຕໍ່ອາທິດ.

You can get this document for free in other formats, such as large print, braille, or audio. Call **<1-855-705-8823>**, 24 hours a day, 7 days a week. TTY users call 711. The call is free.

(Enclosure: Full Notice of Non-Discrimination Insert: <H8016_22MM014>)

Confidential

CalOptima Health
A Public Agency
13300 Garden Grove Blvd.
Garden Grove, CA 92843
☎ 714-468-1100
TTY: 714-468-1063
caloptimahealth.org

<Date>
<Participant's Name or Representative>
<C/o Participant's Name>
<Address>

RE: Notice of Action (NOA) for Service or Payment Request

Dear Mr./Ms. <Name>:

Your request of <insert date> for <insert brief description of requested service or payment for service> has been: ☐**Denied** ☐**Deferred** ☐**Modified** for the reason(s) indicated below:

- ☐ Is not medically necessary by the Interdisciplinary Team (IDT)
- ☐ Requested services will not improve or contribute to sustaining your health
- ☐ An alternative service is provided to meet your care needs
- ☐ Did not meet authorization criteria
- ☐ Is not a benefit of the PACE Program
- ☐ Requires additional information or consult
- ☐ Requested service has potentially negative health and safety issues
- ☐ Other (please describe):_____

This decision was based on the following criteria or clinical guidelines:
_____
_____

If you do not agree with the action above, you have the right to appeal the decision. Please see the attached *"Information for Participants about the Appeals Process"* for your right to request further action. You may call your social worker or our <PACE Quality Improvement Department> at <**1-714-468-1100**> who will explain these processes to you. For the hearing impaired (TTY), please call <**1-714-468-1063**>.

Sincerely,

<Director or IDT Member>, <Professional Discipline>

Enclosures:

- Notice of Non-Discrimination Insert

cc: <Name and Address of Treating Provider>

INFORMATION FOR PARTICIPANTS ABOUT THE APPEALS PROCESS

All of us at CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) share responsibility for your care and your satisfaction with the services you receive. Our appeals process is designed to enable you and/or your representative the opportunity to respond to a decision made by the Interdisciplinary Team regarding your request for a service or payment of a service. At any time, you wish to file an appeal, we are available to assist you. If you do not speak English, a bilingual staff member or translation services will be available to assist you.

You will not be discriminated against because an appeal has been filed. CalOptima Health PACE will continue to provide you with all the required services during the appeals process. The confidentiality of your appeal will be maintained at all times throughout and after the appeals process and information pertaining to your appeal will only be released to authorized individuals.

When CalOptima Health PACE decides not to cover or pay for a service you want, you may take action to change our decision. The action you take — whether verbally or in writing — is called an "**appeal**." You have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information on the appeals process at enrollment (see your Member Enrollment Agreement Terms and Conditions) and annually after that. You will also receive this information and necessary appeals forms whenever CalOptima Health PACE denies, defers or modifies a request for a service or request for payment.

Definitions:
An **appeal** is defined as a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service, including denials, reductions or termination of services.

A **representative** is the person who is acting on your behalf or assisting you, and may include, but is not limited to, a family member, a friend, a PACE employee or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited. Both of these processes are described below.

If you request a **standard appeal**, your appeal must be filed within one-hundred-and eighty (180) calendar days of when your request for service or payment of service was denied, deferred or modified. This is the date which appears on the Notice of Action for Service or Payment Request. (The 180-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. If the treating physician asks for an expedited appeal for you, or supports you in asking for one, we

Back to Item

Back to Agenda

will automatically make a decision on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after we receive your request for an appeal. We may extend this time frame up to fourteen (14) days if you ask for the extension or if we justify to the Department of Health Care Services the need for more information and how the delay benefits you.

If you ask for an **expedited appeal** without support from a treating doctor, we will decide if your health condition requires us to make a decision on an expedited basis. If we decide to deny you an **expedited appeal**, we will let you know within seventy two (72) hours. If this happens, your appeal will be considered a standard appeal.

Note: For CalOptima Health PACE participants enrolled in Medi-Cal — CalOptima Health PACE will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If our initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If you or your representative has requested a service or payment for a service and CalOptima Health PACE denies, defers or modifies the request, you may appeal the decision. A written "*Notice of Action of Service or Payment Request*" (NOA) will be provided to you and/or your representative which will explain the reason for the denial, deferral or modification of your service request or request for payment.

2. You can make your appeal either verbally (in person or by phone) or in writing; ask any of the PACE Program staff of the center you attend to help you start the process. CalOptima Health PACE will make sure that you are provided with written information on the appeals process, and that your appeal is documented on the appropriate form. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review. To submit relevant facts and/or evidence in writing, please send to the address listed below. Otherwise you or your representative may submit this information in person. If more information is needed, you will be contacted by the Quality Improvement Department who will assist you in obtaining the missing information.

3. If you wish to make your appeal by phone, you may contact our Quality Improvement Department at **1-714-468-1100** or toll-free at **1-855-785-2584** to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired, please call TTY at **1-714-468-1082**.

4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

   Attn: Quality Improvement Department
   CalOptima Health PACE
   13300 Garden Grove Blvd
   Garden Grove CA 92843

Back to Item

Back to Agenda

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) working days for a **standard** appeal. For and **expedited** appeal, we will notify you or your representative within one (1) business day by phone or in person that the request for an expedited appeal has been received.

6. The reconsideration of CalOptima Health PACE decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team. We will insure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.

7. Upon CalOptima Health PACE completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, CalOptima Health PACE will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below.

Due Process Requirements:

Constitutional due process means your benefits may not be reduced or terminated without timely and adequate notice. Adequate notice must explain the reasons for the proposed action and allow a participant a chance for a hearing. CalOptima Health PACE participants with a visual impairment or other disabilities require the delivery of written materials in alternative formats. The Department of Health Care Services determined that notice in your selected alternative format or notice that is in compliance with the ADA, Section 504 of the Rehabilitation Act of 1973 and Government Code Section 11135 is considered adequate notice. CalOptima Health PACE may not deny, reduce, suspend or terminate services or treatments without offering adequate notice within proper legal timeframes. CalOptima Health PACE must assess the benefit deadline for participants who need the delivery of written materials in alternative formats, to take action from the adequate notice date, including all deadlines for appeals and aid paid pending.

CalOptima Health PACE participants must exhaust the internal appeal process and get notice that an adverse benefit determination has been upheld, before going on to a state hearing. However, if CalOptima Health PACE fails to offer adequate notice to a participant with a visual impairment or other disability who needs the delivery of written materials in an alternative format, within the related federal or state timeframes, the CalOptima Health PACE participant is deemed to have exhausted the CalOptima Health PACE internal appeal process and may request a state hearing. CalOptima Health PACE is prohibited from requesting dismissal of a state hearing based on failure to exhaust the CalOptima Health PACE internal appeal process in such cases.

The Decision on Your Appeal:

If we decide fully in your favor on a **standard appeal** for a request for **service**, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we received your request for an appeal. **If we decide in your favor** on a request for ***payment***, we are required to

make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

If we do not decide fully in your favor on a **standard appeal** or if we fail to provide you with a decision within thirty (30) calendar days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see **Additional Appeal Rights,** below). We also are required to notify you as soon as we make a decision and also to notify the federal Center for Medicare and Medicaid Services and the Department of Health Care Services. We will inform you in writing of your **external** appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which external program to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

If we decide fully in your favor on an **expedited appeal** we are required to get the service or give you the service as quickly as your health condition requires, but no later than seventy-two (72) hours after we received your request for an appeal.

If we do not decide in your favor on an **expedited appeal** or fail to notify you within seventy-two (72) hours, you have the right to pursue an external appeal process under either Medicare or Medicaid (**see Additional Appeal Rights** below). We are required to notify you as soon as we make a decision and also to notify the Center for Medicare and Medicaid Services and the Department of Health Care Services. We let you know in writing of your **external appeal** rights under the Medicare or Medi-Cal program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

Additional Appeal Rights Under Medi-Cal and Medicare

If we do not decide in your favor on your appeal or fail to provide you a decision within the required timeframe, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program.

The **Medicare program** contracts with an “Independent Review Organization” to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The **Medi-Cal program** conducts their next level of appeal through the State hearing process. If you are enrolled in Medi-Cal, you can appeal if CalOptima Health PACE wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service(s). However, you may have to pay for the service(s) if the decision is not in your favor.

If you are enrolled in **both Medicare and Medi-Cal OR Medi-Cal only,** we will help you choose which external appeal process you should follow. We also will send your appeal on to the appropriate external program for review.

If you are not sure which program you are enrolled in, ask us. The Medicare and Medi-Cal external appeal options are described below.

Back to Item

Back to Agenda

Medi-Cal External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a State hearing through:

California Department of Social Services
State Hearings Division
PO Box 944243 Mail Station 21-37
Sacramento CA 94244-2430

Phone: (800) 743-8525
Facsimile: (833) 281-0905.
TTY: 1-800-952-8349

If you choose to request a State hearing, you must ask for it within ninety (90) days from the date of receiving the *Notice of Action (NOA) for Service or Payment Request* from CalOptima Health PACE.

You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend or an attorney. You may also be able to get free legal help. Attached is a list of Legal Services offices in Orange County if you would like legal services assistance.

If the Administrative Law Judge's (ALJ) decision is in your favor of your appeal, CalOptima Health PACE will follow the judge's instruction as to the timeframe for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ's decision is **not** in your favor of your appeal, for either a standard or an expedited appeal, there are further levels of appeals, and we will assist you in pursuing your appeal.

Medicare External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medicare only,** and choose to appeal our decision using Medicare's external appeals process, we will send your appeal file to the current contracted Medicare appeals entity to impartially review the appeal. The contracted Medicare appeals entity will contact us with the results of their review. The contracted Medicare appeals entity will either maintain our original decision or change our decision and rule in your favor. The current Medicare appeals entity is:

Maximus Federal Services
Medicare Managed Care & PACE
Reconsideration Project
3750 Monroe Avenue Suite 702
Pittsford NY 14524-1302

Phone: 1-585-348-3300

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Back to Item

Back to Agenda

Policy:	MA.3101
Title:	**Claims Processing**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2005
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima Health or a Health Network in accordance with applicable statutory~~,~~ and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima Health or a Health Network shall reimburse a claim for Covered Services rendered to a Member in accordance with the standard allowances set by CalOptima Health Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a ~~contracted~~Contracted Provider.

B. A Provider shall submit a claim for Covered Services ~~rendered on, or after, January 1, 2010,~~ as follows:

1. A Non-Contracted Provider shall submit a claim for Covered Services rendered to a Member within one (1) calendar year after the date of service.

2. A ~~contracted~~Contracted Provider shall submit a claim for Covered Services rendered to a Member within the time frame specified in the ~~contracted~~Contracted Provider agreement. If the ~~contracted~~Contracted Provider agreement does not specify a time frame, the ~~contracted~~Contracted Provider shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima Health or a Health Network shall make timely and reasonable payment for the following Covered Services provided to a Member by a Non-Contracted Provider:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the Member's health, as provided in CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. Emergency Services~~ - Emergency medical services~~ do not require Prior Authorization. If it is determined that the Member is to be admitted and CalOptima Health or a Health Network does not have a notification of an inpatient admission from the ~~ER~~emergency department on file for the room and board charges, CalOptima Health or a Health Network must pay the emergency triage fee and request Medical Records;

3. Urgently needed services;

4. Authorized post-stabilization care services;

5. Renal dialysis services when the Member is temporarily out-of-area and cannot reasonably access a ~~contracted~~Contracted Provider for such Covered Services;

6. Denied Covered Services that are determined in the Appeal processes in CalOptima Health policies to be services the Member was entitled to have furnished, or paid for, by CalOptima Health or a Health Network; and

7. CalOptima Health or a Health Network shall provide Medically Necessary, Covered Services to a Member through an ~~out-of-network~~Non-Contracted Provider when CalOptima Health or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Health Policy EE.1141: CalOptima Provider Contracts.

D. CalOptima Health or a Health Network shall pay, or deny, a claim as follows:

1. Contracted Providers

   a. CalOptima Health or a Health Network shall pay, or deny, a claim from a ~~contracted~~Contracted Provider, or portion thereof, in accordance with the time frames, terms, and conditions of the Provider ~~Agreement~~agreement.

2. Non-Contracted Providers

   a. CalOptima Health or a Health Network shall pay, or deny, ninety-five percent (95%) of all Clean Claims from Non-Contracted Providers within thirty (30) calendar days after the date of receipt.

   b. CalOptima Health or a Health Network shall pay, or deny, all other claims from Non-Contracted Providers within sixty (60) calendar days after the date of receipt.

   c. If CalOptima Health or a Health Network fails to pay a Clean Claim from a Non-Contracted Provider within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

   d. CalOptima Health or a Health Network shall reimburse a Non-Contracted Provider at the Medicare Fee Schedule for Medicare Part B professional services.

   e. ~~For Dates of Service effective beginning January 1, 2019,~~ CalOptima Health or a Health Network shall administer the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) for Part B professional services provided by non-

contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima Health or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by CMS in the MIPS adjustment data files.

i. CalOptima Health or a Health Network shall apply positive MIPS payment adjustments, within thirty (30) calendar days of receipt of a ~~clean claim~~Clean Claim regardless of the dates of service.

E. If CalOptima Health or a Health Network denies payment of a Clean Claim, CalOptima Health or a Health Network shall notify the Member with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima Health or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

   a. The specific reasons for the payment denial;

   b. Inform the Member of his or her right to request an Appeal;

   c. Describe the Appeals process, time frames, and other elements; and

   d. Inform the Member of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program~~,~~ but is covered by and payable under a Member's Medi-Cal coverage, CalOptima Health or a Health Network shall not send the Member a Notice of Denial of Payment.

F. The CalOptima Health Claims Administration Department or a Health Network shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

G. CalOptima Health or a Health Network shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

H. CalOptima Health or a Health Network shall reopen a claim for clerical errors in accordance with this Policy.

I. Provider Dispute Resolution (PDR) and Appeal ~~and Grievance~~

1. A ~~Provider may~~Contracted provider may dispute or Appeal a claim determination in accordance with CalOptima Health ~~Policies MA.9005: Payment Appeal and CMC.9005: Payment Appeal~~Policy MA.9006: Contracted Provider Complaint Process.

2. ~~In case of a Payment Dispute Resolutions (PDR), the CalOptima Health Claim Administration Department or Health Network shall inform the~~A Non-Contracted Provider ~~in the notice of PDR decision of his right to~~may dispute or Appeal a claim determination in accordance with CalOptima Health Policy MA.9009: Non-Contracted

Provider Complaint Process.

~~2.~~3. Providers may file a ~~complaint with CalOptima Health,~~Medical Necessity Appeal in accordance with CalOptima Health Policy MA.~~9006: Provider Complaint Process~~9015: Standard Integrated Appeals.

~~3. The CalOptima Health Claims Administration Department and Health Network staff shall accept, track, report all NCP PDRs as determined by CalOptima Health's Audit & Oversight Department.~~

~~4. Non-Contracted Providers may file a PDR within one hundred and eighty (180) calendar days from the receipt of the Remittance Advice (RA) for level of payment disputes (The notice of initial determination is presumed to be received five (5) calendar days from the date of the RA unless there is evidence to the contrary.).~~

~~5. The Claims Administration Department or the Health Network shall issue a PDR notice to the NCP within thirty (30) calendar days of the receipt of the request.~~

~~6. The CalOptima Health Grievance and Appeals Resolution Service and Claims Administration Departments and Health Networks shall document all actions taken related to the PDR, or Appeal, request in its tracking system and/or hard copy including, but not limited to:~~

~~a. Provider's name;~~

~~b. Date received;~~

~~c. Name of staff that received the complaint at CalOptima Health;~~

~~d. Designated contact person;~~

~~e. Description of the complaint;~~

~~f. Date;~~

~~g. Dispositions; and~~

~~h. Appeal Review.~~

III. PROCEDURE

A. If CalOptima Health or a Health Network receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) business days after the date of receipt, as applicable.

B. Invalid/Incomplete Claims

1. If CalOptima Health or a Health Network receives an Invalid or Incomplete Claim, it shall notify the Provider no later than ten (10) business days after the date of receipt, in writing, with a request for the missing or invalid information.

2. If CalOptima Health or a Health Network does not receive the requested information within forty-

five (45) calendar days after the date of CalOptima Health's notice, or a Health Network notice, CalOptima Health or a Health Network shall review the claim with
~~(45) calendar days after the date of CalOptima Health's notice, CalOptima Health's or a Health Network notice, CalOptima Health or a Health Network shall review the claim with~~
the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima Health or a Health Network denies an Invalid/Incomplete Claim, the Provider shall have no rights to Appeal such denial.

C. Non-Clean Claims

1. If CalOptima Health or a Health Network receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima Health or a Health Network shall notify a Provider of a Non-Clean Claim no later than thirty (30) business days after the date of receipt, in writing, with a request for the missing information. If CalOptima Health or a Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, CalOptima Health or a Health Network shall provide a written explanation of the necessity for such request.

3. Contracted/Non-Contracted Providers:

   a. If CalOptima Health or a Health Network does not receive the requested information within forty- five (45) calendar days after it receives the claim, CalOptima Health or a Health Network shall send a second (2nd) letter to the ~~contracted~~Contracted/Non-Contracted Provider requesting such information.

   b. If CalOptima Health or a Health Network does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima Health or a Health Network shall review the claim with the information available and shall make a determination to pay or deny the claim.

4. CalOptima Health or a Health Network shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima Health or a Health Network denies a claim based on a Provider's failure to provide requested Medical Records or other information, it shall process any dispute arising from the denial of such claim as a ~~Provider Grievance~~PDR or Appeal, in accordance with Section II.I. of this Policy.

6. If CalOptima Health or a Health Network denies a claim based on a Provider's failure to file the claim within the time frames set forth in Section II.B. of this Policy, upon the Provider's submission of a ~~Grievance~~PDR or an Appeal in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima Health or a Health Network shall have the right to accept and adjudicate the claim.

7. CalOptima Health or a Health Network may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima Health or a Health Network may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. CalOptima Health or a Health Network Reopening of Claims

1. CalOptima Health or a Health Network shall reopen a claim for clerical errors including minor errors or omissions such as human or mechanical errors on the part of CalOptima Health or a Health Network, such as:

   a. Mathematical or computational mistakes;

   b. Transposed procedure or diagnostic codes;

   c. Inaccurate data entry;

   d. Misapplication of a fee schedule;

   e. Computer errors;

   f. Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; or

   g. Incorrect data items, such as provider number, use of a modifier or date of service.

2. The following does not constitute grounds for Reopening of a claim:

   a. Failing to bill for certain items or services;

   b. Untimely filing; or

   c. Redetermination requests.

3. CalOptima Health or a Health Network, a Provider, or any other party to the determination decision may request CalOptima Health or a Health Network reopen a claim as follows:

   a. The request may be made verbally or in writing.

   b. CalOptima Health or a Health Network shall complete the claim determination within sixty (60) calendar days from the date of receipt of the party's written or verbal request to reopen.

   c. If the reopening action results in a revised claim determination or decision that results in payment to a Provider, CalOptima Health or a Health Network shall issue a revised electronic or paper remittance advice notice.

   d. If the reopening action results in an adverse revised claim determination or decision, CalOptima Health or a Health Network shall provide a written notice to the Provider that states the basis for the adverse determination and provide ~~Appeal rights.~~the applicable rights according to Section II. I. of this policy.

4. When reviewing a request to reopen a claim, CalOptima Health or a Health Network can consider new and material evidence if it meets the following:

   a. Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination;

b. Does not include evidence that was, or reasonably could have been, available to the decision-maker at the time the decision was made; and

c. May result in a conclusion different from that reached in the initial claim determination or redetermination.

5. CalOptima Health or a Health Network may reopen a claim within one (1) to four (4) years from the date of the initial claim determination, as applicable.

6. The reopening of a claim is separate and distinct from the Appeals process as provided in CalOptima Health Policies MA.9005: Payment Appeal ~~and CMC.9005: Payment Appeal,~~ MA.9009: Non-Contracted Provider Complaint Process, and MA.9015: Standard Integrated Appeals.

7. The decision of CalOptima Health or a Health Network to reopen a claim determination ~~is not an initial claim determination~~constitutes a new Organization Determination and ~~is therefore not subject~~CalOptima or the Health Network must issue an Organization Determination to the provider with instructions on how to Appeal or dispute, consistent with the regulations under 42 CFR, Subpart M.

8. Revised claim determinations resulting from a reopening action will be subject to Appeal.

E. Denial to Reopen a Claim

1. CalOptima Health or a Health Network has the discretion to determine the criteria and corrections necessary to reopen a claim. CalOptima Health or a Health Network shall notify the requesting party in writing of the decision not to reopen.

F. Notifications Related to Determinations that are Reopened and Changed

1. CalOptima Health or a Health Network shall ensure the following for written notifications:

a. Are delivered to the last known address when the determination or decision is reopened and revised;

b. State the rational and basis for the reopening and revision;

c. State the specific reason for the revision or change in rationale, written in a manner that is understandable; and

d. Provide information on any ~~appeal rights.~~additional rights as provided in Section II. I of this policy.

G. Record Maintenance

1. CalOptima Health or a Health Networks shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a Clean Claim, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima Health or a Health Networks took such action, in the same manner that the Provider submitted the claim.

2. CalOptima Health or a Health Networks shall maintain all Member Medical Records and claim information data for a period of at least ten (10) years from the latest CMS contracting

period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare ~~-~~DSNP Coverage Decision Letter Integrated ~~-~~(CMS-10716~~); OMB Approval 0938-1386(Expires: 11/30/2023))~~
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Policy CMC.3103: Claims Coordination of Benefits
E. CalOptima Health Policy CMC.9005: Payment Appeal
F. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
G. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
H. CalOptima Health Policy MA.3103: Coordination of Benefits
I. CalOptima Health Policy MA.9005: Payment Appeal
J. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
K. CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process
L. CalOptima Health Policy MA.9015 Standard Integrated Appeals
~~K.~~M. Centers for Medicare and Medicaid Services (CMS): Release of 2020 MIPS Payment Adjustment Data File
~~L.~~N. Centers for Medicare and Medicaid (CMS): Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments - Update
~~M.~~O. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
~~N.~~P. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
~~O.~~Q. Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revision of Claim Determinations and Decisions
~~P.~~R. Patient Protection and Affordable Care Act, §6404
~~Q.~~S. Title 31, United States Code (U.S.C.), §3902(a)
~~R.~~T. ~~S.~~ Title 42, Code of Federal Regulations (C.F.R.), §§405.927, 405.980(a)(3), 410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
05/05/2022	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	12/03/2020	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2022	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	05/05/2022	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2023	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	TBD	MA.3101	Claims Processing	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Appeal	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima Health -on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination-, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. ~~OneCare Connect: Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima Health and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.~~ OneCare Connect: In general, a Member's actions, both internal and external to CalOptima Health requesting review of CalOptima Health's denial, reduction or termination of benefits or services, from CalOptima Health. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals and 42 CFR sections 422.629 through 422.634, 438.210, 438.400, and 438.402. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima Health of an Adverse Benefit Determination. PACE: A Participant's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Term	Definition
Contracted & Contracting Provider	OneCare/OneCare Connect: A Provider who is obligated by a written contract to provide Covered Services to Members on behalf of CalOptima Health, or its contracted Health Networks. PACE: A Physician, Nurse, technician, teacher, researcher, hospital, home health agency, nursing home or any other individual or institution that contracts with CalOptima PACE to provide medical services to CalOptima PACE's plan Members.
Covered Services	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 Health 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) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.
Emergency Care	Covered Services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima Health PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive ~~prior authorization~~Prior Authorization for emergency care.
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Grievance	~~OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.~~ ~~OneCare Connect:~~ Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima Health's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication thru the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.
~~Non-Clean Claim~~	~~A claim for covered services that lacks required documentation such as medical records or authorization numbers.~~
~~Non-Contracted Provider~~	~~A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.~~
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.
Medical Record	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.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.

Term	Definition
Organization Determination	Any determination made by CalOptima Health, or its delegated entity with respect the following: 1. Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, which the Member believes should be furnished or arranged by CalOptima Health; 4. Reduction or premature discontinuation, of a previously authorized ongoing course of treatment; or 5. Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.
Prior Authorization	OneCare & OneCare Connect: A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a Participant to receive a specific service or procedure.
Provider	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. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, or other person or institution who furnishes Covered Services.

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Title:	**Claims Processing**
Department:	Claims Administration
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CEO Approval:	*/s/*
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Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy ensures the timely and accurate processing and adjudication of claims by CalOptima Health or a Health Network in accordance with applicable statutory and regulatory requirements, and the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima Health or a Health Network shall reimburse a claim for Covered Services rendered to a Member in accordance with the standard allowances set by CalOptima Health Medi-Cal Fee Schedule, Medicare Fee Schedules, or contractual rates with a Contracted Provider.

B. A Provider shall submit a claim for Covered Services as follows:

1. A Non-Contracted Provider shall submit a claim for Covered Services rendered to a Member within one (1) calendar year after the date of service.

2. A Contracted Provider shall submit a claim for Covered Services rendered to a Member within the time frame specified in the Contracted Provider agreement. If the Contracted Provider agreement does not specify a time frame, the Contracted Provider shall submit a claim within one (1) calendar year after the date of service.

C. CalOptima Health or a Health Network shall make timely and reasonable payment for the following Covered Services provided to a Member by a Non-Contracted Provider:

1. Ambulance services dispatched through 911 or its local equivalent, where other means of transportation may endanger the Member's health, as provided in CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical; and in accordance with Title 42 of the Code of Federal Regulations, Section 410.40;

2. Emergency Services do not require Prior Authorization. If it is determined that the Member is to be admitted and CalOptima Health or a Health Network does not have a notification of

an inpatient admission from the emergency department on file for the room and board charges, CalOptima Health or a Health Network must pay the emergency triage fee and request Medical Records;

3. Urgently needed services;

4. Authorized post-stabilization care services;

5. Renal dialysis services when the Member is temporarily out-of-area and cannot reasonably access a Contracted Provider for such Covered Services;

6. Denied Covered Services that are determined in the Appeal processes in CalOptima Health policies to be services the Member was entitled to have furnished, or paid for, by CalOptima Health or a Health Network; and

7. CalOptima Health or a Health Network shall provide Medically Necessary, Covered Services to a Member through an Non-Contracted Provider when CalOptima Health or a Health Network is unable to provide the services in the contracted network in accordance with CalOptima Health Policy EE.1141: CalOptima Provider Contracts.

D. CalOptima Health or a Health Network shall pay, or deny, a claim as follows:

1. Contracted Providers

a. CalOptima Health or a Health Network shall pay, or deny, a claim from a Contracted Provider, or portion thereof, in accordance with the time frames, terms, and conditions of the Provider agreement.

2. Non-Contracted Providers

a. CalOptima Health or a Health Network shall pay, or deny, ninety-five percent (95%) of all Clean Claims from Non-Contracted Providers within thirty (30) calendar days after the date of receipt.

b. CalOptima Health or a Health Network shall pay, or deny, all other claims from Non-Contracted Providers within sixty (60) calendar days after the date of receipt.

c. If CalOptima Health or a Health Network fails to pay a Clean Claim from a Non-Contracted Provider within thirty (30) calendar days after the date of receipt, it shall pay interest at the rate used for purposes of Title 31 of the United States Code, Section 3902(a), for the period beginning on the thirty-first (31st) day after receipt and ending on the date on which CalOptima or a Health Network makes payment.

d. CalOptima Health or a Health Network shall reimburse a Non-Contracted Provider at the Medicare Fee Schedule for Medicare Part B professional services.

e. CalOptima Health or a Health Network shall administer the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) for Part B professional services provided by non- contracted, MIPS-eligible providers in the same manner as any other changes in the applicable Medicare payment schedules. CalOptima Health or a Health Network shall make positive and negative payment adjustments to Medicare Part B professional services as identified by CMS in the MIPS adjustment data

files.

i. CalOptima Health or a Health Network shall apply positive MIPS payment adjustments, within thirty (30) calendar days of receipt of a Clean Claim regardless of the dates of service.

E. If CalOptima Health or a Health Network denies payment of a Clean Claim, CalOptima Health or a Health Network shall notify the Member with the Notice of Denial of Payment.

1. The Notice of Denial of Payment shall clearly state the service denied and the denial reason within time frames set forth in the provisions of this Policy. CalOptima Health or a Health Network shall provide the following information on the Denial of Payment form in a clear, accurate, and understandable format:

a. The specific reasons for the payment denial;

b. Inform the Member of his or her right to request an Appeal;

c. Describe the Appeals process, time frames, and other elements; and

d. Inform the Member of his or her right to submit additional evidence in writing, or in person.

2. If a service is not covered under the Medicare program but is covered by and payable under a Member's Medi-Cal coverage, CalOptima Health or a Health Network shall not send the Member a Notice of Denial of Payment.

F. The CalOptima Health Claims Administration Department or a Health Network shall utilize paid, denied, and pended claims reports to monitor the accuracy and timeliness of claims processing and payment.

G. CalOptima Health or a Health Network shall identify payers that are primary to Medicare, shall determine the amounts payable by them, and shall coordinate benefits in accordance with CalOptima Policies MA.3103: Claims Coordination of Benefits and CMC.3103: Claims Coordination of Benefits.

H. CalOptima Health or a Health Network shall reopen a claim for clerical errors in accordance with this Policy.

I. Provider Dispute Resolution (PDR) and Appeal

1. A Contracted provider may dispute or Appeal a claim determination in accordance with CalOptima Health Policy MA.9006: Contracted Provider Complaint Process.

2. A Non-Contracted Provider may dispute or Appeal a claim determination in accordance with CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process.

3. Providers may file a Medical Necessity Appeal in accordance with CalOptima Health Policy MA.9015: Standard Integrated Appeals.

III. PROCEDURE

A. If CalOptima Health or a Health Network receives a claim for which it is not financially responsible, it shall forward the claim to the responsible party within ten (10) business days after the date of receipt, as applicable.

B. Invalid/Incomplete Claims

1. If CalOptima Health or a Health Network receives an Invalid or Incomplete Claim, it shall notify the Provider no later than ten (10) business days after the date of receipt, in writing, with a request for the missing or invalid information.

2. If CalOptima Health or a Health Network does not receive the requested information within forty-five (45) calendar days after the date of CalOptima Health's notice, or a Health Network notice, CalOptima Health or a Health Network shall review the claim with the information available and shall make an initial determination to pay, or deny, the claim.

3. If CalOptima Health or a Health Network denies an Invalid/Incomplete Claim, the Provider shall have no rights to Appeal such denial.

C. Non-Clean Claims

1. If CalOptima Health or a Health Network receives a claim that lacks required information, it shall change the claim status to "pended."

2. CalOptima Health or a Health Network shall notify a Provider of a Non-Clean Claim no later than thirty (30) business days after the date of receipt, in writing, with a request for the missing information. If CalOptima Health or a Health Network requests reasonably relevant information from a Provider in addition to information that the Provider submits with a claim, CalOptima Health or a Health Network shall provide a written explanation of the necessity for such request.

3. Contracted/Non-Contracted Providers:

a. If CalOptima Health or a Health Network does not receive the requested information within forty- five (45) calendar days after it receives the claim, CalOptima Health or a Health Network shall send a second (2nd) letter to the Contracted/Non-Contracted Provider requesting such information.

b. If CalOptima Health or a Health Network does not receive the requested information within fifty-five (55) calendar days after it receives the claim, CalOptima Health or a Health Network shall review the claim with the information available and shall make a determination to pay or deny the claim.

4. CalOptima Health or a Health Network shall reprocess the pended claim upon receipt of the requested information in accordance with the time frames set forth in this Policy.

5. If CalOptima Health or a Health Network denies a claim based on a Provider's failure to provide requested Medical Records or other information, it shall process any dispute arising from the denial of such claim as a PDR or Appeal, in accordance with Section II.I. of this Policy.

6. If CalOptima Health or a Health Network denies a claim based on a Provider's failure to file the

claim within the time frames set forth in Section II.B. of this Policy, upon the Provider's submission of a PDR or an Appeal in accordance with Section II.I. of this Policy and the demonstration of good cause for the delay, CalOptima Health or a Health Network shall have the right to accept and adjudicate the claim.

7. CalOptima Health or a Health Network may review a claim for National Correct Coding Initiative (NCCI) edits and may deny a claim based on improper coding and/or improper billing of professional and/or facility claims. CalOptima Health or a Health Network may contract with a third-party vendor to review claims for NCCI edits, or improper billing practices.

D. CalOptima Health or a Health Network Reopening of Claims

1. CalOptima Health or a Health Network shall reopen a claim for clerical errors including minor errors or omissions such as human or mechanical errors on the part of CalOptima Health or a Health Network, such as:

   a. Mathematical or computational mistakes;

   b. Transposed procedure or diagnostic codes;

   c. Inaccurate data entry;

   d. Misapplication of a fee schedule;

   e. Computer errors;

   f. Denial of claims as duplicates which the provider believes were incorrectly identified as a duplicate; or

   g. Incorrect data items, such as provider number, use of a modifier or date of service.

2. The following does not constitute grounds for Reopening of a claim:

   a. Failing to bill for certain items or services;

   b. Untimely filing; or

   c. Redetermination requests.

3. CalOptima Health or a Health Network, a Provider, or any other party to the determination decision may request CalOptima Health or a Health Network reopen a claim as follows:

   a. The request may be made verbally or in writing.

   b. CalOptima Health or a Health Network shall complete the claim determination within sixty (60) calendar days from the date of receipt of the party's written or verbal request to reopen.

   c. If the reopening action results in a revised claim determination or decision that results in payment to a Provider, CalOptima Health or a Health Network shall issue a revised electronic or paper remittance advice notice.

   d. If the reopening action results in an adverse revised claim determination or decision,

CalOptima Health or a Health Network shall provide a written notice to the Provider that states the basis for the adverse determination and provide the applicable rights according to Section II. I. of this policy.

4. When reviewing a request to reopen a claim, CalOptima Health or a Health Network can consider new and material evidence if it meets the following:

   a. Was not readily available or known to the person or entity requesting/initiating the reopening at the time of the initial determination;

   b. Does not include evidence that was, or reasonably could have been, available to the decision-maker at the time the decision was made; and

   c. May result in a conclusion different from that reached in the initial claim determination or redetermination.

5. CalOptima Health or a Health Network may reopen a claim within one (1) to four (4) years from the date of the initial claim determination, as applicable.

6. The reopening of a claim is separate and distinct from the Appeals process as provided in CalOptima Health Policies MA.9005: Payment Appeal, MA.9009: Non-Contracted Provider Complaint Process, and MA.9015: Standard Integrated Appeals.

7. The decision of CalOptima Health or a Health Network to reopen a claim determination constitutes a new Organization Determination and CalOptima or the Health Network must issue an Organization Determination to the provider with instructions on how to Appeal or dispute, consistent with the regulations under 42 CFR, Subpart M.

8. Revised claim determinations resulting from a reopening action will be subject to Appeal.

E. Denial to Reopen a Claim

1. CalOptima Health or a Health Network has the discretion to determine the criteria and corrections necessary to reopen a claim. CalOptima Health or a Health Network shall notify the requesting party in writing of the decision not to reopen.

F. Notifications Related to Determinations that are Reopened and Changed

1. CalOptima Health or a Health Network shall ensure the following for written notifications:

   a. Are delivered to the last known address when the determination or decision is reopened and revised;

   b. State the rational and basis for the reopening and revision;

   c. State the specific reason for the revision or change in rationale, written in a manner that is understandable; and

   d. Provide information on any additional rights as provided in Section II. I of this policy.

G. Record Maintenance

1. CalOptima Health or a Health Networks shall maintain a claims retrieval system that identifies and acknowledges the date of receipt, whether or not a claim is a Clean Claim, the action taken on the claim (i.e., paid, denied, pended) and the date CalOptima Health or a Health Networks took such action, in the same manner that the Provider submitted the claim.

2. CalOptima Health or a Health Networks shall maintain all Member Medical Records and claim information data for a period of at least ten (10) years from the latest CMS contracting period, or audit, whichever is later, and shall not remove, or transfer, such records, or data, from its offices except in accordance with applicable laws.

IV. ATTACHMENT(S)

A. OneCare DSNP Coverage Decision Letter Integrated (CMS-10716)
B. OneCare Connect Notice of Denial of Payment
C. PACE Notice of Action (NOA) for Service or Payment Request

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Policy CMC.3103: Claims Coordination of Benefits
E. CalOptima Health Policy CMC.9005: Payment Appeal
F. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
G. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
H. CalOptima Health Policy MA.3103: Coordination of Benefits
I. CalOptima Health Policy MA.9005: Payment Appeal
J. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
K. CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process
L. CalOptima Health Policy MA.9015 Standard Integrated Appeals
M. Centers for Medicare and Medicaid Services (CMS): Release of 2020 MIPS Payment Adjustment Data File
N. Centers for Medicare and Medicaid (CMS): Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments - Update
O. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections
P. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
Q. Medicare Managed Care Claims Processing Manual Chapter 34: Reopening and Revision of Claim Determinations and Decisions
R. Patient Protection and Affordable Care Act, §6404
S. Title 31, United States Code (U.S.C.), §3902(a)
T. Title 42, Code of Federal Regulations (C.F.R.), §§405.927, 405.980(a)(3), 410.40, 422.113, 422.132, 422.214, 422.504(g), 422.520(a)(2), 422.568, 414.1300 et seq., and 414.1400 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
05/05/2022	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2005	MA.3101	Claims Processing	OneCare
Revised	07/01/2007	MA.3101	Claims Processing	OneCare
Revised	07/01/2009	MA.3101	Claims Processing	OneCare
Revised	07/01/2010	MA.3101	Claims Processing	OneCare
Revised	12/01/2014	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2017	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	10/03/2019	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	12/03/2020	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	01/01/2022	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	05/05/2022	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	04/01/2023	MA.3101	Claims Processing	OneCare OneCare Connect PACE
Revised	TBD	MA.3101	Claims Processing	OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Appeal	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima Health on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima Health requesting review of CalOptima Health's denial, reduction or termination of benefits or services, from CalOptima Health. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals and 42 CFR sections 422.629 through 422.634, 438.210, 438.400, and 438.402. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima Health of an Adverse Benefit Determination. PACE: A Participant's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Clean Claim	A claim for covered services that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.
Contracted & Contracting Provider	OneCare/OneCare Connect: A Provider who is obligated by a written contract to provide Covered Services to Members on behalf of CalOptima Health, or its contracted Health Networks. PACE: A Physician, Nurse, technician, teacher, researcher, hospital, home health agency, nursing home or any other individual or institution that contracts with CalOptima PACE to provide medical services to CalOptima PACE's plan Members.

Term	Definition
Covered Services	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 Health 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) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.
Emergency Care	Covered Services provided to a Participant immediately, because of an injury or sudden illness and the time required to reach a CalOptima Health PACE facility or a network provider would cause risk of permanent damage to the Participant's health. This includes inpatient and outpatient services. Participants are not required to receive Prior Authorization for emergency care.
Emergency Services	Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Grievance	Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima Health's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Invalid/Incomplete Claim	Claims lacking minimum data needed for adjudication thru the core operating system. This includes any claim that: 1. Is incomplete or is missing required information; or 2. Contains complete and necessary information, however, the information provided is invalid.

Term	Definition
Medicare Fee Schedule	A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis. CMS develops fee schedules for physicians, ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.
Medical Record	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.
Merit-based Incentive Payment System (MIPS)	The program required by Section 101(b) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which consolidated certain aspects of three current incentive programs – the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, the Physician Quality Reporting System (PQRS), and the Value-based Payment Modifier – into the MIPS program which applies performance-based positive, neutral, or negative adjustments to Medicare Fee Schedule payments to MIPS-eligible clinicians for Medicare Part B professional services.
Non-Clean Claim	A claim for covered services that lacks required documentation such as medical records or authorization numbers.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Organization Determination	Any determination made by CalOptima Health, or its delegated entity with respect the following: 1. Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a Provider that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. Refusal to authorize, provide or pay for services, in whole or in part, including the type or level of services, which the Member believes should be furnished or arranged by CalOptima Health; 4. Reduction or premature discontinuation, of a previously authorized ongoing course of treatment; or 5. Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the health of the Member.

Term	Definition
Prior Authorization	OneCare & OneCare Connect: A process through which a physician or other health care provider is required to obtain advance approval from the plan that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a Participant to receive a specific service or procedure.
Provider	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. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, or other person or institution who furnishes Covered Services.

1

Coverage Decision Letter

<**Date of Letter**>

[*Insert Member name*]
<Beneficiary's street address>
<Beneficiary's city, state, zip>

Claim number:

<Member Health Plan ID>: *[Insert Member CIN]*

Service/item this letter is about:

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan is called "our plan" or "we" in this letter. We are a health plan that contracts with Medicare and Medi-Cal (Medicaid) to provide coverage for both programs. Our plan coordinates your Medicare and Medi-Cal (Medicaid) services and your doctors, hospitals, pharmacies, and other health care providers.

Our plan denied the service *or* **item listed below:**

> [*Insert description of service or item being denied, partially denied, reduced, stopped, or suspended, and include doctor or provider's name if a particular doctor or provider requested the service or item.*]

Our plan made this decision because [*Provide a specific denial reason and a concise explanation of why the service/item was denied and include state or federal law and/or Evidence of Coverage provisions to support the decision. Write rationale in plain language – see instructions for more information*].

You have the right to appeal our decision

You can appeal our plan's decision. Share this letter with your doctor or health care provider and ask about next steps. If you appeal and our plan changes its decision, we may pay for the service *or* item.

You can also call 1-877-412-2734 (TTY: 711) and ask us for a free copy of the information we used to make our decision. This may include health records, guidelines, and other documents. You should show this information to your doctor or health care provider to help you decide if you should appeal.

You must appeal by *60 calendar days from date of letter.* Our plan may give you more time if you have a good reason.

There are two kinds of appeals

Our plan has two kinds of appeals – standard appeals and fast appeals.

1. If you ask for a **standard appeal**, our plan will send you a written decision within **30 calendar days** *or a shorter timeframe if required by the state* **after we get your appeal**.

2. If you ask for a **fast appeal**, our plan will give you a decision within **72 hours** *or a shorter timeframe if required by the state* **after we get your appeal**. You can ask for a fast appeal if you or your doctor believe your health could be **seriously harmed** by waiting up to **30 calendar days** *or a shorter timeframe if required by the state* for a decision. **Note:** You can't get a fast appeal if our plan denied payment for a service you already got.

   Our plan will **automatically** give you a fast appeal if your **doctor** or **health care provider asks for one for you** or if your **doctor supports your request**. If you ask for a fast appeal without support from a doctor, our plan will decide if you can get a fast appeal. If our plan doesn't approve a fast appeal, we'll give you a decision on your appeal within **30 calendar days** *or a shorter timeframe if required by the state*.

For both standard and fast appeals, our decision might take longer if you ask for more time or if we need more information from you. Our plan will send you a letter and tell you if we need more time and why.

How to appeal

You, someone you have named in writing as your representative to act on your behalf (such as a relative, friend, or lawyer), or your doctor or health care provider can appeal. You can contact our plan to appeal in one of these ways:

- **Phone:** Call 1-877-412-2734 (TTY: 711)
- **Fax:** Send a fax to 1-714-481-6499
- **Mail:** Mail it to
  Attn: Grievance and Appeals Resolution Services
  CalOptima Health
  505 City Parkway West
  Orange CA 92868
- **In person:** Deliver it to 505 City Parkway West, Orange, CA 92868

If you appeal in writing, keep a copy. If you call, we'll send you a letter that says what you told us on the phone.

When you appeal, you must give our plan:

- Your name
- Your address or an address where we should send information about your appeal (if you don't have a current address, you can still appeal)
- Your member number with our plan
- The reason(s) you're appealing our decision
- If you want a standard or a fast appeal. (For a fast appeal, tell us why you need one.)
- Anything you want our plan to look at that shows why you need the service *or* item. For example, you can send us:
    - Medical records from your doctor or health care provider,
    - Letters from your doctor or health care provider (such as a statement from your doctor that says why you need a fast appeal), or
    - Other information that says why you need the service *or* item

To get more information on how to appeal, call Customer Service at 1-877-412-2734 (TTY: 711). You can also find more information in our plan's *Evidence of Coverage*. An up-to-date copy of the *Evidence of Coverage* is always available on our website at www.caloptimahealth.org/onecare or by calling our plan.

How to keep getting your service or item during your appeal

If you're already getting the service *or* item listed on the first page of this letter, you can ask to keep getting it during your appeal.

- **You must appeal and ask our plan to continue getting your service** *or* **item by** *<Date of Letter>:(1) 10 calendar days from date of letter (or later than 10 calendar days, if required by the state)*
- See the "How to appeal" section earlier in this letter for information about how to contact our plan.
- If you ask our plan to continue your service or item by*<10 days from Date of Letter>*, your service or item will stay the same during your appeal.
- If your doctor or health care provider is filing the appeal for you and you want to keep getting your service or item, then your doctor must include your written consent.

What happens next

After you appeal, our plan will send you an appeal decision letter to tell you if we approve or deny your appeal. If our plan still denies payment for the service *or* item listed on the first page of this Coverage Decision Letter, the appeal decision letter will tell you what happens next, such as information about a Medicare Level 2 appeal or how to ask California for a Fair Hearing.

What to do if you need help with your appeal

You can get someone to appeal for you and act on your behalf. You must first name them in writing as your "representative" by following the steps below. Your representative can be a relative, friend, lawyer, doctor, health care provider, or someone else you trust.

If you want someone to appeal for you:

- Call our plan at 1-877-412-2734 (TTY: 711) to learn how to name that person as your representative. Or, you can visit www.caloptimahealth.org/onecare.
- You and your representative must sign and date a statement that says this is what you want.
- Mail or fax the signed statement to us at:

  OneCare
  505 City Parkway West
  Orange CA 92868

  Fax: 1-714-481-6499

  Keep a copy.

Get help and more information

- OneCare **Customer Service:** Call 1-877-412-2734 (TTY: 711), <24 hours a day, 7 days a week. You can also visit www.caloptimahealth.org/onecare.
- **Medi-Cal Managed Care Office of the Ombudsman**: Call 1-888-452-8609 (TTY: 1-800-735-2929). Medi-Cal Managed Care Office of the Ombudsman can answer questions if you have a problem with your appeal. They can also help you understand what to do next. They aren't connected with our plan or with any insurance company or health plan. Their services are free.
- **Health Insurance Counseling and Advocacy Program (HICAP):** Call 1-714-560-0424 (TTY: 1-800-735-2929). HICAP counselors can help you with Medicare issues, including how to appeal. HICAP isn't connected with any insurance company or health plan. Their services are free.
- **Medicare:** Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users can call 1-877-486-2048). Or, visit Medicare.gov.

- **Medi-Cal Department of Health Care Services:** Call (800) 541-5555) (TTY: (866) 784-2595).
- **Medicare Rights Center:** Call 1-800-333-4114, or visit www.medicarerights.org.
- **Eldercare Locator**: Call 1-800-677-1116, or visit www.eldercare.acl.gov to find help in your community.
- **Office on Aging, OC Community Services**: 1-800-510-2020

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-877-412-2734 and TTY 711, 24 hours a day, 7 days a week. The call is free.

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan is a Medicare Advantage organization with a Medicare contract. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Contact OneCare Customer Service toll-free at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week.

English
ATTENTION: If you need help in your language call **1-877-412-2734** (TTY **711**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-877-412-2734** (TTY **711**). These services are free of charge.

الشعار بالعربية (Arabic)
. تتوفر أيضًا
يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل ب **1-877-412-2734**
المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير اتصل ب
1-877-412-2734 (TTY **711**). .هذه الخدمات مجانية

Հայերեն պիտակ (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1-877-412-2734** (TTY **711**): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք **1-877-412-2734** (TTY **711**): Այդ ծառայություններն անվճար են:

ប្តោសម្គាល់ជាភាសាខ្មែរ (Cambodian)
ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ **1-877-412-2734** (TTY **711**) ។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **1-877-412-2734** (TTY **711**) ។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 **1-877-412-2734** (TTY **711**)。 另外还提供针对残疾人士的帮助和服膜，例如文盲和需要较大字体阅读，也是方便取用的。 请致电 **1-877-412-2734** (TTY **711**)。 这些服膜都是免费的。

مطلب به زبان فارسی (Farsi)
توجه: اگر م یخواهید به زبان خود کمک دریافت کنید، با **1-877-412-2734** (TTY **711**)
تماس بگیرید.کم کها و خدمات
مخصوص افراد دارای معلولیت، مانند نسخه های خط بریل و چاپ با حروف بزرگ، نیز موجود است. ب

تماس بگیرید. این خدمات رایگان ارائه می شوند.
1-877-412-2734 (TTY **711**)

हिंदी टैगलाइनी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो **1-877-412-2734** (TTY **711**) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं।: **1-877-412-2734** (TTY **711**) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1-877-412-2734** (TTY **711**). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1-877-412-2734** (TTY **711**). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での対応が必要な場合は **1-877-412-2734** (TTY **711**) へお電話ください。点字の資料や文字の拡大表示など、 障がいをお持ちの方のためのサービスも用意しています。**1-877-412-2734** (TTY **711**) へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1-877-412-2734** (TTY **711**) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **1-877-412-2734** (TTY **711**) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ **1-877-412-2734** (TTY **711**). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ **1-877-412-2734** (TTY **711**). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux: **1-877-412-2734** (TTY **711**). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx **1-877-412-2734** (TTY **711**). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ **1-877-412-2734** (TTY **711**). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ **1-877-412-2734** (TTY **711**) ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский (Russian)
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1-877-412-2734** (линия 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1-877-412-2734** (телетайп 711). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al **1-877-412-2734** (TTY **711**). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1-877-412-2734** (TTY **711**). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-877-412-2734** (TTY **711**). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1-877-412-2734** (TTY **711**). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1-877-412-2734** (TTY **711**) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1-877-412-2734** (TTY **711**) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1-877-412-2734** (TTY **711**). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер **1-877-412-2734** (TTY **711**). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1-877-412-2734** (TTY **711**). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **1-877-412-2734** (TTY **711**). Các dịch vụ này đều miễn phí.

Enclosures:

- Notice of Nondiscrimination Insert [H5433_22MM006_C
- Multi-Language Insert IR23_MM002_H5433_H7501

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed toward the end under "Get help & more information." You can also see Chapter 9 of the *Member Handbook* for information about how to make an appeal.

Notice of Denial of Payment

Date:

Member number:

Claim number:

Name: <Beneficiary's full name>
<Beneficiary's street address>
<Beneficiary's city, state, zip>

Your request was denied

We've denied, the payment of medical services/items *or* Part B drug *or* Medicaid drug listed below requested by you or your doctor *or* provider

---

Why did we deny your request?

We denied, the payment of medical services/items listed above because:

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask OneCare Connect to review our decision by asking us for a Level 1 Appeal (sometimes called an "internal appeal" or "plan appeal").

Level 1 Appeal with OneCare Connect: Ask OneCare Connect for a Level 1 Appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for a Level 1 Appeal with OneCare Connect" for information on how to ask for a plan level appeal.

> **How to keep your services while we review your case:** If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed. **If you want the service to continue, you must ask for an appeal within 10 calendar days** of the date of this notice or before the service is stopped or reduced, whichever is later.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: **<1-855-705-8823>** to learn how to name your representative. TTY users call **<711>**. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Standard Appeal – We'll give you a written decision on a standard appeal within **30 calendar days**, after we get your appeal. Our decision might take longer if you ask for an extension or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a medical service/item *or* Part B drug *or* Medicaid drug you've already received, we'll give you a written decision within **60 calendar days**.

We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within **30 calendar days**.

How to ask for a Level 1 Appeal with OneCare Connect

Step 1: You, your representative, or your provider must ask for an appeal within **60 calendar days** of getting this notice.

Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing

We recommend keeping a copy of everything you send us for your records.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

Step 2: Mail, fax, or deliver your appeal or call us.

For a Standard Appeal: Mailing Address:
OneCare Connect
Attention: Grievance and Appeals Resolution Services
<505 City Parkway West
Orange, CA 92868>

Phone: <1-855-705-8823> TTY Users Call: <711>
Fax: <1-714-246-8562>

If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter confirming what you told us. The letter will tell you how to make any corrections.

What happens next?

If you ask for a Level 1 Appeal and we continue to deny your request for payment of a service, we'll send you a written decision.

If the service was originally a Medicare service or a service covered by both Medicare and Medi-Cal, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

If the service was a Medi-Cal service, you can ask for a State Hearing. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

How to ask for a State Hearing

If the service was a Medi-Cal covered service or item, you can ask for a State Hearing. You can only ask for a State Hearing after you have appealed to our health plan and received a written decision with which you disagree.

Step 1: You or your representative must ask for a State Hearing within **120 days** of the date of our notice to you that the adverse benefit determination (Level 1 appeal decision) has been upheld. Fill out the "Form to File a State Hearing" that is included with this notice. Make sure you include all of the requested information.

Step 2: Send your completed form to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
FAX: 916-651-5210 or 916-651-2789

You can also request a State Hearing by calling 1-800-952-5253 (TTY: 1-800-952-8349). If you decide to make a request by phone, you should be aware that the phone lines are very busy.

What happens next?

The State will hold a hearing. You may attend the hearing in person or by phone. You'll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision that will explain if you have additional appeal rights.

Get help & more information

- Call **OneCare Connect** at **<1-855-705-8823>**, 24 hours a day, 7 days a week. TTY users call <711>. You can also visit our website at www.caloptima.org/onecareconnect.
- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. They can talk with you about how to make an appeal and what to expect during the appeal process. The phone number is 1-855-501-3077.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Call the **Medicare Rights Center** at 1-800-333-4114.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- You can also see **Chapter 9 of the *Member Handbook*** for information about how to make an appeal.

OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **<1-855-705-8823>** (TTY **711**), 24 hours a day, 7 days a week. This call is free.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **<1-855-705-8823>** (TTY **711**), las 24 horas al día, los 7 días de la semana. Esta llamada es gratuita.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **<1-855-705-8823>** (TTY **711**). 一周7天, 一天24小時。 此通電話免費。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **<1-855-705-8823>** (TTY **711**), 24 giờ một ngày, 7 ngày một tuần. Cuộc gọi này hoàn toàn miễn phí.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **<1-855-705-8823>** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo. Libre ang tawag na ito.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 주 7 일, 하루 24 시간 운영되는 **<1-855-705-8823>** (TTY **711**) 번으로 전화해 주십시오. 통화는 무료입니다.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **<1-855-705-8823>** (TTY (հեռատիպ)՝ **711**):

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. لطفاً طی 24 ساعت شبانه روز و 7 روز هفته باشماره **<1-855-705-8823>** (TTY **711**) تماس بگیرید. این تماس رایگان است.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **<1-855-705-8823>** (линия TTY **711**), 24 часа, 7 дней в неделю. Звонок бесплатный.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**<1-855-705-8823>** (TTY **711**)まで、お電話にてご連絡ください。24 時間年中無休のフリーダイヤルです。

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل على الرقم **<1-855-705-8823>** وعلى (TTY **711**)، على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع. هذه المكالمة مجانية

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ **<1-855-705-8823>** (TTY **711**) 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਕਾਲ ਮੁਫਤ ਹੈ।

Cambodian: សំខាន់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺមានសម្រាប់អ្នក។ ទូរស័ព្ទទៅលេខ **<1-855-705-8823>** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ ការហៅទូរស័ព្ទនេះគឺឥតគិតថ្លៃ។

Hmong: LUS QHIA: Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau **<1-855-705-8823>** (TTY **711**) 24 teev tuaj ib hnub, 7 hnub tuaj ib lub lim tiam. Hu tau tus xovtooj no dawb xwb.

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। दिन के 24 घंटे, सप्ताह के सातों दिन, **<1-855-705-8823>** (TTY **711**) पर कॉल करें। यह कॉल मुफ्त है।

Thai: โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรฟรี **<1-855-705-8823>** (TTY **711**) ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์.

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣຟຣີ **<1-855-705-8823>** (TTY **711**), ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ມື້ຕໍ່ອາທິດ.

You can get this document for free in other formats, such as large print, braille, or audio. Call **<1-855-705-8823>**, 24 hours a day, 7 days a week. TTY users call 711. The call is free.

(Enclosure: Full Notice of Non-Discrimination Insert: <H8016_22MM014>)

Confidential

CalOptima Health
A Public Agency
13300 Garden Grove Blvd.
Garden Grove, CA 92843
☎ 714-468-1100
TTY: 714-468-1063
caloptimahealth.org

<Date>
<Participant's Name or Representative>
<C/o Participant's Name>
<Address>

RE: Notice of Action (NOA) for Service or Payment Request

Dear Mr./Ms. <Name>:

Your request of <insert date> for <insert brief description of requested service or payment for service> has been: ☐**Denied** ☐**Deferred** ☐**Modified** for the reason(s) indicated below:

- ☐ Is not medically necessary by the Interdisciplinary Team (IDT)
- ☐ Requested services will not improve or contribute to sustaining your health
- ☐ An alternative service is provided to meet your care needs
- ☐ Did not meet authorization criteria
- ☐ Is not a benefit of the PACE Program
- ☐ Requires additional information or consult
- ☐ Requested service has potentially negative health and safety issues
- ☐ Other (please describe):_____

This decision was based on the following criteria or clinical guidelines:
_____
_____

If you do not agree with the action above, you have the right to appeal the decision. Please see the attached *"Information for Participants about the Appeals Process"* for your right to request further action. You may call your social worker or our <PACE Quality Improvement Department> at <**1-714-468-1100**> who will explain these processes to you. For the hearing impaired (TTY), please call <**1-714-468-1063**>.

Sincerely,

<Director or IDT Member>, <Professional Discipline>

Enclosures:

- Notice of Non-Discrimination Insert

cc: <Name and Address of Treating Provider>

INFORMATION FOR PARTICIPANTS ABOUT THE APPEALS PROCESS

All of us at CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) share responsibility for your care and your satisfaction with the services you receive. Our appeals process is designed to enable you and/or your representative the opportunity to respond to a decision made by the Interdisciplinary Team regarding your request for a service or payment of a service. At any time, you wish to file an appeal, we are available to assist you. If you do not speak English, a bilingual staff member or translation services will be available to assist you.

You will not be discriminated against because an appeal has been filed. CalOptima Health PACE will continue to provide you with all the required services during the appeals process. The confidentiality of your appeal will be maintained at all times throughout and after the appeals process and information pertaining to your appeal will only be released to authorized individuals.

When CalOptima Health PACE decides not to cover or pay for a service you want, you may take action to change our decision. The action you take — whether verbally or in writing — is called an "**appeal**." You have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information on the appeals process at enrollment (see your Member Enrollment Agreement Terms and Conditions) and annually after that. You will also receive this information and necessary appeals forms whenever CalOptima Health PACE denies, defers or modifies a request for a service or request for payment.

Definitions:
An **appeal** is defined as a participant's action taken with respect to the PACE organization's noncoverage of, or nonpayment for, a service, including denials, reductions or termination of services.

A **representative** is the person who is acting on your behalf or assisting you, and may include, but is not limited to, a family member, a friend, a PACE employee or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited. Both of these processes are described below.

If you request a **standard appeal**, your appeal must be filed within one-hundred-and eighty (180) calendar days of when your request for service or payment of service was denied, deferred or modified. This is the date which appears on the Notice of Action for Service or Payment Request. (The 180-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. If the treating physician asks for an expedited appeal for you, or supports you in asking for one, we

Back to Item

Back to Agenda

will automatically make a decision on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after we receive your request for an appeal. We may extend this time frame up to fourteen (14) days if you ask for the extension or if we justify to the Department of Health Care Services the need for more information and how the delay benefits you.

If you ask for an **expedited appeal** without support from a treating doctor, we will decide if your health condition requires us to make a decision on an expedited basis. If we decide to deny you an **expedited appeal**, we will let you know within seventy two (72) hours. If this happens, your appeal will be considered a standard appeal.

Note: For CalOptima Health PACE participants enrolled in Medi-Cal — CalOptima Health PACE will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If our initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.

The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal:

1. If you or your representative has requested a service or payment for a service and CalOptima Health PACE denies, defers or modifies the request, you may appeal the decision. A written "*Notice of Action of Service or Payment Request*" (NOA) will be provided to you and/or your representative which will explain the reason for the denial, deferral or modification of your service request or request for payment.

2. You can make your appeal either verbally (in person or by phone) or in writing; ask any of the PACE Program staff of the center you attend to help you start the process. CalOptima Health PACE will make sure that you are provided with written information on the appeals process, and that your appeal is documented on the appropriate form. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review. To submit relevant facts and/or evidence in writing, please send to the address listed below. Otherwise you or your representative may submit this information in person. If more information is needed, you will be contacted by the Quality Improvement Department who will assist you in obtaining the missing information.

3. If you wish to make your appeal by phone, you may contact our Quality Improvement Department at **1-714-468-1100** or toll-free at **1-855-785-2584** to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired, please call TTY at **1-714-468-1082**.

4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

   Attn: Quality Improvement Department
   CalOptima Health PACE
   13300 Garden Grove Blvd
   Garden Grove CA 92843

Back to Item

Back to Agenda

5. You will be sent a written acknowledgement of receipt of your appeal within five (5) working days for a **standard** appeal. For and **expedited** appeal, we will notify you or your representative within one (1) business day by phone or in person that the request for an expedited appeal has been received.

6. The reconsideration of CalOptima Health PACE decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team. We will insure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.

7. Upon CalOptima Health PACE completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, CalOptima Health PACE will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor. Please refer to the information described below.

Due Process Requirements:

Constitutional due process means your benefits may not be reduced or terminated without timely and adequate notice. Adequate notice must explain the reasons for the proposed action and allow a participant a chance for a hearing. CalOptima Health PACE participants with a visual impairment or other disabilities require the delivery of written materials in alternative formats. The Department of Health Care Services determined that notice in your selected alternative format or notice that is in compliance with the ADA, Section 504 of the Rehabilitation Act of 1973 and Government Code Section 11135 is considered adequate notice. CalOptima Health PACE may not deny, reduce, suspend or terminate services or treatments without offering adequate notice within proper legal timeframes. CalOptima Health PACE must assess the benefit deadline for participants who need the delivery of written materials in alternative formats, to take action from the adequate notice date, including all deadlines for appeals and aid paid pending.

CalOptima Health PACE participants must exhaust the internal appeal process and get notice that an adverse benefit determination has been upheld, before going on to a state hearing. However, if CalOptima Health PACE fails to offer adequate notice to a participant with a visual impairment or other disability who needs the delivery of written materials in an alternative format, within the related federal or state timeframes, the CalOptima Health PACE participant is deemed to have exhausted the CalOptima Health PACE internal appeal process and may request a state hearing. CalOptima Health PACE is prohibited from requesting dismissal of a state hearing based on failure to exhaust the CalOptima Health PACE internal appeal process in such cases.

The Decision on Your Appeal:

If we decide fully in your favor on a **standard appeal** for a request for **service**, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we received your request for an appeal. **If we decide in your favor** on a request for ***payment***, we are required to

make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

If we do not decide fully in your favor on a **standard appeal** or if we fail to provide you with a decision within thirty (30) calendar days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program (see **Additional Appeal Rights,** below). We also are required to notify you as soon as we make a decision and also to notify the federal Center for Medicare and Medicaid Services and the Department of Health Care Services. We will inform you in writing of your **external** appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which external program to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

If we decide fully in your favor on an **expedited appeal** we are required to get the service or give you the service as quickly as your health condition requires, but no later than seventy-two (72) hours after we received your request for an appeal.

If we do not decide in your favor on an **expedited appeal** or fail to notify you within seventy-two (72) hours, you have the right to pursue an external appeal process under either Medicare or Medicaid (**see Additional Appeal Rights** below). We are required to notify you as soon as we make a decision and also to notify the Center for Medicare and Medicaid Services and the Department of Health Care Services. We let you know in writing of your **external appeal** rights under the Medicare or Medi-Cal program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

Additional Appeal Rights Under Medi-Cal and Medicare

If we do not decide in your favor on your appeal or fail to provide you a decision within the required timeframe, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program.

The **Medicare program** contracts with an “Independent Review Organization” to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The **Medi-Cal program** conducts their next level of appeal through the State hearing process. If you are enrolled in Medi-Cal, you can appeal if CalOptima Health PACE wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service(s). However, you may have to pay for the service(s) if the decision is not in your favor.

If you are enrolled in **both Medicare and Medi-Cal OR Medi-Cal only,** we will help you choose which external appeal process you should follow. We also will send your appeal on to the appropriate external program for review.

If you are not sure which program you are enrolled in, ask us. The Medicare and Medi-Cal external appeal options are described below.

Back to Item

Back to Agenda

Medi-Cal External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a State hearing through:

California Department of Social Services
State Hearings Division
PO Box 944243 Mail Station 21-37
Sacramento CA 94244-2430

Phone: (800) 743-8525
Facsimile: (833) 281-0905.
TTY: 1-800-952-8349

If you choose to request a State hearing, you must ask for it within ninety (90) days from the date of receiving the *Notice of Action (NOA) for Service or Payment Request* from CalOptima Health PACE.

You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend or an attorney. You may also be able to get free legal help. Attached is a list of Legal Services offices in Orange County if you would like legal services assistance.

If the Administrative Law Judge's (ALJ) decision is in your favor of your appeal, CalOptima Health PACE will follow the judge's instruction as to the timeframe for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ's decision is **not** in your favor of your appeal, for either a standard or an expedited appeal, there are further levels of appeals, and we will assist you in pursuing your appeal.

Medicare External Appeals Process

If you are enrolled in **both Medicare and Medi-Cal OR Medicare only,** and choose to appeal our decision using Medicare's external appeals process, we will send your appeal file to the current contracted Medicare appeals entity to impartially review the appeal. The contracted Medicare appeals entity will contact us with the results of their review. The contracted Medicare appeals entity will either maintain our original decision or change our decision and rule in your favor. The current Medicare appeals entity is:

Maximus Federal Services
Medicare Managed Care & PACE
Reconsideration Project
3750 Monroe Avenue Suite 702
Pittsford NY 14524-1302

Phone: 1-585-348-3300

Facsimile: 1-5

Back to Item

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Adopt Resolution No. 23-1207-03 Declaring CalOptima Health Employee Handbook as a Guideline Document and Adopt Resolution No. 23-1207-04 Approving and Adopting Updated CalOptima Health Human Resources Policies

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405

Recommended Actions

1. Adopt Resolution No. 23-1207-03 Declaring the CalOptima Health Employee Handbook as a guideline document that does not require future Board of Directors (Board) approvals for changes consistent with policies, practices, and procedures approved by the Board.
2. Adopt resolution No. 23-1207-04 approving updated CalOptima Health policies:
    a. AA.1250: Disability Awareness and Sensitivity, Cultural Competency, Diversity, Equity, Inclusion, and Bias Staff Training.
    b. GA.8012: Conflicts of Interest.
    c. GA.8037: Leave of Absence.
    d. GA.8042: Supplemental Compensation.
    e. GA.8057: Compensation Program.

Background

Near CalOptima Health's inception, the Board delegated authority to the Chief Executive Officer to develop, implement, and amend employee policies and procedures, subject to bi-annual updates to the Board, which emphasize changes to these policies and procedures. 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

The Employee Handbook is an employee resource that provides guidance and information related to CalOptima Health's mission, vision, values, employee benefits, employee engagement, and training and development. The Employee Handbook also references key personnel-related policies and expectations of employee conduct. To accurately reflect CalOptima Health's policies, procedures, and expectations, which evolve over time, the Employee Handbook requires regular and timely updates.

Because the Employee Handbook merely highlights policies approved by the Board and does not establish policies, staff recommends that the Employee Handbook, last revised on December 20, 2021, be considered a guideline document going forward that would not require future Board approval to update in alignment with approved policies. By allowing staff to contemporaneously update the Employee Handbook whenever a policy has been approved by the Board, the Handbook will maintain

Back to Agenda

alignment as a reference guide for employees. Human Resources would submit Employee Handbook revisions to outside general counsel for review prior to Chief Executive Officer approval.

In addition, staff included a list of revised policies for Board approval and a summary of changes for the updated policies.

AA.1250: Disability Awareness and Sensitivity, Cultural Competency, Diversity, Equity, Inclusion, and Bias Staff Training: This policy ensures that all CalOptima Health Employees are knowledgeable, informed, and trained on standards for disability competency, cultural awareness, sensitivity, diversity, equity, inclusion, and bias for all CalOptima Health members, in accordance with applicable Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) requirements.

Policy Section	Proposed Change	Rationale	Impact
Throughout	Adds the terms "diversity, equity, inclusion, and bias" to the policy title and to the training topics.	Aligns with the 2024 DHCS Contract readiness and future National Committee for Quality Assurance (NCQA) Health Equity Accreditation requirements.	Expands required staff training to include diversity, equity, inclusion, and bias, both to promote access and delivery of services to members and potential members, and to comply with DHCS and NCQA requirements.
II.D	Adds a statement that CalOptima Health will address the impact of structural and institutional racism and health inequities and communicate pertinent information regarding Population Needs Assessment findings and identified targeted strategies.	Aligns with 2024 DHCS Contract readiness and CalOptima Health Policy EE.1103: Provider Network Training.	Affirms CalOptima Health's commitment to addressing the impact of racism and health inequities experienced by members, staff providers, and subcontractors.

Back to Agenda

GA.8012: Conflicts of Interest: This policy establishes guidelines and standards for CalOptima Health employees to avoid conflicts of interest and incompatible outside activities.

Policy Section	Proposed Change	Rationale	Impact
II.L	Adds language precluding employees performing audit functions from auditing Health Networks and or other contracted entities with which they were previously employed. This preclusion can be waived with the approval of the Executive Director of Network Operations in consultation with the Chief Compliance Officer and the Health Network and or other contracted entity.	Minimizes the risk of potential, suspected, or actual conflicts of interest and avoids any actual or potential conflict between an employee's personal interests and the interest of CalOptima Health.	Minimizes CalOptima Health's risk and appearance of conflicts of interest.

GA.8037: Leaves of Absence: This policy outlines the general rules and restrictions applicable to a leave of absence.

Policy Section	Proposed Change	Rationale	Impact
II.E.16	Adds "Reproductive Loss Leave" to the list of leave types covered under the policy.	Complies with Senate Bill 848, adding new reproductive loss leave requirements effective January 1, 2024.	Guarantees eligible employees up to five (5) days per instance of reproductive loss leave, up to twenty (20) days total per twelve (12) month period. Enables CalOptima Health to comply with Senate Bill 848.
III.D.	Adds "Benefit Income" to the list of supplemental compensation that an employee is not eligible for during a continuous leave of absence.	Clarifies that employees on a continuous leave of absence do not receive Benefit Income during their leave of absence.	Promotes transparency and employee understanding of pay expectations during a continuous leave of absence.

Back to Agenda

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.A.6	Adds "Temporary Upgrade Pay" to the list of special compensation types.	Complies with CalPERS rules regarding payment of employees fulfilling temporary upgrade roles.	Provides clarity that Temporary Upgrade Pay is reported to CalPERS as special compensation based on employee eligibility.
II.V	Adds "Benefit Income" to the list of supplemental compensation provided to employees.	Aligns with the Board-approved practice to provide a bi-monthly taxable medical stipend to employees who have medical coverage outside of CalOptima Health and decline coverage provided through CalOptima Health.	Provides alignment with practice and promotes transparency.
II.W and III.R	Adds "Temporary Upgrade Pay" to the list of supplemental compensation provided to employees.	Complies with CalPERS rules regarding payment of employees fulfilling temporary upgrade roles. Provides clarity on the provisions of Temporary Upgrade Pay in relation to qualification, rate of pay, duration of temporary assignment, and CalPERS designation.	Provides clarity on the process and procedure of administering temporary upgrades.
III.Q.	Adds how long the election to waive medical insurance	Clarifies that changes to the election to waive medical	Promotes transparency and clarifies what

	remains in effect to the "Benefit Income" procedure.	insurance remains in effect until the end of the plan year or unless the employee has a qualifying event.	employees can expect related to receiving "Benefit Income."
III.R.	Adds that Human Resources will calculate the Temporary Upgrade Pay.	Clarifies that Human Resources is responsible for calculating Temporary Upgrade Pay and that only employees who are authorized and appointed will receive it.	Promotes transparency and clarifies what employees can expect related to receiving "Temporary Upgrade Pay."

GA.8057: Compensation Program: This policy establishes CalOptima Health's pay philosophy and a compensation program for CalOptima Health's job classifications within clearly defined guidelines that promote consistent, competitive, equitable, and merit-based pay practices.

Policy Section	**Proposed Change**	**Rationale**	**Impact**
I. and II.A.	Updates CalOptima Health's pay philosophy and pay practices to include attracting, retaining, and motivating employees through market competitive, internally equitable, and merit-based pay practices.	Aligns with current practice and Policy GA.8060 - Recruitment, Selection, and Hiring.	Improves clarity and transparency regarding pay philosophy and pay practices and promotes consistent application of merit-based practices.
II.B.2.	Expands description of qualifications considered when determining pay rates.	Aligns with California Equal Pay Act bona fide factors and current practice.	Provides transparency, promotes consistent application of merit-based pay practices.
Attachment A	Removes and reorganizes sections throughout the document. Replaces certain provisions with succinct language.	Provides clarity on the intent and purpose of the guidelines in the administration of pay practices.	Aligns policy with practice and reduces future policy changes in this area.

Back to Agenda

Attachment A, Page 3, Lines 3-9	Adds section on pay philosophy and pay strategy.	Reiterates the pay philosophy and pay strategy as stated in the policy.	Aligns Attachment A with the policy so that the pay philosophy and pay strategy are known even when referencing Attachment A only.
Attachment A, Page 3, Lines 13-23	Updates to include language that the pay practices are merit-based and do not discriminate. Notes that except where permissible by law, applicant's salary information is not sought or relied upon to determine offer of employment or salary offer.	Aligns with California Equal Pay Act, current practice, and Policy GA.8060 - Recruitment, Selection, and Hiring.	Improves clarity and transparency regarding pay practices and promotes consistent application of merit-based practices.
Attachment A, Page 3, Lines 25-31	Adds section on authority to make compensation changes.	Documents a procedure on obtaining approvals for changes to compensation.	Improves transparency regarding future changes to the compensation program.
Attachment A, Page 9, Lines 9-12	Adds clarity on use of pay grades and pay ranges with supporting example.	Provides explanation on the design and methodology of the Salary Schedule pay grades and ranges.	Improves transparency regarding the application of the Salary Schedule with internal equity.
Attachment A, Page 9, Lines 33-34 Page 10, Lines 2-5	Updates and expands the training position for purposes of compensation and developing talent.	Allows candidates to work in a training position for 12 months instead of six months.	Increases opportunities for incumbents to enter positions by reducing the minimum experience requirements for trainees.
Attachment A, Page 13, Line 7	Clarifies annual merit eligibly.	Documents that employees in temporary assignments are eligible for merit pay.	Aligns Attachment A to practice in regard to annual merit eligibility.
Attachment A, Page 13, Lines 19-21	Adds section to address CalPERS pension ability	Documents that merit lump sum bonuses are not considered	Provides clarity on frequently asked questions from staff

	of merit lump sum bonuses.	regular or special compensation under CalPERS regulations.	regarding the pension treatment of merit lump sum bonuses.
Attachment A, Page 13, Lines 36-38	Adds section on application of merit eligibility for rehired employees.	For rehired employees, service time prior to the rehire date is not included in the merit calculation for that period.	Aligns Attachment A to the practice on merit pay.
Attachment A, Page 13, Lines 40-42	Removes section on manager discretion to determine annual merit increase amount.	Managers review and approve the annual review score. The merit is then calculated the same for all employees based on the score and approved by executive.	Aligns Attachment A to practice on merit pay calculations for consistency and transparency.
Attachment A, Page 14, Lines 21-23	Adds section clarifying the timing of merit pay for employees on an approved leave of absence.	Creates parity between employees on a leave of absence and those who are not for purposes of merit pay timing.	Aligns with practice on annual merit pay administration.
Attachment A, Page 21, Lines 34-44	Adds section on Cost of Living Adjustment.	Documents a procedure to study, recommend and, if approved, implement a Cost of Living Adjustment.	Aligns the market competitive pay philosophy detailed in the policy and current practice.
Attachment A, Page 25, Line 40	Revises criteria for turnover statistics for Market-Sensitive jobs from a lookback of 3 months to 18 months.	Expands turnover lookback period to 18 months, as turnover does not change significantly in the short term.	Aligns Attachment A to practice of calculating turnover when identifying market sensitive positions.
Attachment A, Page 26, Lines 35-45	Adds section on Special One-time Pay Considerations for retention and recruitment incentives.	Aligns with recruitment and retention incentives already included in GA.8042:	Promotes transparency and alignment with GA.8042 Supplemental Compensation.

Back to Agenda

		Supplemental Compensation.	
Attachment A, Page 25, Line 40 Page 27, Line 25 through Page 28, Line 11.	Revises section on how employees are paid upon promotion to include pay grade and pay range of the job, employee's qualifications, job designation as market sensitive, and internal pay equity to a higher-level position from a lookback of 3 months to 18 months.	Documents merit-based criteria and method used to evaluate promotion rate of pay.	Aligns Attachment A with practice on pay upon promotion.
Attachment A, Page 28, Lines 13-39	Revises section on how employees are paid upon lateral position with the same pay grade to include pay grade and pay range of the job, employee's qualifications, job designation as market sensitive, and internal pay equity.	Documents criteria and method used to evaluate rate of pay upon lateral transfer.	Aligns Attachment A with practice on pay upon lateral transfer, promotes transparency and consistency of application.
Attachment A, Page 29, Line 23 through Page 30, Line 24	Revises section to include Temporary Upgrade Pay.	Complies with CalPERS rules regarding payment of employees fulfilling temporary upgrade roles. Provides clarity on the provisions of Temporary Upgrade Pay in relation to qualification, rate of pay, duration of temporary assignment, and CalPERS designation.	Complies with CalPERS rules, aligns with GA.8042: Supplemental Compensation, provides transparency, and promotes consistent application of Temporary Upgrade Pay, promotes transparency and consistency of application.
Attachment A, Page 30, Line 36 through Page 31, Line 30.	Revises section on Job Evaluations to include description of re-classification to a	Documents the process for determining the appropriateness of a	Aligns Attachment A with practice on job re-evaluation assessment, promotes transparency

	higher, lower, or similarly graded position and the eligibility and evaluation criteria used in that determination.	job re-evaluation through a study and listed reclassification criteria.	and consistency of application.
Attachment A, Page 31, Lines 33-46	Adds a Salary Schedule Revisions section outlining the process for directors to request changes to the Salary Schedule.	Documents and clarifies the procedure for department directors to request changes to the Salary Schedule.	Aligns policy with practice and promotes transparency and consistency of application.
Attachment A, Page 32	Adds glossary of compensation program terms used in Attachment A.	Defines and organizes key terms to enhance mutual understanding.	Provides clarity on compensation related terms used in Attachment.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2023-24 Operating Budget.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Adopt Resolution No. 23-1207-03 Declaring CalOptima Health Employee Handbook as a Guideline Document
2. Adopt Resolution No. 23-1207-04 Approving and Adopting Updated CalOptima Health Human Resources Policies
   a. AA.1250: Disability Awareness and Sensitivity, Cultural Competency, Diversity, Equity, Inclusion, and Bias Staff Training
   b. GA.8012: Conflicts of Interest
   c. GA.8037: Leave of Absence
   d. GA.8042: Supplemental Compensation
   e. GA.8057: Compensation Program

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

RESOLUTION NO. 23-1207-03

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

DESIGNATE THE EMPLOYEE HANDBOOK AS A GUIDELINE DOCUMENT

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;

WHEREAS, the Employee Handbook (i) is a resource that provides guidance and information related to CalOptima Health's mission, vision, values, employee benefits, employee engagement and training, and development; and (ii) references key personnel-related policies and expectations of employee conduct; and

WHEREAS, the Employee Handbook merely highlights and summarizes procedures, practices, and policies approved by the Board of Directors and functions as a guideline resource for employees.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby (i) declares and shall treat the Employee Handbook as a guideline document that does not require future Board of Directors approval, and (ii) authorizes staff to revise the Employee Handbook consistent with Board of Directors-approved procedures, practices, and policies without the need to present those Employee Handbook revisions to the Board of Directors for approval.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima Health this 7th day of December 2023.

AYES:
NOES:
ABSENT:
ABSTAIN:

Back to Item

Back to Agenda

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

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

Back to Item

Back to Agenda

RESOLUTION NO. 23-1207-04

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:

- AA.1250: Disability Awareness and Sensitivity, Cultural Competency, Diversity, Equity, Inclusion, and Bias Staff Training.
- GA.8012: Conflicts of Interest and Attachments A-C.
- GA.8037: Leave of Absence.
- GA.8042: Supplemental Compensation and Attachments A-B.
- GA.8057: Compensation Program and Attachment A.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima Health this 7th day of December 2023.

AYES:
NOES:
ABSENT:
ABSTAIN:

Back to Item

Back to Agenda

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

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

Back to Item

Back to Agenda

Policy:	GA.8012
Title:	**Conflicts of Interest**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	02/01/2000
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines and standards for CalOptima Health Employees to avoid conflicts of interest and incompatible outside activities.

II. POLICY

A. CalOptima Health Employees shall avoid anything that constitutes a real or apparent conflict between their personal interests and the interests of CalOptima Health.

B. CalOptima Health Employees shall avoid conflicts of interest and shall adhere to applicable state and federal laws and regulations, including, but not limited to:

1. California Government Code Section 81000 et seq., requiring all designated employees to comply with the reporting requirements in CalOptima Health's Conflict of Interest Code;

2. California Government Code Section 87100, prohibiting each CalOptima Health Employee from making, participating in making or in any way attempting to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she has a financial interest;

3. California Government Code section 1090, prohibiting each CalOptima Health Employee from being financially interested in any contract made by the employee in his or her official capacity, and prohibiting each employee from being a purchaser at any sale or vendor at any purchase made by him or her in his or her official capacity.

4. California Government Code section 1126, which prohibits each CalOptima Health Employee from engaging in any employment, activity, or enterprise for compensation which is inconsistent, incompatible, in conflict with, or inimical to his or her duties as a local agency officer or employee or with the duties, functions, or responsibilities of CalOptima Health.

5. Title 42 of the United States Code section 1320-7b(b), prohibiting the knowing and willful offer, payment, solicitation or receipt of incentives or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Title 42 of the Code of Federal Regulations section 460.68 regarding the disclosure and recusal requirement of the governing board for direct or indirect interest in any contract that supplies any administrative or care-related service or materials to PACE.

C. A conflict of interest exists in any situation in which an employee uses his or her position or association with CalOptima Health for personal or financial gain. The following guidelines are used to determine whether a real or apparent conflict of interest would exist.

1. *Avoidance of Unfair Competitive Advantage*. An employee's outside employment, consulting, or other business activity outside CalOptima Health may not influence decisions made by CalOptima Health in such a way as to give unfair competitive advantage to the employee's outside business activity.

2. *Use of Privileged or Official Information*. The use of privileged or official information for personal financial gain while employed with or after separating from employment is a type of conflict of interest and is prohibited. Privileged or official information is information that is known to an employee because of his or her employment with CalOptima Health but is not available to the public. The information covered under this provision includes, but is not limited to, personal health information (PHI), provider rates, personnel records, or proprietary information.

3. *Protection of Information Not Yet in Public Domain*. A CalOptima Health Employee acting as an independent consultant or as an employee of another organization may not use information, skills or knowledge obtained as a result of CalOptima Health employment, that is material or necessary to a current, in-progress, or proposed CalOptima Health project, that is proprietary to CalOptima Health and that is not yet in the public domain.

4. *Noncompetition with CalOptima Health*. An employee's outside employment or consulting activity must not compete with current or proposed CalOptima Health projects, programs or initiatives.

D. CalOptima Health Employees shall not handle member or provider issues, applications, requests, or cases on behalf of CalOptima Health for member(s) of the employee's own family or for personal friends.

E. CalOptima Health Employees shall comply with the Code of Conduct and CalOptima Health Policies AA.1204: Gifts, Honoraria, and Travel Payments and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health. Other than as permitted in CalOptima Health Policies, employees shall not receive gratuity, rebates, kickbacks, accommodation, or other unlawful consideration from any one provider, supplier, vendor, firm, or organization with whom CalOptima Health is currently doing or could potentially do business with. It is the responsibility of the employee to return any gift delivered to them and to notify the Clerk of the Board of such action.

F. CalOptima Health Employees shall be aware of what outside activities, investments, and/or positions may conflict with or detract from their effectiveness in employment with CalOptima Health and shall avoid such conflicts.

G. CalOptima Health Employees shall promptly disclose all potential, suspected, or actual conflicts of interest to CalOptima Health's Human Resources Department (HR) and shall personally withdraw from discussion, voting, or other decision-making process where an employee knows or has reason to know the employee has a real or apparent conflict of interest.

H. Designated CalOptima Health Employees in those positions listed in the CalOptima Health Conflict of Interest Code shall complete Statements of Economic Interests (FPPC Form 700) and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon termination of employment. If an employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member, the employee must disclose this fact in writing to HR.

1. CalOptima Health Employees are prohibited from performing a second job that would create a conflict of interest. Employees are required to promptly report any non-CalOptima Health job positions that might be considered one of the situations described in Section II.H.2., on an Employee Report of Outside Interest and/or Other Employment form provided by HR for approval. Employees are to resubmit the Employee Report of Outside Interest and/or Other Employment annually for subsequent approval. Employees are to notify HR when the approved activity ends.

2. CalOptima Health employees shall not participate in any of the following activities without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Health Board of Directors):

   a. Perform work or render services for any Contractor/Vendor/Provider, association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health;

   b. Perform work or hold a position with a job-related non-profit/charitable businesses or organization;

   c. Be a director, officer, or consultant of any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health; or

   d. Permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor/Vendor/Provider or association of Contractors/Vendors/ Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health.

3. CalOptima Health Employees are prohibited from performing a second job during the same hours or schedule as their position with CalOptima Health.

I. Employees may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima Health in these activities.

J. As required in CalOptima Health's contract with the Department of Health Care Services (DHCS) and applicable state and federal laws and regulations, CalOptima Health shall avoid conflicts of interest in the employment of current and former state officers and employees.

K. Employees in Executive Staff positions shall not, for a period of twelve (12) months after leaving that position or employment with CalOptima Health, act as an agent for, or otherwise represent, for compensation, any other person, contractor, or organization, directly or indirectly, by negotiating, servicing, or soliciting contracts with CalOptima Health.

L. To avoid conflicts of interests or potential conflicts of interests, employees performing audit functions are precluded from auditing Health Networks (HNs) and or other contracted entities with which they were previously employed. This preclusion can be waived with the approval of the Executive Director of Network Operations in consultation with the Chief Compliance Officer and the Health Network and or other contracted entity.

~~L.~~M. Failure to adhere to this Policy, including failure to promptly disclose any potential or actual conflicts or seek an exception may result in corrective action, up to and including termination of employment and/or legal action. Conflicts that violate state or federal laws may result in regulatory or legal action, including possible fines and criminal prosecution.

III. PROCEDURE

A. HR shall:

1. Provide all new CalOptima Health Employees with a copy of this Policy and CalOptima Health's Code of Conduct.

2. Provide each designated CalOptima Health employee with a copy of the Conflict of Interest Code and a link to the County of Orange's eDisclosure System to the Form 700 Statement of Economic Interests, to complete when assuming office, annually, and upon termination of employment. HR will also provide the Supplement to Form 700 upon hire and annually.

3. Make the Employee Report of Outside Interest and/or Other Employment form available to all CalOptima Health employees.

4. Collect and review the completed Supplement to Form 700 forms and/or Employee Report of Outside Interest and/or Other Employment Forms and obtain necessary approvals where required.

5. Not employ an individual holding a permanent or intermittent position in the State civil service or other appointed State official or an individual who was employed within the previous one (1) year as an appointee or civil service employee with DHCS, subject to certain exceptions which employment determination shall be made in conjunction with the Compliance Department.

B. All CalOptima Health Employees shall:

1. Review and comply with this Policy, CalOptima Health's Code of Conduct, and the CalOptima Health Employee Handbook;

2. Avoid any actual or potential conflict between their personal interests and the interest of CalOptima Health;

3. Promptly report any job-related outside or personal positions or interests on the Employee Report of Outside Interest and/or Other Employment form and submit such forms to HR.

4. Not make, or participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest.

5. Not offer, pay, solicit or receive an incentive or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of

business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Promptly report any suspected or apparent violation of this Policy to CalOptima Health's HR Department with detailed information sufficient for HR to investigate the issue and cooperate with any subsequent investigation.

7. CalOptima Health Employees unsure as to whether a certain transaction, activity, or relationship constitutes a conflict of interest should discuss it with their supervisor or HR for clarification.

8. Upon being notified that an actual or apparent conflict exists, and an exception is not granted, the employee must promptly resolve the conflict by:

   a. Terminating the outside activity;

   b. Cooperating in reassignment, when appropriate or reasonable or;

   c. Resigning from CalOptima Health.

C. Designated CalOptima Health Employees in those positions listed in the CalOptima Health Conflict of Interest Code shall:

1. Upon assuming office, annually, and upon termination of employment, complete and submit a Statement of Economic Interests (FPPC Form 700) on the County of Orange eDisclosure system (https://cob.ocgov.com/disclosure); and

2. Complete a Supplement to Form 700 upon hire and annually.

IV. ATTACHMENT(S)

A. Conflict of Interest Code Exhibits A and B
B. Supplement to Form 700
C. Employee Report of Outside Interest and/or Other Employment Form

V. REFERENCE(S)

A. California Government Code, §§1090 *et. seq*.
B. California Government Code, §1126
C. California Government Code, §§87206.3 and 87206.3(c)
D. CalOptima Health Code of Conduct
E. CalOptima Health Conflict of Interest Code
F. CalOptima Health Contract with the Department of Health Care Services (DHCS)
G. CalOptima Health Employee Handbook
H. CalOptima Health Policy AA.1204: Gifts, Honoraria and Travel Payments
I. CalOptima Health Policy AA.1216: Solicitation and Receipt of Gifts to CalOptima Health
J. Political Reform Act, Government Code §§81000-91014
K. Title 2, California Code of Regulations (C.C.R.), §§18730 *et seq.*
L. Title 22, California Code of Regulations, §53600
M. Title 42, United States Code, §§1320a-7b(b)
N. Title 42, Code of Federal Regulations, §460.68

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/08/2009	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
09/01/2022	Regular Meeting of the CalOptima Health Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2000	GA.8012	Conflicts of Interest	Administrative
Revised	07/01/2007	GA.8012	Conflicts of Interest	Administrative
Revised	05/04/2017	GA.8012	Conflicts of Interest	Administrative
Revised	02/07/2019	GA.8012	Conflicts of Interest	Administrative
Revised	12/03/2020	GA.8012	Conflicts of Interest	Administrative
Revised	09/01/2022	GA.8012	Conflicts of Interest	Administrative
Revised	12/01/2022	GA.8012	Conflicts of Interest	Administrative
Revised	05/04/2023	GA.8012	Conflicts of Interest	Administrative
Revised	TBD	GA.8012	Conflicts of Interest	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Health Employee(s)	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima Health employees, all temporary employees, interns, CalOptima Health Board members, and applicable contractors and consultants.

Policy:	GA.8012
Title:	**Conflicts of Interest**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	02/01/2000
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines and standards for CalOptima Health Employees to avoid conflicts of interest and incompatible outside activities.

II. POLICY

A. CalOptima Health Employees shall avoid anything that constitutes a real or apparent conflict between their personal interests and the interests of CalOptima Health.

B. CalOptima Health Employees shall avoid conflicts of interest and shall adhere to applicable state and federal laws and regulations, including, but not limited to:

1. California Government Code Section 81000 et seq., requiring all designated employees to comply with the reporting requirements in CalOptima Health's Conflict of Interest Code;

2. California Government Code Section 87100, prohibiting each CalOptima Health Employee from making, participating in making or in any way attempting to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she has a financial interest;

3. California Government Code section 1090, prohibiting each CalOptima Health Employee from being financially interested in any contract made by the employee in his or her official capacity, and prohibiting each employee from being a purchaser at any sale or vendor at any purchase made by him or her in his or her official capacity.

4. California Government Code section 1126, which prohibits each CalOptima Health Employee from engaging in any employment, activity, or enterprise for compensation which is inconsistent, incompatible, in conflict with, or inimical to his or her duties as a local agency officer or employee or with the duties, functions, or responsibilities of CalOptima Health.

5. Title 42 of the United States Code section 1320-7b(b), prohibiting the knowing and willful offer, payment, solicitation or receipt of incentives or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Title 42 of the Code of Federal Regulations section 460.68 regarding the disclosure and recusal requirement of the governing board for direct or indirect interest in any contract that supplies any administrative or care-related service or materials to PACE.

C. A conflict of interest exists in any situation in which an employee uses his or her position or association with CalOptima Health for personal or financial gain. The following guidelines are used to determine whether a real or apparent conflict of interest would exist.

1. *Avoidance of Unfair Competitive Advantage*. An employee's outside employment, consulting, or other business activity outside CalOptima Health may not influence decisions made by CalOptima Health in such a way as to give unfair competitive advantage to the employee's outside business activity.

2. *Use of Privileged or Official Information*. The use of privileged or official information for personal financial gain while employed with or after separating from employment is a type of conflict of interest and is prohibited. Privileged or official information is information that is known to an employee because of his or her employment with CalOptima Health but is not available to the public. The information covered under this provision includes, but is not limited to, personal health information (PHI), provider rates, personnel records, or proprietary information.

3. *Protection of Information Not Yet in Public Domain*. A CalOptima Health Employee acting as an independent consultant or as an employee of another organization may not use information, skills or knowledge obtained as a result of CalOptima Health employment, that is material or necessary to a current, in-progress, or proposed CalOptima Health project, that is proprietary to CalOptima Health and that is not yet in the public domain.

4. *Noncompetition with CalOptima Health*. An employee's outside employment or consulting activity must not compete with current or proposed CalOptima Health projects, programs or initiatives.

D. CalOptima Health Employees shall not handle member or provider issues, applications, requests, or cases on behalf of CalOptima Health for member(s) of the employee's own family or for personal friends.

E. CalOptima Health Employees shall comply with the Code of Conduct and CalOptima Health Policies AA.1204: Gifts, Honoraria, and Travel Payments and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health. Other than as permitted in CalOptima Health Policies, employees shall not receive gratuity, rebates, kickbacks, accommodation, or other unlawful consideration from any one provider, supplier, vendor, firm, or organization with whom CalOptima Health is currently doing or could potentially do business with. It is the responsibility of the employee to return any gift delivered to them and to notify the Clerk of the Board of such action.

F. CalOptima Health Employees shall be aware of what outside activities, investments, and/or positions may conflict with or detract from their effectiveness in employment with CalOptima Health and shall avoid such conflicts.

G. CalOptima Health Employees shall promptly disclose all potential, suspected, or actual conflicts of interest to CalOptima Health's Human Resources Department (HR) and shall personally withdraw from discussion, voting, or other decision-making process where an employee knows or has reason to know the employee has a real or apparent conflict of interest.

H. Designated CalOptima Health Employees in those positions listed in the CalOptima Health Conflict of Interest Code shall complete Statements of Economic Interests (FPPC Form 700) and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon termination of employment. If an employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member, the employee must disclose this fact in writing to HR.

1. CalOptima Health Employees are prohibited from performing a second job that would create a conflict of interest. Employees are required to promptly report any non-CalOptima Health job positions that might be considered one of the situations described in Section II.H.2., on an Employee Report of Outside Interest and/or Other Employment form provided by HR for approval. Employees are to resubmit the Employee Report of Outside Interest and/or Other Employment annually for subsequent approval. Employees are to notify HR when the approved activity ends.

2. CalOptima Health employees shall not participate in any of the following activities without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Health Board of Directors):

   a. Perform work or render services for any Contractor/Vendor/Provider, association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health;

   b. Perform work or hold a position with a job-related non-profit/charitable businesses or organization;

   c. Be a director, officer, or consultant of any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health; or

   d. Permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor/Vendor/Provider or association of Contractors/Vendors/ Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health.

3. CalOptima Health Employees are prohibited from performing a second job during the same hours or schedule as their position with CalOptima Health.

I. Employees may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima Health in these activities.

J. As required in CalOptima Health's contract with the Department of Health Care Services (DHCS) and applicable state and federal laws and regulations, CalOptima Health shall avoid conflicts of interest in the employment of current and former state officers and employees.

K. Employees in Executive Staff positions shall not, for a period of twelve (12) months after leaving that position or employment with CalOptima Health, act as an agent for, or otherwise represent, for compensation, any other person, contractor, or organization, directly or indirectly, by negotiating, servicing, or soliciting contracts with CalOptima Health.

L. To avoid conflicts of interests or potential conflicts of interests, employees performing audit functions are precluded from auditing Health Networks (HNs) and or other contracted entities with which they were previously employed. This preclusion can be waived with the approval of the Executive Director of Network Operations in consultation with the Chief Compliance Officer and the Health Network and or other contracted entity.

M. Failure to adhere to this Policy, including failure to promptly disclose any potential or actual conflicts or seek an exception may result in corrective action, up to and including termination of employment and/or legal action. Conflicts that violate state or federal laws may result in regulatory or legal action, including possible fines and criminal prosecution.

III. PROCEDURE

A. HR shall:

1. Provide all new CalOptima Health Employees with a copy of this Policy and CalOptima Health's Code of Conduct.

2. Provide each designated CalOptima Health employee with a copy of the Conflict of Interest Code and a link to the County of Orange's eDisclosure System to the Form 700 Statement of Economic Interests, to complete when assuming office, annually, and upon termination of employment. HR will also provide the Supplement to Form 700 upon hire and annually.

3. Make the Employee Report of Outside Interest and/or Other Employment form available to all CalOptima Health employees.

4. Collect and review the completed Supplement to Form 700 forms and/or Employee Report of Outside Interest and/or Other Employment Forms and obtain necessary approvals where required.

5. Not employ an individual holding a permanent or intermittent position in the State civil service or other appointed State official or an individual who was employed within the previous one (1) year as an appointee or civil service employee with DHCS, subject to certain exceptions which employment determination shall be made in conjunction with the Compliance Department.

B. All CalOptima Health Employees shall:

1. Review and comply with this Policy, CalOptima Health's Code of Conduct, and the CalOptima Health Employee Handbook;

2. Avoid any actual or potential conflict between their personal interests and the interest of CalOptima Health;

3. Promptly report any job-related outside or personal positions or interests on the Employee Report of Outside Interest and/or Other Employment form and submit such forms to HR.

4. Not make, or participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest.

5. Not offer, pay, solicit or receive an incentive or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of

business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Promptly report any suspected or apparent violation of this Policy to CalOptima Health's HR Department with detailed information sufficient for HR to investigate the issue and cooperate with any subsequent investigation.

7. CalOptima Health Employees unsure as to whether a certain transaction, activity, or relationship constitutes a conflict of interest should discuss it with their supervisor or HR for clarification.

8. Upon being notified that an actual or apparent conflict exists, and an exception is not granted, the employee must promptly resolve the conflict by:

   a. Terminating the outside activity;

   b. Cooperating in reassignment, when appropriate or reasonable or;

   c. Resigning from CalOptima Health.

C. Designated CalOptima Health Employees in those positions listed in the CalOptima Health Conflict of Interest Code shall:

1. Upon assuming office, annually, and upon termination of employment, complete and submit a Statement of Economic Interests (FPPC Form 700) on the County of Orange eDisclosure system (https://cob.ocgov.com/disclosure); and

2. Complete a Supplement to Form 700 upon hire and annually.

IV. ATTACHMENT(S)

A. Conflict of Interest Code Exhibits A and B
B. Supplement to Form 700
C. Employee Report of Outside Interest and/or Other Employment Form

V. REFERENCE(S)

A. California Government Code, §§1090 *et. seq*.
B. California Government Code, §1126
C. California Government Code, §§87206.3 and 87206.3(c)
D. CalOptima Health Code of Conduct
E. CalOptima Health Conflict of Interest Code
F. CalOptima Health Contract with the Department of Health Care Services (DHCS)
G. CalOptima Health Employee Handbook
H. CalOptima Health Policy AA.1204: Gifts, Honoraria and Travel Payments
I. CalOptima Health Policy AA.1216: Solicitation and Receipt of Gifts to CalOptima Health
J. Political Reform Act, Government Code §§81000-91014
K. Title 2, California Code of Regulations (C.C.R.), §§18730 *et seq.*
L. Title 22, California Code of Regulations, §53600
M. Title 42, United States Code, §§1320a-7b(b)
N. Title 42, Code of Federal Regulations, §460.68

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/08/2009	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
09/01/2022	Regular Meeting of the CalOptima Health Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2000	GA.8012	Conflicts of Interest	Administrative
Revised	07/01/2007	GA.8012	Conflicts of Interest	Administrative
Revised	05/04/2017	GA.8012	Conflicts of Interest	Administrative
Revised	02/07/2019	GA.8012	Conflicts of Interest	Administrative
Revised	12/03/2020	GA.8012	Conflicts of Interest	Administrative
Revised	09/01/2022	GA.8012	Conflicts of Interest	Administrative
Revised	12/01/2022	GA.8012	Conflicts of Interest	Administrative
Revised	05/04/2023	GA.8012	Conflicts of Interest	Administrative
Revised	TBD	GA.8012	Conflicts of Interest	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Health Employee(s)	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima Health employees, all temporary employees, interns, CalOptima Health Board members, and applicable contractors and consultants.

Conflict of Interest Code
EXHIBIT A

Approved May 4, 2023, by
CalOptima Health Board of Directors

Entity: Other Misc. Authorities, Districts and Commissions
Agency: CalOptima Health

Position	Disclosure Category	Files With
Associate Director I	OC-41	COB
Associate Director II	OC-41	COB
Associate Director III	OC-41	COB
Associate Director IV	OC-41	COB
Buyer	OC-01	COB
Buyer, Int.	OC-01	COB
Buyer, Sr.	OC-01	COB
Chief Compliance Officer	OC-01	COB
Chief Executive Officer	OC-01	COB
Chief Financial Officer	OC-01	COB
Chief Health Equity Officer	OC-01	COB
Chief Human Resources Officer	OC-01	COB
Chief Information Officer	OC-01	COB
Chief Medical Officer	OC-01	COB
Chief of Staff	OC-01	COB
Chief Operating Officer	OC-01	COB
Chief Strategy Officer	OC-01	COB
Clerk of the Board	OC-06	COB
Clinical Pharmacist	OC-20	COB
Consultant	OC-01	Agency
Contract Administrator	OC-06	COB
Contracts Manager	OC-06	COB
Contracts Manager, Sr.	OC-06	COB
Contracts Specialist	OC-06	COB
Contracts Specialist, Int.	OC-06	COB
Contracts Specialist, Sr.	OC-06	COB
Controller	OC-01	COB
Deputy Chief Medical Officer	OC-01	COB

Back to Item

Back to Agenda

Conflict of Interest Code
EXHIBIT A

Approved May 4, 2023, by
CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Director I	OC-01	COB
Director II	OC-01	COB
Director III	OC-01	COB
Director IV	OC-01	COB
Enterprise Analytics Manager	OC-06	COB
Executive Director	OC-01	COB
Financial Analyst I	OC-01	COB
Financial Analyst II	OC-01	COB
Financial Analyst III	OC-01	COB
Financial Analyst IV	OC-01	COB
Financial Reporting Analyst	OC-01	COB
Litigation Support Specialist	OC-41	COB
Manager, Accounting	OC-01	COB
Manager, Actuary	OC-01	COB
Manager, Audit and Oversight	OC-01	COB
Manager, Behavioral Health	OC-41	COB
Manager, Business Integration	OC-06	COB
Manager, Case Management	OC-41	COB
Manager, Claims	OC-41	COB
Manager, Clinic Operations	OC-06	COB
Manager, Clinical Pharmacists	OC-20	COB
Manager, Coding Quality	OC-06	COB
Manager, Communications	OC-13	COB
Manager, Community Relations	OC-06	COB
Manager, Contracting	OC-41	COB
Manager, Cultural & Linguistics	OC-06	COB
Manager, Customer Service	OC-41	COB
Manager, Electronic Business	OC-06	COB
Manager, Encounters	OC-06	COB
Manager, Environmental Health & Safety	OC-06	COB

Conflict of Interest Code
EXHIBIT A

Approved May 4, 2023, by
CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Manager, Finance	OC-01	COB
Manager, Financial Analysis	OC-01	COB
Manager, Government Affairs	OC-41	COB
Manager, Grievance and Appeals	OC-41	COB
Manager, Human Resources	OC-11	COB
Manager, Information Technology Services	OC-08	COB
Manager, Long Term Support Services	OC-41	COB
Manager, Marketing and Enrollment (PACE)	OC-06	COB
Manager, Member Liaison Program	OC-41	COB
Manager, Member Outreach & Education	OC-41	COB
Manager, MSSP	OC-41	COB
Manager, OneCare Clinical	OC-41	COB
Manager, OneCare Customer Service	OC-41	COB
Manager, Outreach & Enrollment	OC-41	COB
Manager, PACE Center	OC-41	COB
Manager, Population Health Management	OC-41	COB
Manager, Process Excellence	OC-41	COB
Manager, Program Implementation	OC-06	COB
Manager, Provider Data Management Services	OC-41	COB
Manager, Provider Network	OC-41	COB
Manager, Provider Relations	OC-41	COB
Manager, Purchasing	OC-01	COB
Manager, QI Initiatives	OC-41	COB
Manager, Quality Analytics	OC-06	COB
Manager, Quality Improvement	OC-41	COB
Manager, Regulatory Affairs and Compliance	OC-41	COB
Manager, Reporting & Financial Compliance	OC-01	COB
Manager, Strategic Development	OC-41	COB
Manager, Utilization Management	OC-06	COB
Medical Case Manager	OC-41	COB

Conflict of Interest Code
EXHIBIT A

Approved May 4, 2023, by
CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Medical Case Manager (LVN)	OC-41	COB
Medical Director	OC-01	COB
Medical Services Case Manager	OC-41	COB
Nurse Practitioner (PACE)	OC-41	COB
OneCare Operations Manager	OC-41	COB
Pharmacy Resident	OC-20	COB
Pharmacy Services Specialist	OC-20	COB
Pharmacy Services Specialist, Int.	OC-20	COB
Pharmacy Services Specialist, Sr.	OC-20	COB
Policy Advisor, Sr.	OC-41	COB
Principal Financial Analyst	OC-01	COB
Privacy Manager	OC-41	COB
Privacy Officer	OC-41	COB
Process Excellence Manager II	OC-41	COB
Process Excellence Manager III	OC-41	COB
Process Excellence Manager IV	OC-41	COB
Program Manager	OC-06	COB
Program Manager, Sr.	OC-06	COB
Project Manager II	OC-O6	COB
Project Manager III	OC-O6	COB
Project Manager IV	OC-O6	COB
QI Nurse Specialist (RN or LVN)	OC-06	COB
Records Manager	OC-06	COB
Regulatory Affairs and Compliance Analyst	OC-41	COB
Regulatory Affairs and Compliance Analyst, Sr.	OC-41	COB
Regulatory Affairs and Compliance, Lead	OC-41	COB
RN (PACE)	OC-41	COB
Sr Director	OC-01	COB
Sr Manager I	OC-01	COB
Sr Manager II	OC-01	COB

Conflict of Interest Code
EXHIBIT A

Approved May 4, 2023, by
CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Sr Manager III	OC-01	COB
Sr Manager IV	OC-01	COB
Supervisor, Accounting	OC-01	COB
Supervisor, Audit and Oversight	OC-01	COB
Supervisor, Behavioral Health	OC-41	COB
Supervisor, Budgeting	OC-01	COB
Supervisor, Case Management	OC-41	COB
Supervisor, Claims	OC-06	COB
Supervisor, Coding Initiatives	OC-06	COB
Supervisor, Credentialing	OC-41	COB
Supervisor, Customer Service	OC-06	COB
Supervisor, Data Entry	OC-06	COB
Supervisor, Day Center (PACE)	OC-06	COB
Supervisor, Dietary Services (PACE)	OC-41	COB
Supervisor, Encounters	OC-06	COB
Supervisor, Facilities	OC-41	COB
Supervisor, Finance	OC-01	COB
Supervisor, Grievance and Appeals	OC-41	COB
Supervisor, Information Technology Services	OC-08	COB
Supervisor, Long Term Support Services	OC-41	COB
Supervisor, Medical Assistant	OC-41	COB
Supervisor, Member Outreach and Education	OC-06	COB
Supervisor, MSSP	OC-06	COB
Supervisor, Nursing Services (PACE)	OC-41	COB
Supervisor, OneCare Customer Service	OC-06	COB
Supervisor, Payroll	OC-06	COB
Supervisor, Pharmacist	OC-20	COB
Supervisor, Population Health Management	OC-41	COB
Supervisor, Provider Data Management Services	OC-06	COB
Supervisor, Provider Relations	OC-41	COB

Conflict of Interest Code
EXHIBIT A

Approved May 4, 2023, by
CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Supervisor, Quality Analytics	OC-06	COB
Supervisor, Quality Improvement	OC-41	COB
Supervisor, Regulatory Affairs and Compliance	OC-41	COB
Supervisor, Social Work (PACE)	OC-41	COB
Supervisor, Therapy Services (PACE)	OC-41	COB
Supervisor, Utilization Management	OC-06	COB

Total: 154

OFFICIALS WHO ARE SPECIFIED IN GOVERNMENT CODE SECTION 87200

Officials who are specified in Government Code section 87200 (including officials who manage public investments, as defined by 2 Cal. Code of Regs. § 18700.3 (b)), are NOT subject to the Agency's Conflict of Interest Code but are subject to the disclosure requirements of the Political Reform Act, Government Code section 87100, et seq. Gov't Code § 87203. These positions are listed here for informational purposes only.

The positions listed below are officials who are specified in Government Code section 87200:

Alternate Member of the Board of Directors	Files with	COB
Chief Executive Officer	Files with	COB
Chief Financial Officer	Files with	COB
Member of the Board of Directors	Files with	COB

The disclosure requirements for these positions are set forth in Government Code section 87200, et. seq. They require the disclosure of interests in real property in the agency's jurisdiction, as well as investments, business positions and sources of income (including gifts, loans and travel payments).

Disclosure Descriptions
EXHIBIT B

Entity: **Other Misc. Authorities, Districts and Commissions Agency:** **CalOptima Health**

Disclosure Category	Disclosure Description
87200 Filer	Form 87200 filers shall complete all schedules for Form 700 and disclose all reportable sources of income, interests in real property, investments and business positions in business entities, if applicable, pursuant to Government Code Section 87200 *et seq*...
OC-01	All interests in real property in Orange County, the authority or the District as applicable, as well as investments, business positions and sources of income (including gifts, loans and travel payments).
OC-06	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide leased facilities and goods, supplies, equipment, vehicles, machinery or services (including training and consulting services) of the types used by the County Department, Authority or District, as applicable.
OC-08	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that develop or provide computer hardware/software, voice data communications, or data processing goods, supplies, equipment, or services (including training and consulting services) used by the County Department, Authority or District, as applicable.
OC-11	All interests in real property in Orange County or located entirely or partly within the Authority or District boundaries as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that are engaged in the supply of equipment related to recruitment, employment search & marketing, classification, training, or negotiation with personnel; employee benefits, and health and welfare benefits.
OC-13	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that produce or provide promotional items for public outreach programs; present, facilitate, market or otherwise act as agent for media relations with regard to public relations; provide printing, copying, or mail services; or provide training for or development of customer service representatives.
OC-20	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide pharmaceutical services, supplies, materials or equipment.

Disclosure Category	Disclosure Description
OC-30	Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest category in the code subject to the following limitation: The County Department Head/Director/General Manager/Superintendent/etc. may determine that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and based upon that description, a statement of the extent of disclosure required. The determination of disclosure is a public record and shall be filed with the Form 700 and retained by the Filing Officer for public inspection.
OC-41	All interests in real property in Orange County, the District or Authority, as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide services, supplies, materials, machinery, vehicles, or equipment (including training and consulting services) used by the County Department, Authority or District, as applicable.

Grand Total: 9

SUPPLEMENT TO FORM

700 CALOPTIMA HEALTH

Please print:

Name: _____

The purpose of this disclosure form is to ensure that decisions are in the best interest of CalOptima Health and that no individual achieves personal gain because of his / her position with or without knowledge of CalOptima Health.

Please complete the following:

1. Are you or anyone in your family a director, officer, employee or owner in any business or entity (e.g., bank, real estate brokerage firm, consulting firm, construction company, insurance broker, architectural, law firm, medical group, etc.) which has done business in the past 12 months with CalOptima Health, or currently is or contemplates doing business with CalOptima Health in the next 12 months? _____(yes or no)

   Entity for these purposes includes any for profit, non-profit or public entity. *If yes, please disclose at end*

Please explain your relationship with such business or entity and the transaction with CalOptima Health.

_____

_____

_____

2. Are there any circumstances or other matters of a personal or family nature, direct or indirect, which could conflict with the interests of CalOptima Health ____(yes or no) *If yes, please disclose at end.*

3. Disclose any other activities which you or anyone in your family are engaging in, or are considering engaging in, which may be deemed by CalOptima Health's management or Board to present a potential conflict of interest.

_____ _____

Signature Date

Please disclose any information here:

_____

_____

_____

_____

_____

(Please attach additional sheets if needed)

Human Resources *Approved:*

Back to Item

Back to Agenda

Employee Report of Outside Interest and/or Other Employment

Employees are required to submit this form to Human Resources for determination of any outside interest(s) they may have which could be perceived as a potential conflict of interest with their employment with CalOptima Health. It is understood that not all personal outside interest(s) which may interact with and/or relate to CalOptima Health employment constitute a conflict of interest. By reporting any such related outside interest(s), it is hoped that any potential conflict may be avoided.

Name_____ **Position** _____

Department_____ **Supervisor** _____

A) **Other Job / Position:**

Place of Employment _____

Location/Address _____

Hours/Schedule _____

B) **Outside Interest:** Describe the nature of your association/position in which you have an outside interest, which may have a real or perceived connection, influence or interaction with your employment/position at CalOptima Health:

Explain any actions/precautions that you will take to avoid any conflict of interest with your CalOptima Health employment:

I understand that it is my responsibility to ensure there are no conflicts of interest with my CalOptima Health employment. If approved, I will notify Human Resources when the outside activity ends and for ongoing activities will resubmit this form annually for reapproval:

Employee Name (please print):_____

Employee signature: _____ Date _____

Approved by:

Manager/Executive: _____ Date _____

Compliance: _____ Date _____

Human Resources: _____ Date _____

Legal (if necessary): _____ Date _____

Additional Comments:

This form must be typed. Signatures need to be in blue or black ink.

Policy:	GA.8037
Title:	**Leave of Absence**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the general rules and restrictions applicable to a Leave of Absence (LOA).

II. POLICY

A. CalOptima Health shall comply with all applicable state and federal LOA laws and regulations and will implement and administer changes to entitlements as required by law.

B. CalOptima Health will grant a LOA to eligible employees in accordance with CalOptima Health's respective policies and procedures. For leaves specified herein, an employee must submit a Leave of Absence Request Form, available on the InfoNet, to the Human Resources (HR) Department.

C. An employee's manager may approve up to five (5) scheduled workdays of excused absences for an illness or pre-planned surgery; however, absences of more than five (5) scheduled workdays for illnesses or pre-planned surgery, must be submitted to and approved by HR. Use of Paid Time Off (PTO) for pre-planned vacations does not require HR approval pursuant to CalOptima Health Policy GA.8018: Paid Time Off (PTO).

D. If an employee requires additional time off work beyond the amount of time authorized herein, and their manager and HR grant a Personal LOA pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence, the Personal LOA will start on the first day after the termination of the LOA granted pursuant to one (1) of the leaves authorized herein.

E. Types of LOA:

1. Bereavement Leave: An employee may take up to three (3) scheduled workdays off with pay [maximum of twenty-four (24) hours] in the event of a death of an employee's: spouse; registered domestic partner; biological, adopted, step or foster child; biological, adopted, step or foster parent; legal guardian; siblings, including step brother and step sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law. An employee is entitled to take an additional two (2) workdays off as either PTO or unpaid time off [maximum of sixteen (16) hours]. The first five (5) days of paid or unpaid bereavement leave taken in the three (3) months following the death of the family member are considered protected leave. A Bereavement Leave Request Form, available on the InfoNet, must be submitted to HR within thirty (30) calendar days of leave. The employee's manager may approve up to an additional five (5) workdays off to be taken as either PTO or unpaid time off [maximum of forty (40) hours]. An employee must

submit a Leave of Absence Request Form to HR and request a Personal LOA pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence if the employee plans to take additional PTO or unpaid time off exceeding the additional five (5) scheduled workdays taken as PTO or unpaid time off.

2. Pregnancy Disability Leave (PDL): In accordance with California Pregnancy Regulations, CalOptima Health provides up to four (4) months (calculated based on number of days or hours the employee would normally work within four (4) calendar months) of unpaid PDL per pregnancy to women requiring time off work because of a disability caused by an employee's pregnancy, childbirth, or a related medical condition as described in CalOptima Health Policy GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation.

3. Family and Medical Leave Act (FMLA): Under the FMLA, employers must provide eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per rolling twelve (12) month period. In most circumstances, FMLA leave will run at the same time as PDL and/or California Family Rights Act (CFRA) leave (see below), where applicable, and is not in addition to those leaves. FMLA also includes a special leave entitlement for eligible employees to take up to twenty-six (26) weeks of unpaid leave to care for a covered military service member with a qualifying serious injury or illness during a single twelve (12) month period. (See CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence for details.)

4. California Family Rights Act (CFRA) Leave: CFRA provides eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per rolling twelve (12) month period, as detailed in CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.

5. Military Family Leave: Eligible employees may take an unpaid LOA under FMLA and/or CFRA as described in Sections II.D.3. and 4. of this Policy, to care for a qualified family member or due to a qualifying exigency arising out of the fact that the qualified family member is on covered active duty or has been notified of an impending call or order to active duty.

6. Military Service Leave: The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a Federal law that provides a cumulative of five (5) years of leave (with certain exceptions) and re-employment rights for veterans and members of the National Guard and Reserve following qualifying military service. USERRA requires that a person re-employed under its provisions be given credit for any months they would have been employed but for the military service in determining eligibility for FMLA leave. A person re-employed following military service should be given credit for the period of military service towards the months-of-employment eligibility requirement.

   a. Salary and Compensation for First Thirty (30) Calendar Days for Military Service LOA: Pursuant to Military and Veterans Code, Sections 395.01 and 395.05, an employee may be entitled to their full salary, or compensation, including all appropriate benefits, for the first thirty (30) calendar days of their absence while they are engaged in the performance of ordered duty, active military training, inactive duty training, encampment, naval cruises, special exercises, National Guard active duty, inactive duty training drill periods, or like activity. Pay under this provision is limited to not more than thirty (30) calendar days in any given fiscal year.

   b. A military leave of absence without pay shall be granted to employee members of reserve military units and the National Guard required to perform inactive duty obligations. Employee may use accrued PTO if sufficient PTO is accrued or may take this time as unpaid.

c. Supplemental Compensation and Continuation of Benefits for Military Service LOA resulting from the National Emergency declared as a Result of the War on Terror: Upon the exhaustion of pay and benefits for the first thirty (30) calendar days, an employee called to active duty or active training duty with the U.S. Armed Forces or National Guard as a result of the National Emergency, may receive supplemental pay in an amount equal to the difference between the amount of the employee's military pay, including any allotments or additional allowances paid to their families, as calculated at the beginning of the employee's leave, and the amount the employee earned as base salary at CalOptima Health in the month prior to the LOA, assuming the amount the employee earned at CalOptima Health is greater than their military pay. The employee is also authorized to receive a continuation of appropriate benefits, including CalOptima Health payment of the employer cost for applicable health insurance premiums for employees and, if applicable, their dependents. In the event the employee's military pay is greater than their CalOptima Health base salary, CalOptima Health will continue the employee's eligible benefits, if elected, and pay for the employee's cost of such benefits without seeking reimbursement. In instances where training or service with the U.S. Armed Forces is not mandatory and is not covered by state, or federal law, the LOA will be unpaid.

7. Military Spouse Leave: Pursuant to Military & Veterans Code, Section 395.10, eligible employees may take up to ten (10) scheduled workdays of unpaid leave when their spouse is on leave from active duty in the U.S. Armed forces, Reserves or National Guard. Employee may use accrued PTO if sufficient PTO is accrued or may take this time as unpaid.

8. Workers' Compensation: In accordance with state law, CalOptima Health provides Workers' Compensation insurance coverage for employees in case of work-related injury or illness. CalOptima Health may grant a LOA subject to any limitations permitted by law for work-related injuries, in accordance with CalOptima Health Policy GA.8041: Workers' Compensation Leave of Absence.

9. Jury or Witness Duty Leave: Employees may be granted a LOA with regular pay for those hours that coincide with the employee's regularly scheduled working hours for jury duty. CalOptima Health may grant an employee a LOA with pay to appear as a witness in court, other than as a litigant, or to respond to an official order from another governmental jurisdiction for reasons not brought about through the connivance or misconduct of the employee. On days employees are not required to report to court, or on days when the court either dismisses the employee early or requests that the employee report at a later time, whenever practical, the employee must report to work to perform regular duties prior to or after completing jury duty or appearing as a witness, unless the employee's manager approves that the remaining work time is less than reasonable travel time to court and work location. Employees are expected to work with and coordinate with their manager to ensure that their time away from work does not adversely impact business needs, their coworkers, or CalOptima Health members.

10. Parental School Attendance: Pursuant to Labor Code, Section 230.8, employees can take time off up to eight (8) hours in one (1) month or forty (40) hours each year to participate in Child-Related Activities, subject to limitations under applicable laws. Pursuant to Labor Code, Section 230.7, employees can take time off to appear in the school pursuant to a request made under Education Code, Section 48900.1 (Suspension of Pupil), subject to limitations under applicable laws. Accrued PTO shall automatically be used for time-off for Child-Related Activities and/or to appear in a pupil's school, subject to the limitations under applicable laws. Otherwise, the Employee may take this time as unpaid if there is not enough accrued PTO available in accordance with CalOptima Health Policy GA.8018: Paid Time Off (PTO).

11. Victims of Crime or Abuse: Subject to the requirements under Labor Code, sections 230 and 230.1, an employee who is a victim of a crime or abuse, may, with reasonable advance notice, unless the advance notice is not feasible, request a LOA. For purposes of LOA request eligibility, "victim" includes (1) a victim of stalking, domestic violence, or sexual assault; (2) a victim of a crime that caused physical injury or that caused mental injury and a threat of physical injury; and/or (3) a person whose immediate family member is deceased as the direct result of the crime. Employees may elect to use accrued PTO, if available, when a LOA is granted; however, the PTO cannot be used to adjust the start date and will count as part of the LOA. This type of LOA is limited to twelve (12) weeks in a rolling twelve (12) month period. After an employee exhausts their PTO accruals, if elected, the remaining time off will be unpaid. LOAs under this paragraph may be granted for any of the following:

    a. To seek medical attention for injuries caused by crime or abuse;

    b. To obtain services from a domestic violence shelter, program, rape crisis center, or victim services organization or agency as a result of the crime or abuse;

    c. To obtain psychological counseling or mental health services related to an experience of crime or abuse;

    d. To participate in safety planning and take other actions to increase safety from future crime or abuse, including temporary or permanent relocation; and/or

    e. To obtain or attempt to obtain relief, including, but not limited to, a temporary restraining order, restraining order, or other injunctive relief, to help ensure the health, safety, or welfare of the employee, or their child.

12. Victims of Crime Leave: An employee who is a victim of a crime or whose immediate family member(s) is/are a crime victim may take time off subject to the procedural conditions imposed pursuant to Labor Code, section 230.2, to attend judicial proceedings related to that crime. A copy of the official notice to the victim of each scheduled legal, or judicial, proceeding, or documentation substantiating the employee's attendance at a judicial proceeding is required for this leave. The employee can elect to use accrued PTO for the absence.

13. Volunteer Civil Service Leave: A Civil Service LOA for an unlimited duration may be granted for employees who are required to perform emergency duty as a volunteer firefighter, a reserve police officer, or emergency rescue personnel. An employee who performs duty as a volunteer firefighter, a reserve peace officer, or as emergency rescue personnel is also permitted to take a LOA, not to exceed an aggregate of fourteen (14) scheduled workdays per calendar year for the purpose of fire, law enforcement, or emergency rescue training. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

14. Civil Air Patrol Leave: Employees who have been employed for at least ninety (90) calendar days may request a maximum total of ten (10) scheduled workdays per calendar year (three (3) scheduled workdays maximum for a single emergency operational mission, unless otherwise authorized by HR) for Civil Air Patrol duty. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

15. LOA as a Reasonable Accommodation: ~~-~~Consistent with the requirements under the Americans with Disabilities Act and the California Fair Employment and Housing Act, subject to a good faith interactive process, CalOptima Health may grant an employee a LOA as a reasonable accommodation, if appropriate.

16. Reproductive Loss Leave: An employee who has worked for CalOptima Health for at least thirty (30) days may take up to five (5) scheduled workdays off following a reproductive loss event (day of or multiple-days), including the final day of a failed adoption, failed surrogacy, miscarriage, stillbirth, or an unsuccessful assisted reproduction. If an employee experiences more than one (1) reproductive loss event within a twelve (12) month period, the employee is only entitled to a total of twenty (20) days within a twelve (12) month period. Eligible employees are required to use their accrued Paid Time Off (PTO), if available, during their leave. The leave need not be taken on consecutive days or immediately following the reproductive loss event~~,~~ but must be taken within three (3) months of the event triggering the leave. A Leave of Absence Request Form, available on the InfoNet, must be submitted to HR within thirty (30) calendar days of leave. If the desired leave exceeds five (5) workdays per event or twenty (20) days in a twelve (12) month period, an employee may submit for consideration a request for Personal LOA pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence.

~~16.~~17. Other Leaves: See CalOptima Health Policy GA.8038: Personal Leave of Absence.

F. Except as required by federal or state law, or as necessary to protect the employee's safety in the workplace, CalOptima Health management and HR shall reasonably maintain the confidentiality, to the extent possible under the circumstances, of any employee requesting time off pursuant to a LOA described herein.

G. To the extent that this policy conflicts with CalOptima Health Policies GA.8038: Personal Leave of Absence, GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation, or GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, those specific policies shall supersede.

III. PROCEDURE

A. Reinstatement: When an employee is placed on a protected LOA, CalOptima Health shall make an effort to hold the employee's position open for the period of the approved leave, with the exception of Personal LOAs in which there is no guarantee of reinstatement. However, to meet business needs, CalOptima Health may need to fill such positions. If an employee's former position is unavailable when the employee returns promptly to work upon the expiration of an approved LOA, CalOptima Health shall make every effort to place the employee in a comparable position for which the employee is qualified. If such a position is not available, the employee will be offered the next suitable position for which the employee is qualified that becomes available. In addition, CalOptima Health will attempt to reasonably accommodate employees who are released for partial or modified duty. An employee who does not accept a position offered by CalOptima Health is considered to have voluntarily terminated employment, effective the day such refusal is made. Employees returning from a LOA related to the employee's own medical condition must obtain a release to return to work from their health care provider (where applicable) stating that they are able to resume work. CalOptima Health also reserves the right to require employees to participate in a fitness for duty examination at the expense of CalOptima Health prior to return to work.

B. Paid Time Off (PTO) accruals: PTO only accrues during the period an employee is on active duty or utilizing PTO for an approved LOA. Once an employee elects not to use PTO accruals or exhausts all PTO accruals, the remaining time off for an approved LOA shall not be considered time worked for purposes of accruing PTO hours.

C. Holidays: If a paid holiday occurs during the period an employee is on a LOA, the employee may be eligible for the holiday pay if PTO is being used for the LOA the day before and the day after the holiday and the holiday pay will be prorated based on the employee's full-time or part-time status as it was in effect prior to the LOA. If a holiday falls on a day in which the employee would have been regularly scheduled to work, the holiday will count against the employee's LOA entitlement.

D. Supplemental Compensation: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift Premium, Call Back or On Call Pay, Active Certified Case Manager (CCM) Pay, Internet Stipend, Commuter Allowance, ~~or~~ Automobile Allowance, or Benefit Income during their LOA. An employee on a Continuous LOA may be eligible for Employer-Paid Member Contribution or Supplemental Retirement Benefit during any portion of a paid LOA but shall not be eligible if the LOA is unpaid. Executive incentives will be prorated to account for an executive's Personal LOA time period. Executives must be current employees during the pay period the executive incentive is paid out to be eligible to receive the incentive. Continuous LOA is leave that is taken continuously and not broken into separate blocks of time. Supplemental compensation will resume when the employee returns to an active status, and may be prorated, where applicable.

E. Outside employment: Employees may not engage in outside work for other employers, including self-employment, while on an approved LOA from CalOptima Health, unless specifically authorized under this Policy, such as for military service.

F. Documentation: Failure to provide all the required information and/or documentation within the requested or required timeframe may result in a delay in CalOptima Health's approval of the LOA request, CalOptima Health's denial of the employee's request for a LOA, and/or an impact to the employee's ability to take a LOA as requested.

G. Failure to return promptly: If an employee fails to return to work upon the expiration of an approved LOA and has not submitted required documentation and/or obtained an extension from HR prior to such expiration date, the employee will be considered to have voluntarily resigned. HR will process the employee's voluntary resignation effective three (3) consecutive scheduled workdays following the date the employee failed to return to work, or as soon as reasonably possible given the circumstances. It is the responsibility of the employee to ensure a request for an extended LOA is submitted timely with all required documentation in support of extending the LOA.

H. Misrepresentations: Misrepresenting reasons or information submitted when applying for a LOA may result in corrective action, up to and including termination.

I. Health benefits for PDL, FMLA, CFRA, Military Service or Workers' Compensation Leaves of Absence: Employer contributions towards an employee's health benefits (medical, vision, and dental) who is on leave pursuant to PDL, FMLA, CFRA, Military Service, or Workers' Compensation LOAs, will not continue beyond the FMLA/CFRA covered period pursuant to CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence. Employees may elect to purchase continuation of such health benefits coverage through COBRA. When an employee returns to work, the eligibility and accrual dates for such benefits may be adjusted to reflect the period of the LOA.

J. Other benefits: All other benefits not specified herein, provided by CalOptima Health, shall be administered according to HR procedures.

K. Eligibility and Specific Leave Requirements: Refer to specific CalOptima Health policies listed below for detailed information about eligibility and other leave requirements:

1. CalOptima Health Policy GA.8018: Paid Time Off (PTO);

2. CalOptima Health Policy GA.8038: Personal Leave of Absence;

3. CalOptima Health Policy GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation;

4. CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence; and/or

5. CalOptima Health Policy GA.8041: Workers' Compensation Leave of Absence.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Bereavement Leave Request Form
B. California Code, Education Code, §48900.1
C. California Code, Government Code, §12945.1 et seq. (CFRA)
D. California Code, Government Code, §19774-19775 (Military Service Leave)
E. California Code, Labor Code, §230 et seq. (Jury service and other leaves)
F. California Code, Military & Veterans Code, §395.10 (Military Service Leave)
G. CalOptima Health Policy GA.8018: Paid Time Off (PTO)
H. CalOptima Health Policy GA.8038: Personal Leave of Absence
I. CalOptima Health Policy GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation
J. CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence
K. CalOptima Health Policy GA.8041: Workers' Compensation Leave of Absence
L. CalOptima Health Policy GA.8059: Attendance and Timekeeping
M. Leave of Absence Request Form
N. Title 2, California Code of Regulations (C.C.R.), §7291.2 et seq. (Pregnancy Regulations)
O. Title 2, California Code of Regulations (C.C.R.), §7293.5 et seq. (Disability Regulations)
P. Title 29, Code of Federal Regulations (C.F.R.), Part 825 (FMLA Regulations)
Q. Title 29, United States Code (U.S.C.), §2601 et seq. (FMLA)
R. Title 38, United States Code (U.S.C.), §4301 et seq. (USSERA)

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
08/07/2014	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8037	Leave of Absence	Administrative
Revised	02/01/2014	GA.8037	Leave of Absence	Administrative
Revised	05/04/2017	GA.8037	Leave of Absence	Administrative
Revised	08/03/2017	GA.8037	Leave of Absence	Administrative
Revised	09/03/2020	GA.8037	Leave of Absence	Administrative
Revised	12/20/2021	GA.8037	Leave of Absence	Administrative
Revised	05/04/2023	GA.8037	Leave of Absence	Administrative
Revised	TBD	GA.8037	Leave of Absence	Administrative

IX. GLOSSARY

Term	Definition
Child-Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of their child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima Health.
Continuous Leave of Absence (LOA)	Leave that is taken continuously and not broken into separate blocks of time.
Leave of Absence (LOA)	A term used to describe ~~a scheduled~~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.

Policy:	GA.8037
Title:	**Leave of Absence**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the general rules and restrictions applicable to a Leave of Absence (LOA).

II. POLICY

A. CalOptima Health shall comply with all applicable state and federal LOA laws and regulations and will implement and administer changes to entitlements as required by law.

B. CalOptima Health will grant a LOA to eligible employees in accordance with CalOptima Health's respective policies and procedures. For leaves specified herein, an employee must submit a Leave of Absence Request Form, available on the InfoNet, to the Human Resources (HR) Department.

C. An employee's manager may approve up to five (5) scheduled workdays of excused absences for an illness or pre-planned surgery; however, absences of more than five (5) scheduled workdays for illnesses or pre-planned surgery, must be submitted to and approved by HR. Use of Paid Time Off (PTO) for pre-planned vacations does not require HR approval pursuant to CalOptima Health Policy GA.8018: Paid Time Off (PTO).

D. If an employee requires additional time off work beyond the amount of time authorized herein, and their manager and HR grant a Personal LOA pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence, the Personal LOA will start on the first day after the termination of the LOA granted pursuant to one (1) of the leaves authorized herein.

E. Types of LOA:

1. Bereavement Leave: An employee may take up to three (3) scheduled workdays off with pay [maximum of twenty-four (24) hours] in the event of a death of an employee's: spouse; registered domestic partner; biological, adopted, step or foster child; biological, adopted, step or foster parent; legal guardian; siblings, including step brother and step sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law. An employee is entitled to take an additional two (2) workdays off as either PTO or unpaid time off [maximum of sixteen (16) hours]. The first five (5) days of paid or unpaid bereavement leave taken in the three (3) months following the death of the family member are considered protected leave. A Bereavement Leave Request Form, available on the InfoNet, must be submitted to HR within thirty (30) calendar days of leave. The employee's manager may approve up to an additional five (5) workdays off to be taken as either PTO or unpaid time off [maximum of forty (40) hours]. An employee must

submit a Leave of Absence Request Form to HR and request a Personal LOA pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence if the employee plans to take additional PTO or unpaid time off exceeding the additional five (5) scheduled workdays taken as PTO or unpaid time off.

2. Pregnancy Disability Leave (PDL): In accordance with California Pregnancy Regulations, CalOptima Health provides up to four (4) months (calculated based on number of days or hours the employee would normally work within four (4) calendar months) of unpaid PDL per pregnancy to women requiring time off work because of a disability caused by an employee's pregnancy, childbirth, or a related medical condition as described in CalOptima Health Policy GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation.

3. Family and Medical Leave Act (FMLA): Under the FMLA, employers must provide eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per rolling twelve (12) month period. In most circumstances, FMLA leave will run at the same time as PDL and/or California Family Rights Act (CFRA) leave (see below), where applicable, and is not in addition to those leaves. FMLA also includes a special leave entitlement for eligible employees to take up to twenty-six (26) weeks of unpaid leave to care for a covered military service member with a qualifying serious injury or illness during a single twelve (12) month period. (See CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence for details.)

4. California Family Rights Act (CFRA) Leave: CFRA provides eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per rolling twelve (12) month period, as detailed in CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.

5. Military Family Leave: Eligible employees may take an unpaid LOA under FMLA and/or CFRA as described in Sections II.D.3. and 4. of this Policy, to care for a qualified family member or due to a qualifying exigency arising out of the fact that the qualified family member is on covered active duty or has been notified of an impending call or order to active duty.

6. Military Service Leave: The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a Federal law that provides a cumulative of five (5) years of leave (with certain exceptions) and re-employment rights for veterans and members of the National Guard and Reserve following qualifying military service. USERRA requires that a person re-employed under its provisions be given credit for any months they would have been employed but for the military service in determining eligibility for FMLA leave. A person re-employed following military service should be given credit for the period of military service towards the months-of-employment eligibility requirement.

   a. Salary and Compensation for First Thirty (30) Calendar Days for Military Service LOA: Pursuant to Military and Veterans Code, Sections 395.01 and 395.05, an employee may be entitled to their full salary, or compensation, including all appropriate benefits, for the first thirty (30) calendar days of their absence while they are engaged in the performance of ordered duty, active military training, inactive duty training, encampment, naval cruises, special exercises, National Guard active duty, inactive duty training drill periods, or like activity. Pay under this provision is limited to not more than thirty (30) calendar days in any given fiscal year.

   b. A military leave of absence without pay shall be granted to employee members of reserve military units and the National Guard required to perform inactive duty obligations. Employee may use accrued PTO if sufficient PTO is accrued or may take this time as unpaid.

c. Supplemental Compensation and Continuation of Benefits for Military Service LOA resulting from the National Emergency declared as a Result of the War on Terror: Upon the exhaustion of pay and benefits for the first thirty (30) calendar days, an employee called to active duty or active training duty with the U.S. Armed Forces or National Guard as a result of the National Emergency, may receive supplemental pay in an amount equal to the difference between the amount of the employee's military pay, including any allotments or additional allowances paid to their families, as calculated at the beginning of the employee's leave, and the amount the employee earned as base salary at CalOptima Health in the month prior to the LOA, assuming the amount the employee earned at CalOptima Health is greater than their military pay. The employee is also authorized to receive a continuation of appropriate benefits, including CalOptima Health payment of the employer cost for applicable health insurance premiums for employees and, if applicable, their dependents. In the event the employee's military pay is greater than their CalOptima Health base salary, CalOptima Health will continue the employee's eligible benefits, if elected, and pay for the employee's cost of such benefits without seeking reimbursement. In instances where training or service with the U.S. Armed Forces is not mandatory and is not covered by state, or federal law, the LOA will be unpaid.

7. Military Spouse Leave: Pursuant to Military & Veterans Code, Section 395.10, eligible employees may take up to ten (10) scheduled workdays of unpaid leave when their spouse is on leave from active duty in the U.S. Armed forces, Reserves or National Guard. Employee may use accrued PTO if sufficient PTO is accrued or may take this time as unpaid.

8. Workers' Compensation: In accordance with state law, CalOptima Health provides Workers' Compensation insurance coverage for employees in case of work-related injury or illness. CalOptima Health may grant a LOA subject to any limitations permitted by law for work-related injuries, in accordance with CalOptima Health Policy GA.8041: Workers' Compensation Leave of Absence.

9. Jury or Witness Duty Leave: Employees may be granted a LOA with regular pay for those hours that coincide with the employee's regularly scheduled working hours for jury duty. CalOptima Health may grant an employee a LOA with pay to appear as a witness in court, other than as a litigant, or to respond to an official order from another governmental jurisdiction for reasons not brought about through the connivance or misconduct of the employee. On days employees are not required to report to court, or on days when the court either dismisses the employee early or requests that the employee report at a later time, whenever practical, the employee must report to work to perform regular duties prior to or after completing jury duty or appearing as a witness, unless the employee's manager approves that the remaining work time is less than reasonable travel time to court and work location. Employees are expected to work with and coordinate with their manager to ensure that their time away from work does not adversely impact business needs, their coworkers, or CalOptima Health members.

10. Parental School Attendance: Pursuant to Labor Code, Section 230.8, employees can take time off up to eight (8) hours in one (1) month or forty (40) hours each year to participate in Child-Related Activities, subject to limitations under applicable laws. Pursuant to Labor Code, Section 230.7, employees can take time off to appear in the school pursuant to a request made under Education Code, Section 48900.1 (Suspension of Pupil), subject to limitations under applicable laws. Accrued PTO shall automatically be used for time-off for Child-Related Activities and/or to appear in a pupil's school, subject to the limitations under applicable laws. Otherwise, the Employee may take this time as unpaid if there is not enough accrued PTO available in accordance with CalOptima Health Policy GA.8018: Paid Time Off (PTO).

11. Victims of Crime or Abuse: Subject to the requirements under Labor Code, sections 230 and 230.1, an employee who is a victim of a crime or abuse, may, with reasonable advance notice, unless the advance notice is not feasible, request a LOA. For purposes of LOA request eligibility, "victim" includes (1) a victim of stalking, domestic violence, or sexual assault; (2) a victim of a crime that caused physical injury or that caused mental injury and a threat of physical injury; and/or (3) a person whose immediate family member is deceased as the direct result of the crime. Employees may elect to use accrued PTO, if available, when a LOA is granted; however, the PTO cannot be used to adjust the start date and will count as part of the LOA. This type of LOA is limited to twelve (12) weeks in a rolling twelve (12) month period. After an employee exhausts their PTO accruals, if elected, the remaining time off will be unpaid. LOAs under this paragraph may be granted for any of the following:

    a. To seek medical attention for injuries caused by crime or abuse;

    b. To obtain services from a domestic violence shelter, program, rape crisis center, or victim services organization or agency as a result of the crime or abuse;

    c. To obtain psychological counseling or mental health services related to an experience of crime or abuse;

    d. To participate in safety planning and take other actions to increase safety from future crime or abuse, including temporary or permanent relocation; and/or

    e. To obtain or attempt to obtain relief, including, but not limited to, a temporary restraining order, restraining order, or other injunctive relief, to help ensure the health, safety, or welfare of the employee, or their child.

12. Victims of Crime Leave: An employee who is a victim of a crime or whose immediate family member(s) is/are a crime victim may take time off subject to the procedural conditions imposed pursuant to Labor Code, section 230.2, to attend judicial proceedings related to that crime. A copy of the official notice to the victim of each scheduled legal, or judicial, proceeding, or documentation substantiating the employee's attendance at a judicial proceeding is required for this leave. The employee can elect to use accrued PTO for the absence.

13. Volunteer Civil Service Leave: A Civil Service LOA for an unlimited duration may be granted for employees who are required to perform emergency duty as a volunteer firefighter, a reserve police officer, or emergency rescue personnel. An employee who performs duty as a volunteer firefighter, a reserve peace officer, or as emergency rescue personnel is also permitted to take a LOA, not to exceed an aggregate of fourteen (14) scheduled workdays per calendar year for the purpose of fire, law enforcement, or emergency rescue training. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

14. Civil Air Patrol Leave: Employees who have been employed for at least ninety (90) calendar days may request a maximum total of ten (10) scheduled workdays per calendar year (three (3) scheduled workdays maximum for a single emergency operational mission, unless otherwise authorized by HR) for Civil Air Patrol duty. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

15. LOA as a Reasonable Accommodation: Consistent with the requirements under the Americans with Disabilities Act and the California Fair Employment and Housing Act, subject to a good faith interactive process, CalOptima Health may grant an employee a LOA as a reasonable accommodation, if appropriate.

16. Reproductive Loss Leave: An employee who has worked for CalOptima Health for at least thirty (30) days may take up to five (5) scheduled workdays off following a reproductive loss event (day of or multiple-days), including the final day of a failed adoption, failed surrogacy, miscarriage, stillbirth, or an unsuccessful assisted reproduction. If an employee experiences more than one (1) reproductive loss event within a twelve (12) month period, the employee is only entitled to a total of twenty (20) days within a twelve (12) month period. Eligible employees are required to use their accrued Paid Time Off (PTO), if available, during their leave. The leave need not be taken on consecutive days or immediately following the reproductive loss event but must be taken within three (3) months of the event triggering the leave. A Leave of Absence Request Form, available on the InfoNet, must be submitted to HR within thirty (30) calendar days of leave. If the desired leave exceeds five (5) workdays per event or twenty (20) days in a twelve (12) month period, an employee may submit for consideration a request for Personal LOA pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence.

17. Other Leaves: See CalOptima Health Policy GA.8038: Personal Leave of Absence.

F. Except as required by federal or state law, or as necessary to protect the employee's safety in the workplace, CalOptima Health management and HR shall reasonably maintain the confidentiality, to the extent possible under the circumstances, of any employee requesting time off pursuant to a LOA described herein.

G. To the extent that this policy conflicts with CalOptima Health Policies GA.8038: Personal Leave of Absence, GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation, or GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, those specific policies shall supersede.

III. PROCEDURE

A. Reinstatement: When an employee is placed on a protected LOA, CalOptima Health shall make an effort to hold the employee's position open for the period of the approved leave, with the exception of Personal LOAs in which there is no guarantee of reinstatement. However, to meet business needs, CalOptima Health may need to fill such positions. If an employee's former position is unavailable when the employee returns promptly to work upon the expiration of an approved LOA, CalOptima Health shall make every effort to place the employee in a comparable position for which the employee is qualified. If such a position is not available, the employee will be offered the next suitable position for which the employee is qualified that becomes available. In addition, CalOptima Health will attempt to reasonably accommodate employees who are released for partial or modified duty. An employee who does not accept a position offered by CalOptima Health is considered to have voluntarily terminated employment, effective the day such refusal is made. Employees returning from a LOA related to the employee's own medical condition must obtain a release to return to work from their health care provider (where applicable) stating that they are able to resume work. CalOptima Health also reserves the right to require employees to participate in a fitness for duty examination at the expense of CalOptima Health prior to return to work.

B. Paid Time Off (PTO) accruals: PTO only accrues during the period an employee is on active duty or utilizing PTO for an approved LOA. Once an employee elects not to use PTO accruals or exhausts all PTO accruals, the remaining time off for an approved LOA shall not be considered time worked for purposes of accruing PTO hours.

C. Holidays: If a paid holiday occurs during the period an employee is on a LOA, the employee may be eligible for the holiday pay if PTO is being used for the LOA the day before and the day after the holiday and the holiday pay will be prorated based on the employee's full-time or part-time status as it was in effect prior to the LOA. If a holiday falls on a day in which the employee would have been regularly scheduled to work, the holiday will count against the employee's LOA entitlement.

D. Supplemental Compensation: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift Premium, Call Back or On Call Pay, Active Certified Case Manager (CCM) Pay, Internet Stipend, Commuter Allowance, Automobile Allowance, or Benefit Income during their LOA. An employee on a Continuous LOA may be eligible for Employer-Paid Member Contribution or Supplemental Retirement Benefit during any portion of a paid LOA but shall not be eligible if the LOA is unpaid. Executive incentives will be prorated to account for an executive's Personal LOA time period. Executives must be current employees during the pay period the executive incentive is paid out to be eligible to receive the incentive. Continuous LOA is leave that is taken continuously and not broken into separate blocks of time. Supplemental compensation will resume when the employee returns to an active status, and may be prorated, where applicable.

E. Outside employment: Employees may not engage in outside work for other employers, including self-employment, while on an approved LOA from CalOptima Health, unless specifically authorized under this Policy, such as for military service.

F. Documentation: Failure to provide all the required information and/or documentation within the requested or required timeframe may result in a delay in CalOptima Health's approval of the LOA request, CalOptima Health's denial of the employee's request for a LOA, and/or an impact to the employee's ability to take a LOA as requested.

G. Failure to return promptly: If an employee fails to return to work upon the expiration of an approved LOA and has not submitted required documentation and/or obtained an extension from HR prior to such expiration date, the employee will be considered to have voluntarily resigned. HR will process the employee's voluntary resignation effective three (3) consecutive scheduled workdays following the date the employee failed to return to work, or as soon as reasonably possible given the circumstances. It is the responsibility of the employee to ensure a request for an extended LOA is submitted timely with all required documentation in support of extending the LOA.

H. Misrepresentations: Misrepresenting reasons or information submitted when applying for a LOA may result in corrective action, up to and including termination.

I. Health benefits for PDL, FMLA, CFRA, Military Service or Workers' Compensation Leaves of Absence: Employer contributions towards an employee's health benefits (medical, vision, and dental) who is on leave pursuant to PDL, FMLA, CFRA, Military Service, or Workers' Compensation LOAs, will not continue beyond the FMLA/CFRA covered period pursuant to CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence. Employees may elect to purchase continuation of such health benefits coverage through COBRA. When an employee returns to work, the eligibility and accrual dates for such benefits may be adjusted to reflect the period of the LOA.

J. Other benefits: All other benefits not specified herein, provided by CalOptima Health, shall be administered according to HR procedures.

K. Eligibility and Specific Leave Requirements: Refer to specific CalOptima Health policies listed below for detailed information about eligibility and other leave requirements:

1. CalOptima Health Policy GA.8018: Paid Time Off (PTO);

2. CalOptima Health Policy GA.8038: Personal Leave of Absence;

3. CalOptima Health Policy GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation;

4. CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence; and/or

5. CalOptima Health Policy GA.8041: Workers' Compensation Leave of Absence.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Bereavement Leave Request Form
B. California Code, Education Code, §48900.1
C. California Code, Government Code, §12945.1 et seq. (CFRA)
D. California Code, Government Code, §19774-19775 (Military Service Leave)
E. California Code, Labor Code, §230 et seq. (Jury service and other leaves)
F. California Code, Military & Veterans Code, §395.10 (Military Service Leave)
G. CalOptima Health Policy GA.8018: Paid Time Off (PTO)
H. CalOptima Health Policy GA.8038: Personal Leave of Absence
I. CalOptima Health Policy GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation
J. CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence
K. CalOptima Health Policy GA.8041: Workers' Compensation Leave of Absence
L. CalOptima Health Policy GA.8059: Attendance and Timekeeping
M. Leave of Absence Request Form
N. Title 2, California Code of Regulations (C.C.R.), §7291.2 et seq. (Pregnancy Regulations)
O. Title 2, California Code of Regulations (C.C.R.), §7293.5 et seq. (Disability Regulations)
P. Title 29, Code of Federal Regulations (C.F.R.), Part 825 (FMLA Regulations)
Q. Title 29, United States Code (U.S.C.), §2601 et seq. (FMLA)
R. Title 38, United States Code (U.S.C.), §4301 et seq. (USSERA)

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
08/07/2014	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8037	Leave of Absence	Administrative
Revised	02/01/2014	GA.8037	Leave of Absence	Administrative
Revised	05/04/2017	GA.8037	Leave of Absence	Administrative
Revised	08/03/2017	GA.8037	Leave of Absence	Administrative
Revised	09/03/2020	GA.8037	Leave of Absence	Administrative
Revised	12/20/2021	GA.8037	Leave of Absence	Administrative
Revised	05/04/2023	GA.8037	Leave of Absence	Administrative
Revised	TBD	GA.8037	Leave of Absence	Administrative

IX. GLOSSARY

Term	Definition
Child-Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of their child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima Health.
Continuous Leave of Absence (LOA)	Leave that is taken continuously and not broken into separate blocks of time.
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.

Policy:	GA.8042
Title:	**Supplemental Compensation**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2011
Revised Date:	11/01/2023
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; ~~and~~
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

Back to Item

Back to Agenda

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, 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. 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 ~~an~~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~~/OneCare Connect~~ Community Partner and Senior (Sr.) Community Partner staff in the Member Outreach & Education Department shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare ~~and OneCare Connect programs~~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 ~~and OneCare Connect~~ program in accordance with the table in Paragraph II.I.2. below. No incentive will be paid for the first thirty (30) enrollments each month, regardless of how many enrollments are made under, at or over thirty (30). For enrollments over thirty (30), licensed Community Partner and Sr. Community Partner staff will be eligible to receive the incentive payment of one hundred sixty-five dollars ($165.00) for each new enrollment within that tier between thirty-one (31) – fifty (50). In other words, each tier is independent and does not alter the amount paid per enrollment in any other tier. For example, eligible staff who enroll fifty-three (53) members in a month will be eligible to receive payment based on the following calculation (from tier thirty-one (31) – fifty(50)) twenty (20) members multiplied by one hundred sixty-five dollars ($165.00), 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 ~~and OneCare Connect programs~~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.

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.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, ~~the~~ bilingual pay shall be established.

D. Translation Pay: If an eligible exempt employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay identified above will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.

E. Night Shift:

1. Night Shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) consecutive hours or more of work between 3:00 p.m. and 8:00 a.m.

~~1.~~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.

~~2.~~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. Sales Incentive Program

1. The OneCare~~/OneCare Connect~~ Community Partner and Sr. Community Partner staff, in the Member Outreach & Education Department, shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare ~~and OneCare Connect Programs.~~Program.

2. The Community Partner and Sr. Community Partner staff shall be eligible to receive sales incentive pay as described in Section II.I.1 of this Policy for successfully enrolling new members into the OneCare ~~and OneCare Connect Programs.~~Program. Sales incentive pay for the Manager, Member Outreach & Education, shall be based on the number of members enrolled into the OneCare ~~and OneCare Connect Programs~~Program by the Community Partner and Sr. Community Partner as described in Section II.I.2 of this Policy.

   a. CalOptima Health shall follow the Medicare Marketing Guidelines (MMGs) charge-back guidelines of ninety (90) calendar day rapid disenrollment and recouping the sales incentive with the exceptions as specified under the guidelines and applicable CalOptima 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 eligible employee enrolled the new member. However, the sales incentive is not earned until the member has been enrolled in the respective program for ninety-one (91) days.

   a. In the event a OneCare ~~or OneCare Connect~~ member disenrolls from their respective program within ninety (90) calendar days for reasons other than the exceptions specified under the guidelines and applicable CalOptima 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.

6. The Director, Network Management, Executive Director of Network Operations, and the Chief Operations Officer will review the sales incentive structure on an annual basis.

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

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
TBD	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

Action	Date	Policy	Policy Title	Program(s)
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	TBD	GA.8042	Supplemental Compensation	Administrative

1

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 Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to January 1, 2013, of another California public retirement system who is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to January 1, 2013, of another California public retirement system who is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
Central Worksite	CalOptima 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.
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 ~~a scheduled~~an authorized period of time off longer than five (5) days that ~~employees are~~an employee is to be away from their primary ~~jobs~~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 ~~or/ OneCare Connect~~ Program.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).
Threshold Language	For purposes of this policy, a threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

1

Policy:	GA.8042
Title:	**Supplemental Compensation**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2011
Revised Date:	11/01/2023
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

Back to Item

Back to Agenda

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, 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. 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.I.2. below. No incentive will be paid for the first thirty (30) enrollments each month, regardless of how many enrollments are made under, at or over thirty (30). For enrollments over thirty (30), licensed Community Partner and Sr. Community Partner staff will be eligible to receive the incentive payment of one hundred sixty-five dollars ($165.00) for each new enrollment within that tier between thirty-one (31) – fifty (50). In other words, each tier is independent and does not alter the amount paid per enrollment in any other tier. For example, eligible staff who enroll fifty-three (53) members in a month will be eligible to receive payment based on the following calculation (from tier thirty-one (31) – fifty(50)) twenty (20) members multiplied by one hundred sixty-five dollars ($165.00), 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.

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.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. Sales Incentive Program

1. The OneCare Community Partner and Sr. Community Partner staff, in the Member Outreach & Education Department, shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare Program.

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.

   a. CalOptima Health shall follow the Medicare Marketing Guidelines (MMGs) charge-back guidelines of ninety (90) calendar day rapid disenrollment and recouping the sales incentive with the exceptions as specified under the guidelines and applicable CalOptima 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 eligible employee enrolled the new member. However, the sales incentive is not earned until the member has been enrolled in the respective program for ninety-one (91) days.

   a. In the event a OneCare 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.

6. The Director, Network Management, Executive Director of Network Operations, and the Chief Operations Officer will review the sales incentive structure on an annual basis.

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

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
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TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
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Revised	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	TBD	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 Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to January 1, 2013, of another California public retirement system who is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to January 1, 2013, of another California public retirement system who is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
Central Worksite	CalOptima 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.
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 Programsand 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, Learningand 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.8057
Title:	**Compensation Program**
Department:	~~CalOptima Health Administrative~~Human Resources
Section:	~~Human Resources~~Not Applicable
CEO Approval:	
Effective Date:	05/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes CalOptima Health's pay philosophy and a compensation program for CalOptima Health's job classifications within clearly defined guidelines that promote consistent, competitive ~~and~~, equitable, and merit-based pay practices.

II. POLICY

~~A. CalOptima's compensation program~~CalOptima Health's pay philosophy is intended to~~:~~

~~1. Provide fair compensation based on organization and individual performance;~~

~~2. Attract~~ attract, retain, and motivate employees~~;~~

~~B.~~A. ~~Balance internal equity and~~ through market ~~competitiveness to recruit and retain qualified employees; and~~competitive, internally equitable, and merit-based pay practices.

~~1. Be mindful of CalOptima's status as a public agency.~~

~~C.~~B. The Chief Executive Officer (CEO), in conjunction with the ~~Executive Director of~~Chief Human Resources~~,~~ Officer (CHRO), is directed to administer the compensation program in consideration of CalOptima Health's status as a public agency and consistent with the attached Compensation Administration Guidelines, which ~~defines~~define the principles and procedures upon which ~~CalOptima's~~CalOptima Health's compensation practices will be managed~~, procedural aspects of how the compensation procedures will be administered,~~ and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay ranges and rates based on the market fiftieth (50th) percentile~~.~~ to ensure market competitiveness.

2. Determining appropriate pay rates within the pay range for a ~~position~~job title by assessing an employee's or applicant's qualifications (knowledge, skills, and abilities), such as in-position experience, related experience, and education, including degrees, licenses, certifications, and the pay rates currently being paid to similarly situated incumbents. Employees may be paid

Back to Item

Back to Agenda

anywhere on or within the pay range based on ~~proficiency levels. The following criteria shall be considered:~~job performance, qualifications, and internal equity.

~~Minimum (Min)~~	~~The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations~~
~~Midpoint (Mid) aka: 50th percentile~~	~~The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations~~
~~Maximum (Max)~~	~~The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance~~

3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, ~~unless the minimum job requirements are not met, then~~except when a training rate equal to ten percent (10%) below the ~~salary grade minimum may be used for six (6~~pay range minimum is offered and included in the job posting to allow candidates to meet the minimum requirements within twelve (12) months of hire.

4. Base pay for all employees shall be capped at the pay range maximum, and ~~once~~while an ~~employee reaches~~employee's pay is at the ~~base~~ pay range maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus distributed in two (2) installments, provided that the employee's performance warrants this additional compensation.

~~D.~~C. The CEO is authorized and directed to take all steps necessary and proper to implement the CalOptima Health's compensation program and the Compensation Administration Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

~~Not Applicable~~
A. 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
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors

03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health's Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	06/04/2020	GA.8057	Compensation Program	Administrative
Revised	TBD	GA.8057	Compensation Program	Administrative

~~IX. GLOSSARY~~

~~Not Applicable~~

Policy:	GA.8057
Title:	**Compensation Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	
Effective Date:	05/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes CalOptima Health's pay philosophy and a compensation program for CalOptima Health's job classifications within clearly defined guidelines that promote consistent, competitive, equitable, and merit-based pay practices.

II. POLICY

A. CalOptima Health's pay philosophy is intended to attract, retain, and motivate employees through market competitive, internally equitable, and merit-based pay practices.

B. The Chief Executive Officer (CEO), in conjunction with the Chief Human Resources Officer (CHRO), is directed to administer the compensation program in consideration of CalOptima Health's status as a public agency and consistent with the attached Compensation Administration Guidelines, which define the principles and procedures upon which CalOptima Health's compensation practices will be managed and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay ranges and rates based on the market fiftieth (50^{th}) percentile to ensure market competitiveness.

2. Determining appropriate pay rates within the pay range for a job title by assessing an employee's or applicant's qualifications (knowledge, skills, and abilities), such as in-position experience, related experience, and education, including degrees, licenses, certifications, and the pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere on or within the pay range based on job performance, qualifications, and internal equity.

3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, except when a training rate equal to ten percent (10%) below the pay range minimum is offered and included in the job posting to allow candidates to meet the minimum requirements within twelve (12) months of hire.

4. Base pay for all employees shall be capped at the pay range maximum, and while an employee's pay is at the pay range maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible

for merit pay delivered as a lump sum bonus distributed in two (2) installments, provided that the employee's performance warrants this additional compensation.

C. The CEO is authorized and directed to take all steps necessary and proper to implement the CalOptima Health's compensation program and the Compensation Administration Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

A. CalOptima Health Policy GA.8042: Supplemental Compensation

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
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Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	06/04/2020	GA.8057	Compensation Program	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	TBD	GA.8057	Compensation Program	Administrative

1

Back to Item

Back to Agenda

Compensation Administration Guidelines

Revised ~~June 04, 2020~~Month, Day, 2023

Implemented ~~March 29, 2020~~TBD

Contents

Pay Philosophy and Strategys

CalOptima Health's pay philosophy is intended to attract, retain, and motivate employees through market competitive, internally equitable, and merit-based pay practices. CalOptima Health's labor market is where we compete to hire employees and may include private, public, governmental, and/or non-profit healthcare and related industries. CalOptima Heath's salary structure is intended to be competitive in the labor market. Availability to fund and stewardship of public funds are also considered when determining the competitiveness of our salary structure and pay practices.

Administration Guidelines

These Compensation Administration Guidelines (Guidelines) are intended to support consistent, competitive, equitable, and merit-based pay practices to be administered by HR under the direction of the Chief Executive Officer (CEO). These Guidelines and CalOptima Health's pay practices are merit-based and do not discriminate based on political affiliation, race, color, creed, ancestry, national origin, sex (pregnancy or gender), sexual orientation, gender identity and expression, medical condition, genetic information, marital status, age (40 and over), mental or physical disability, military or veteran status, or other protected characteristics or activities. Except as permissible by law, CalOptima Health will not seek an applicant's' salary history information, nor will it rely on an applicant's salary history information as a factor in determining an offer of employment or in determining what salary amount to offer.

The CalOptima Health Salary Schedule, which includes, but is not limited to job titles, pay grades, job codes, and pay ranges is approved by the CalOptima Health Board of Directors (Board) and posted publicly on www.CalOptima.org and on the employee intranet. The minimum and maximum of the pay ranges will be included on all job postings and announcements and provided to an applicant applying for employment or to an employee upon their request. Human Resources (HR) will maintain records of job titles and salary rate history for every employee during the duration of the employee's tenure.

Compensation Authorization

The compensation of the CEO will be determined and approved by the Board.

The compensation of Executive Level Positions, which includes positions of executive director and above, will be recommended by the Chief Human Resources Officer (CHRO), approved by the CEO, and reported to the Board. Medical Director is not considered Executive Level Positions. Additional Executive Level Positions require Board approval.

The compensation of all other positions will be recommended by HR and approved by the CHRO or the CHRO's designee.

Salary Structure

The structure of the Salary Schedule establishes the spread between the minimums and maximums of the pay range for each pay grade, the difference between the pay range minimums, midpoints, and maximums from one pay grade to another, and the number of pay grades to be utilized, to support recruiting and retention of talent with competitive base pay.

The salary structure should be reviewed as needed and on a regular basis, such as annually or every other year, to assess current market competitiveness. A comparison of CalOptima Health's pay grade midpoints to the market benchmark job titles is used to determine market competitiveness. The following criteria may be used to determine market benchmarks:

- Job titles with benchmarks commonly found in the marketplace
- Job titles with above average separation rates (high turnover not due to promotion)
- Job titles with above average recruiting efforts and expenses
- Job titles with above average time to fill
- Job titles with job offer rejections and candidate counter offers
- The top ten (10) highest populated jobs
- Market-sensitive jobs
- Two (2) job titles from every pay grade where available

Any jobs ~~Pay Administration Guidelines ..... 3~~

~~Pay Administration Guidelines~~

~~*Common pay administration guidelines for CalOptima are detailed in this section. These Guidelines help maintain the integrity of the base pay program by introducing a common set of standards and assist managers in ongoing compensation program administration.*~~

~~In addition, note the following administration of the Guidelines:~~

- ~~Chief Executive Officer (CEO) compensation will be established by the Board of Directors.~~
- ~~Chief and Executive Director compensation will be established by the CEO within the Guidelines.~~

for which market data is not available can be slotted into the salary structure based on internal pay equity considerations to peer positions. Based on market findings and internal pay equity considerations, the CHRO may recommend to the CEO that the pay grades, pay ranges, job titles, and/or pay grade assignments captured in the Salary Schedule be adjusted. A recommendation from the CEO to the Board and Board approval is required to make any revisions to the Salary Schedule.

- ~~The Board will be informed of all Chief and Executive Director hires and compensation changes.~~

~~Proposed Pay Administration Guidelines~~

~~Pay ranges and pay levels~~	~~Pay range target~~ ~~Range minimums and maximums~~ ~~Pay above range maximums~~ ~~Pay range thirds~~ ~~Pay range halves~~ ~~Compa-ratio~~
~~Periodic pay adjustments/increases~~	~~New hire/Rehire~~ ~~Promotion~~ ~~Lateral Transfer~~ ~~Demotion~~ ~~Temporary Assignment~~ ~~Secondary job~~ ~~Job Re-evaluation~~ ~~Appeal Process~~ ~~Register/Certified Status~~ ~~Base pay program maintenance~~ ~~Salary structure adjustment~~ ~~Annual competitive assessment~~ ~~Market sensitive jobs~~
~~Annual pay adjustments/increases~~	~~Market Adjustment~~ ~~Merit pay~~ ~~Step increase~~
~~Special one-time pay considerations~~	~~Recruitment incentive~~

Pay Grades,

1

Ranges and ~~Pay~~ Levels

~~**Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects**~~**Pay Grade**: An identifier of ~~**the job's requirements and performance expectations.**~~

~~For benchmark jobs, the~~a pay range ~~(i.e.~~in the Salary Schedule. Each job classification (job title) is assigned to a pay grade~~) is determined based on the comparability of values between market median base pay rates and the~~ . Jobs with similar pay range targets are assigned the same pay grade, with the same pay range.

Range Target $40.0 is Closest to Market Median of $41.5; job is assigned to Pay Range A

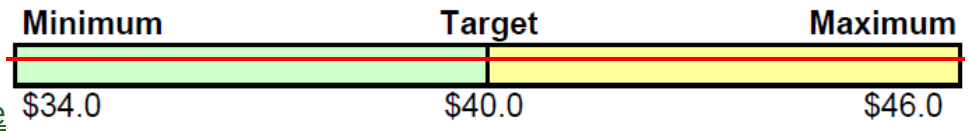
~~For non-benchmark jobs, the~~**Pay Range:** A pay range is the minimum and maximum of the pay grade and every amount between minimum and maximum.

Pay~~determined based on comparability~~ **Range Target:** The pay range target is the midpoint of the pay range and is intended to reflect the market rate paid to employees whose qualifications surpass the minimum requirements of the job~~ to benchmark jobs within the same job family or other~~, which may include internal ~~positions in terms of knowledge, skills, complexity and organizational impact~~and/or external experience performing the job duties and responsibilities of the job.

Table 1.

Pay Grade	Minimum	Midpoint (Target)	Maximum
A	$41,600	$46,100	$50,600
B	$42,432	$48,716	$55,000
Market Median Base Salary:		$47,000	

Example: Market Median for a Data Entry Tech is $47,000. The Range Target of $46,100 is closest to Market Median of $47,000; job title would be assigned to Pay Range A.



Note

Pay Grades A and B overlap across their pay ranges by design. An employee in pay grade A may have a higher base pay than an employee in pay grade B. For example, a staff member with extensive experience and/or education can earn more than their supervisor when their supervisor is new to the role.

Data Entry Tech would display on the Salary Schedule as such:

Table 2.

Job Title	Pay Grade	Minimum	Midpoint (Target)	Maximum
Data Entry Tech	A	$41,600	$46,100	$50,600

Pay Range Minimum: ~~represents~~The pay range minimum is the least amount paid to employees whose job titles are assigned to the pay grade.* The pay range minimum is intended to reflect the rate paid to ~~individuals possessing the minimum job~~ employees whose qualifications ~~and meeting~~align with the minimum requirements of the job ~~performance expectations~~.

All employees should have a pay rate equal to or greater than the pay range minimum. When the minimum of the pay range is increased and employees' pay rates fall below the minimum of the adjusted pay range, the employees' pay rates will be brought to the minimum of the new pay range in the pay period the new pay range is effective. Adjustments to pay range minimums occur prior to merit pay calculations.

- ~~If the minimum job requirements are not met,~~HR may post a recruitment as a training position, allowing candidates to meet the minimum requirements within twelve (12) months of hire.

- *A training rate equal to ten percent (10%) below the ~~salary grade~~ minimum of the pay grade range may be used ~~for six (6) months while a new~~ until the incumbent ~~is learning the skills to become proficient in the new role.~~meets the minimum experience requirements within the twelve (12) month period.

Pay Range Maximum: ~~**represents the maximum**~~ The pay range maximum is the greatest amount paid to employees whose job titles are assigned to the pay grade. The pay range maximum is intended to reflect the rate paid to ~~**individuals who possess**~~employees whose qualifications significantly ~~**above market norms and consistently deliver superior performance**~~surpass the minimum job requirements and typically include internal and/or external experience performing the job duties and responsibilities of the job.

Base pay ~~growth~~ is capped at the pay range maximum; therefore, employee base pay is not increased beyond the pay range maximum of the assigned pay grade.

Pay Above Range Maximum: Employees are not ~~**paid above the range maximum.**~~assigned pay above the pay range maximum. In rare cases where employees' pay becomes above the pay range maximum, typically due to an adjustment made to the pay grade that resulted in a decrease to the pay range maximum, the following applies:

- Employees whose current pay becomes at or above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.

- ~~In lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation.~~

- As the pay structures and pay ranges ~~move every twelve (12) – thirty-six (36) months or as necessary, the~~increase, employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases again, as appropriate.

~~**Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable, and appropriate pay levels**~~

- ~~Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations.~~

- ~~Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate one hundred percent (100%) proficiency in all aspects of the job's duties, responsibilities and performance expectations.~~

- ~~Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills, or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities, and performance expectations.~~

~~Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness.~~

- ~~Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target.~~

- ~~Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate.~~

- ~~Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target.~~

- ~~Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target.~~

~~Illustrative Range Shown Below:~~

	Minimum	Target	Maximum
~~*Compa-Ratio RNs*~~	~~87.5%~~	~~100.0%~~	~~117.0%~~
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Employee Base

~~Note~~*: ~~Range minimums and maximums will be based on the developed salary range spreads.~~*

~~Annual~~ Pay Adjustments~~/Increases~~

Market Adjustment: ~~A market adjustment is an~~ An increase or decrease to an employee's base pay ~~range grades based on~~due to internal pay equity and/or market ~~pay practices.~~competitiveness.

Upon recommendation from the CHRO and approval of the CEO, a market adjustment up to the maximum of the employee's pay range may be granted to maintain market competitiveness and internal pay equity.

- ~~A~~ A market adjustment may result in base pay increases for full-time, part-time, and some as-needed and limited term staff ~~paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target).~~

  - ~~For some market-sensitive jobs, a market adjustment may also be granted to full-time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression.~~

~~A market adjustment may result in a base pay increase to some staff to ensure employees are~~ . When the salary schedule is adjusted, employees will be paid a base pay rate at least equal to the new pay range minimum when the employee meets all the minimum requirements of the position.

  - ~~If a market adjustment is made, employees~~Employees paid below the ~~new~~pay range minimum will receive an increase ~~to~~in their base pay to ensure it is at least equal to the pay range minimum of their grade. Move to pay range minimum occurs before any ~~merit pay is awarded (cap at 10%).~~

- ~~The appropriateness of a market~~other adjustment ~~is determined based on:~~

  1. ~~A competitive assessment~~to base pay such as merit pay or cost of ~~the pay range target versus market base pay practices;~~

  2. ~~Market trends and practices relative to average base pay and pay range increases; and~~

  3. ~~Current recruiting and retention issues.~~

living adjustment (COLA). Market adjustments are made prior to determining merit pay. Market adjustment effective dates are not delayed based on an employee's leave status.

- ~~Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target.~~

~~Base~~Merit Pay Adjustment: ~~All~~Merit pay recognizes employees' job proficiency and performance. All regular employees who achieve a satisfactory level or higher of performance will be eligible for a merit pay adjustment.

- ~~Merit Pay: Merit pay is variable pay that typically affects employees' base pay; it recognizes employees' job proficiency and performance of job duties.~~

Merit pay is applicable to full-time and part-time employees ~~paid below, at, or above the pay range target; Per diem~~, including employees in temporary assignments paid anywhere in the pay range. Limited term, as needed, paid interns, extra help, and temporary agency employees are not eligible for merit pay.

~~To be eligible for merit pay, the~~An employee must have started ~~work~~employment at CalOptima Health on or before March 31 to be eligible for a merit pay increase in July of the same year and ~~have successfully completed the introductory period [three (3) months for transfers and new hires] prior to the annual pay adjustment date.~~achieved an overall satisfactory or higher rating on the annual performance review.

Merit pay will typically be an increase to base pay; however, it may also be delivered as ~~a one-time~~ lump sum bonus for individuals paid ~~above the pay range maximum.~~at or above the pay range maximum. Merit lump sum bonuses are not considered regular or special compensation under CalPERS regulations (Gov. Code section 20636). CalOptima Health is not able to report lump sum bonuses as compensation earnable.

The budgeted amount for merit pay, if any, is based on 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and~~,~~ 4) recruiting and retention issues.

~~Merit Pay – Staff Paid At and Above Pay Range Target~~

- ~~The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity.~~

Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked during the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year. When prorating merit pay for employees who leave and are rehired within the same review year, the rehire date is used. Service prior to rehire date is not included in merit proration.

  - ~~Managers have the discretion to determine the actual increase amount within the published Guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives.~~

Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and ~~also~~ receive a lump sum amount for the remaining portion of the merit pay. Employees paid at or over the pay range maximum may be eligible to receive merit

pay as a lump sum payment paid out in two (2) incremental amounts - the first half when merit pay is normally distributed; and the second half six (6) months later. Incumbents must be employed with CalOptima Health at time of distribution to receive the merit lump sum.

- Employees who did not achieve an overall satisfactory level of performance are not eligible for merit pay. Merit pay may be held withheld altogether or delayed for ninety (90) days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning the employee is active not in their record.

Merit pay is typically awarded once a year good standing as of March 31. On or before the conclusion of the ninety (90) days, the supervisor must notify HR as to whether the employee should be granted a merit pay increase to be processed at a specific time the start of the next applicable pay period.

Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at in the same time. pay period.

Merit pay is typically effective the beginning of the start of the pay period that includes July 1.

Employees on a leave of absence who are eligible for merit pay will receive the adjustment effective the beginning of the start of the pay period that includes July 1. Merit pay is not delayed based on an employee's leave status.

Executive Directors and Chief's Chiefs must approve merit pay increases for all areas for which they are responsible before submitting to HR. HR has final approval of all merit increases.

- HR has final approval of all merit increases.

A Merit Pay **Grid** Matrix similar to the one shown below** [**assumes** displaying a three and a half percent (3.5%) merit increase budget] is **often** used to provide **managers** supervisors with a **guideline as to** sample of what merit pay increase may be **appropriate** awarded based upon performance and **to reflect:**
an employee's

1. The organization's financial status;

Market trends relative to average base pay increases; within the pay range.

2. Competitiveness of current base practices; and

3. Recruiting and retention issues.

	Pay Range Position					
Performance Rating	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Above Max	Above Max = Lump Sum Bonus
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%	
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%	
Needs Improvement	0%	0%	0%	0%	0%	

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Performance Score Low	-	Performance Score High	Q1	Q2	Q3	Q4	Above Max
4.30	-	5.00	5.55%	4.95%	4.60%	4.50%	4.50%
4.00	-	4.29	5.30%	4.70%	4.35%	4.25%	4.25%
3.61	-	3.99	4.65%	4.35%	4.10%	4.00%	4.00%
3.31	-	3.60	4.40%	4.10%	3.85%	3.75%	3.75%
3.00	-	3.30	4.15%	3.85%	3.60%	3.50%	3.50%
2.90	-	2.99	3.30%	3.20%	3.10%	3.00%	3.00%
2.51	-	2.89	1.50%	1.25%	1.00%	0.75%	0.75%
0.00	-	2.50	0.00%	0.00%	0.00%	0.00%	0.00%

**This* Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

- ~~Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay.~~

- ~~The increase may be withheld altogether or delayed ninety (90) days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be retroactive; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase.~~

- ~~Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above.~~

~~Special One-time Pay Considerations~~

~~Recruitment Incentive~~

- ~~Recruitment incentives up to fifteen percent (15%) of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima.~~
    - ~~Recruitment incentives require the approval of the CEO.~~
    - ~~Board approval is required for recruitment incentives offered to Executive Director and above positions.~~

~~Incentives are provided with a "pay-back" provision if the employee terminates within twenty four (24) months of hire.~~

New Hires/Rehires

- A new hire's pay level corresponds to the appropriate pay range quartile and typically should not exceed the pay range target. Offers above the pay range target require the approval of the Executive Director of Human Resources and the CEO, when necessary.

- Factors to be considered in determining an appropriate pay level for a new hire include:

  - Job-related experience: What is the estimated learning curve given the individual's prior work experience? How many years of experience does the individual have in the same or equivalent classification?

  - Market conditions: What is the going rate of pay in the external market for the individual's skills and knowledge?

  - Internal equity: Is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service.

  - For example, an RN having three (3) years of prior job experience is viewed comparably to an RN having three (3) years of job experience at CalOptima.

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions.

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications.

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate).

- Determine appropriate pay rate by assessing candidate's knowledge, skills, and experience, as well as pay rates currently being paid to similarly situated incumbents.

- Candidates with superior knowledge, skills, and experience can be paid above the pay range midpoint. Starting pay rates above the pay range midpoint must have approval of the Executive Director of Human Resources and CEO, when necessary.

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical).

- Pay rates for all positions are reviewed with the Compensation Unit before an offer is made. The Compensation Unit will review internal equity across the system to ensure that the appropriate offer is made.

- Rehires to the same classification should be paid at least the same amount they earned prior to termination, with adjustments and/or credit for recent additional career experience

~~or education earned while away from CalOptima.~~

- ~~The above policy applies to the current organization structure.~~
- ~~Additional positions at the level of Chief or Executive Director require Board approval.~~

~~Promotion~~

~~An employee receives a promotion when the employee applies for and is selected for a job with a higher pay range target.~~

- ~~An employee will receive a promotional increase to at least the pay range minimum of the new pay range.~~

- ~~The amount of a promotional increase will be determined based on the incumbent's qualifications, performance, and internal pay practices. The typical promotional increase for a promotion without external competition is up to five percent (5%) of the employee's base pay per one (1) pay grade increase.~~

- ~~Typically, the promotional increase should not exceed the pay range target.~~

- ~~When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.~~

- ~~The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.~~

- ~~Employees who are promoted after March 31, but prior to receiving their merit increase, will have their merit increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance evaluation rating and therefore merit increase amount is not known at the time the promotional pay is being calculated, a merit increase equivalent to "Fully Meets Expectations" will be included in the base pay used to calculate their promotional pay.~~

- ~~The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.~~

~~Lateral Transfer~~

~~It is considered a lateral transfer if an employee moves to a job having the same pay range target.~~

- ~~Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the Executive Director of Human Resources.~~

- ~~Employees who are laterally transferred after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.~~

~~Demotion~~

~~An employee is classified as having been demoted if the employee moves to a job with a lower pay range target.~~

- ~~The pay of an employee demoted due to an organizational restructure, will not be decreased unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.~~

- For an involuntary demotion, due to performance, or for a voluntary demotion, the pay grade of the demoted employee will be assigned to the pay grade of the employee's new classification. The employee's base pay will typically be reduced up to five percent (5%) for each pay grade demoted.

- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.

- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.

- Employees who are demoted after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Temporary Assignment

An employee who is asked to assume a full-time temporary assignment in a job having a higher pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase.

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate.

- This increased secondary pay rate is eliminated when the temporary assignment ends.

- The amount of the temporary assignment increase should be consistent with the promotion policy.

~~**Training/Transition Overlap**~~

~~In order to provide for a transition and/or training period, CalOptima may fill a regular position with a replacement in advance of the separation of a terminating employee. For the transition and/or training period, two employees may fill the same budgeted position for up to thirty (30) calendar days during the period of overlap. The immediate supervisor will determine which employee will be designated for decision-making and regulatory reporting purposes, if applicable.~~

~~**Job Re-Evaluations**~~

~~Job re-evaluations will be reviewed in the following priority order:~~

~~1. New Positions.~~

~~2. Change of thirty-five percent (35%) or more of duties [any change in responsibilities less than thirty-five percent (35%) will not be considered].~~

- ~~Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification.~~
- ~~Additional duties that do not require the above will not be considered for reclassification.~~
- ~~All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation Unit.~~
- ~~In the case of management positions being re-classified, the appropriate Chief must sign the documentation.~~
- ~~The request must include the incumbent's current job description and revised job description with enhancements highlighted.~~

Cost of Living Adjustment: Annually, HR will identify the over-the-year percent change in the Consumer Price Index (CPI) from a blend of regional metropolitan areas (e.g., Los Angeles-Long Beach-Anaheim and Riverside-San Bernardino-Ontario). Availability to fund a cost-of-living adjustment (COLA) and competitiveness of our salary structure and pay practices are also reviewed and considered. Upon which, HR may recommend a COLA to base pay for evaluation by the Chief Financial Officer (CFO) and recommendation to the Board by the CEO. COLA adjustments are typically provided to all employees in the pay period following approval by the Board and are not retroactive. Employees at or above pay range maximum will not receive a COLA base pay adjustment. They may receive COLA adjustment as a lump sum bonus. COLA adjustment to base pay is not delayed based on an employee's leave status, lump sum bonus is paid upon return from leave of absence.

- ~~The request must also include justification that the re-classification supports a business need.~~

~~**If the job is determined to be a priority, the Compensation Unit will analyze the job according to:**~~

1. ~~The job's scope against other jobs in the same discipline.~~

2. ~~Available market data.~~

3. ~~Appropriate title identification. The Compensation Unit will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended.~~

4. ~~Job family.~~

5. ~~Fair Labor Standards Act (FLSA) status.~~

6. ~~Appropriate pay grade – the job will be fit into one (1) of the pay grades that currently exists. No new pay grades created.~~

7. ~~A pay rate will be determined.~~

8. ~~A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager.~~

~~If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date. The manager will be informed of the decision to move the job to a higher pay grade by the Compensation Unit. The amount of the pay increase should follow the guidelines in the Promotion section. If the upgrade and a pay change occur less than six (6) months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated.~~

~~If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director of Human Resources.~~

~~If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed.~~

~~If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed.~~

~~Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one (1) month of the request.~~

~~If a job is not a priority or does not meet the guidelines, the manager will be notified.~~

Base Pay Program Maintenance

Salary Structure Adjustment

The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness.

- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate, and retain the workforce.

- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data.

- Market adjustments will be applied to the salary schedule as needed at least every two (2) years, using surveyed salary structure adjustment percentages.

- The salary structure adjustment approval process includes:

  - The Executive Director of Human Resources makes a recommendation to the CEO for approval.

  - CEO takes the recommendation to the Board for final approval.

Annual Competitive Assessment

- On a regular basis either annually or every other year, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices.

  - CalOptima will on a regular basis either annually or every other year spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates.

  - Based on market findings, the pay grade and ranges will be updated.

  - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations.

- The results of these analyses, along with CalOptima's current financial performance and economic situation, will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets.

- The following criteria is typically used to determine which jobs to market price each year:

  - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues.

  - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and

expenses to identify jobs with potential recruiting issues.

- Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues.

- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%.

- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%.

- Review all market-sensitive jobs and those on the "watch list."

- Review top ten (10) highest populated jobs on an annual basis.

- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced.

- It is recommended that at least two (2) jobs be selected from every pay range.

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends.

- On a regular basis either annually or every other year, the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments.

- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process.

    - Adjustments to pay range minimums occur prior to merit pay calculations.

Process for Making Market Adjustments

- HR performs, on a regular basis either annually or every other year, a review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs.

- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues.

- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount.

- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.).

- HR identifies the cost implications for the market adjustment by identifying the difference between 1) current pay rates and new pay range minimums, and, 2) current pay rates.

- The market adjustment approval process will work as follows:

    - The Executive Director of Human Resources recommends an adjustment to the CEO for approval.

    - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the classification as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruitingrecruitment and retention challenging.

Premium pay is built into the pay range targets for these jobs.

- Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.

    - The desired market target rate is established on a job-by-job basis to reflect specific market conditions.

Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:

- Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.

- Job offer rejections – statistics will illustrate an increase in the number of employmentjob offers rejected due to low starting ratesby candidates.

- Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to six (6eighteen (18) months; turnover. Turnover for the job will be compared to historical results for the same job and/or to other similarly- situated jobs.

- Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:

    - aA year-to-year market rate increase significantly greater than the average year-to-

year increase for other jobs analyzed~~,~~.

~~a~~A competitive market rate significantly higher [~~approximately~~ typically ten percent (10~~%)~~]%) than its current ~~pay range target,~~midpoint] or

- a competitive market rate with significantly higher pay practices [~~approximately~~ typically ten percent (10%)] in the labor market than the average of current internal pay practices.

~~▪ When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.~~

Jobs classified as market-sensitive are reviewed at least annually to determine if this status still applies.

Once a job is classified as market-sensitive, it typically remains classified as ~~such~~market-sensitive for not less than one (1) year or until the recruiting and retention challenges subside and/or the market pay rates adjust themselves~~—~~. When a job is no longer considered market-sensitive, the job's premium pay is no longer applicable; however, no change is typically ~~not less than one (1) year~~made to the employees' base pay rates at this time.

~~○ When a job is no longer considered market-sensitive, the job's pay range and grade is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.~~

Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are ~~placed on a "watch list" and monitored~~monitored. If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

Special One-time Pay Considerations

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, the CEO may award a retention incentive consistent with CalOptima Health Policy GA.8042: Supplemental Compensation.

Recruitment Incentive: Recruitment incentives may be utilized to entice a candidate to join CalOptima Health. The CHRO may present the circumstances and recommendation for a recruitment incentive to the CEO for approval consistent with CalOptima Health Policy GA.8042: Supplemental Compensation.

Pay Upon Hire/Rehire

Compensation is merit-based in consideration of the job requirements and responsibilities, market conditions, the applicant's qualifications, and internal pay equity. Factors to be considered in determining pay for new hires and re-hires include:

- The pay grade and pay range of the job.

- The candidate's job-related qualifications (knowledge, skills, and abilities), such as in-position experience, related experience, and education, including degrees, licenses, and certifications. At hire, external service is typically valued comparable to internal service.

    - For example, three (3) years of prior job experience is viewed comparable to three (3) years of job experience at CalOptima Health.

- Job designation as Market Sensitive, as described in these Guidelines.

- Internal pay equity – compensation of incumbents performing substantially similar work.

Starting pay rates cannot be below the minimum of the pay range (unless it is viewed as a training rate).

Pay rates for all positions are prepared by HR before a job offer is extended. HR will review internal and external equity to support CalOptima Health's pay philosophy and strategy.

Pay Upon Promotion

An employee receives a promotion when the employee is selected for a job with a higher pay grade. Selection for a job with a higher pay grade may occur through a recruitment or when reclassified into a job with a higher pay grade through a job re-evaluation.

An employee who has been promoted will be paid at least the minimum of the new pay range. In addition to performance, pay upon promotion will be determined based on the following:

- The pay grade and pay range of the job.

- The employee's job-related qualifications (knowledge, skills, and abilities), such as in-position experience, related experience, and education, including degrees, licenses, and certifications.

- Job designation as Market Sensitive, as described in these Guidelines.

- Internal pay equity – compensation of incumbents performing substantially similar work.

The pay determination may result in an increase or no change to the pay of an employee who is promoted. In rare cases, the pay determination may result in a decrease to the pay of an employee who is promoted, to ensure internal pay equity.

Employees who are promoted after March 31, but prior to receiving their merit pay increase, will have their merit pay increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance review rating and therefore merit pay increase amount is not known and/or approved at the time the promotional pay is being calculated, a merit increase equivalent to an "Exceeds Expectations" performance rating will be included in the base pay used to calculate their promotional pay. The merit matrix from the prior fiscal year will be referenced when determining the merit increase percentage.

The pay rate adjustment, if any, will be effective on the first day in which the promotion takes effect.

Pay Upon Lateral Transfer

An employee receives a lateral transfer when the employee is selected for a different job with the same pay grade through a recruitment or when placed into a job with the same pay grade through a job re-classification, organizational restructure, reasonable accommodation, or corrective action.

An employee who has been laterally transferred will be paid at least the minimum of the pay range. In addition to performance, pay upon transfer will be determined based on the following:

- The pay grade and pay range of the job.
- The employee's job-related qualifications (knowledge, skills, and abilities), such as in position experience, related experience, and education, including degrees, licenses, and certifications.
- Job designation as Market Sensitive, as described in these Guidelines.
- Internal pay equity – compensation of incumbents performing substantially similar work.

The pay determination may result in a decrease, increase, or no change to the pay of an employee who is transferred.

A transfer does not affect how future merit pay increases and/or market adjustments are awarded. The pay rate adjustment, if any, will be effective on the first day of the pay period in which the transfer takes effect.

Pay Upon Demotion

An employee receives a demotion when the employee is selected for a job with a lower pay grade through a recruitment or when placed into a job with a lower pay grade through a job re-classification, organizational restructure, reasonable accommodation, or corrective action.

An employee who has been voluntarily or involuntarily demoted will be paid at least the minimum of the new pay range. In addition to performance, pay upon demotion will be determined based on the following:

- The pay grade and pay range of the job.
- The employee's job-related qualifications (knowledge, skills, and abilities), such as in position experience, related experience, and education, including degrees, licenses, and certifications.
- Job designation as Market Sensitive, as described in these Guidelines.
- Internal pay equity – compensation of incumbents performing substantially similar work.

The pay determination may result in a decrease or no change to the pay of an employee who is demoted. In rare cases, the pay determination may result in an increase to the pay of an employee who is demoted, to ensure internal pay equity.

A demotion does not directly affect how future merit pay increases and/or market adjustments are awarded. The pay rate adjustment, if any, will be effective on the first day in which the demotion takes effect.

Temporary Upgrade Appointments ~~Pay Upon Temporary Appointment~~

An employee who is appointed to a job having a higher pay grade for limited duration 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.

1. Temporary Upgrade Pay:

    a. An employee in a temporary upgrade assignment will maintain their regular base pay. Temporary upgrade pay will be a separate premium amount paid in a lump sum based on regular hours worked per pay period (excluding overtime).

    b. Temporary upgrade pay will be the minimum of the new pay range or a five percent (5%) of base pay increase, whichever is greater. The premium will be effective on the first day of the pay period in which the temporary upgrade appointment takes effect.

    c. Temporary upgrade pay is supplemental compensation above regular base pay to compensate for business needs under CalOptima Health Policy GA.8042 (Supplemental Compensation).

    d. Temporary Upgrade Pay is considered premium pay pursuant to Title 2 California Code of Regulations (CCR) Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS classic members.

e. Temporary Upgrade Pay is eliminated when the temporary appointment ends.

2. Duration of Temporary Upgrade Appointments:

~~Temporary upgrade appointments shall not exceed 960-hours.~~ ~~An employee who assumes a full-time temporary appointment in a job having a higher pay grade is eligible for a temporary base pay increase. The employee must meet minimum requirements for the position and assume most or all the essential job functions and responsibilities of the new job to qualify for a temporary assignment pay increase.~~

a.

~~The employee's base pay prior to the temporary appointment will be maintained and the higher temporary assignment will be added as a secondary job title and pay rate. This temporary assignment pay rate is eliminated when the temporary assignment ends.~~

~~The amount of the temporary appointment increase should be consistent with the Pay Upon Promotion section of these Guidelines. The pay rate adjustment, if any, will be effective on the first day in which the temporary assignment takes effect. Temporary appointments shall not be continued for more than six (6) months from date of appointment unless an extension of no more than one (1) year from the original date of the temporary appointment is recommended by the CHRO and approved by the CEO.~~

Training/~~-~~Transition Overlap

To provide for a transition and/or training period, CalOptima Health may fill a regular position with a replacement in advance of the separation of a terminating employee or in advance of returning an employee from a temporary assignment to their former position. For the transition and/or training period, two employees may fill the same budgeted position for up to thirty (30) calendar days during the period of overlap. The immediate supervisor will determine which employee will be designated for decision-making, timesheet approval, and regulatory reporting purposes, if applicable.

Job Re-Evaluations

A job re-evaluation is the study of an employee's current job duties and responsibilities in comparison to the job description of their current job classification. The results of a job re-evaluation may be a job re-classification to a new job title with a higher, lower or same pay grade, reassignment of duties, or other administrative actions to resolve substantive discrepancies between the employee's job duties and those described in the job description. A job re-evaluation study may be appropriate when a position's job duties and responsibilities have changed over time as to become out of alignment with the current job classification.

- Re-classification to a higher pay grade must require a higher level of skills, abilities, scope

of authority, autonomy, and/or minimum qualifications for a period of one (1) year to be eligible for a re-evaluation.

- A change in job duties and responsibilities of thirty-five percent (35%) or more is typical in considering whether a job re-evaluation is to be conducted.

- Employee can only be re-evaluated into a job title that currently exists on the Salary Schedule.

- Employee must meet the minimum requirements of the re-classified position as stated in the job description.

- Employee has worked in their current position for at least one (1) year prior to the re-evaluation request date.

- Re-evaluations cannot be used to fill a job vacancy.

- The proposed position exists in a similar job series, hierarchy, or growth progression.

- All requests for job re-evaluations must be signed by the department director; department Chief must sign if request to be re-classified to management classifications.

The request must also include justification that the ~~If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.~~

- job re-evaluation supports a business need.

- The request must include the incumbent's current job description and revised job description with the change in responsibilities highlighted and percentage of time spent performing the change in responsibilities assigned (total responsibilities not to exceed 100%).

Salary Schedule Revisions

Outside of the cyclical market studies performed by HR, department directors may request a review to add, remove, or revise a job title, and/or reassign the pay grade of an existing job title.

All requests must be approved by the by the department executive prior to submission to HR. Submissions must include a business justification and supporting documentation e.g., reorganization plan, strategic plan, or specific recruitment/retention concerns.

After review and study of the request and in the event that a revision is approved by HR and requires a change to the Salary Schedule, HR will inform the director. It will be held by HR until such time that the Salary Schedule is scheduled to be presented to the Board of Directors.

Compensation Terms

Term	Definition
Base Pay	Base pay is a fixed amount paid to an employee in exchange for time and services most often expressed as an hourly rate or annual salary. It does not include benefits, allowances, or other supplemental compensation.
Internal Pay Equity	The compensation of employees performing the same work is paid consistently based on qualifications and performance.
Merit Pay	A performance-based increase to an employee's base pay or lump sum bonus.
Pay Grade	An identifier of a pay range in the Salary Schedule. Each job classification (job title) is assigned to a pay grade. Jobs with similar pay range targets are assigned the same pay grade with the same pay range.
Pay Range	The minimum and maximum of the pay grade and every amount between minimum and maximum.
Pay Range Maximum	The pay range maximum is the greatest amount paid to employees whose job titles are assigned to the pay grade. The pay range maximum is intended to reflect the rate paid to employees whose qualifications significantly surpass the minimum job requirements and typically include internal and/or external experience performing the job duties and responsibilities of the job.
Pay Range Midpoint	Typically, the middle amount of the pay range, equidistant to the range minimum and range maximum and aligned to the market value for the job classification. The pay range target is intended to reflect the market rate paid to employees whose qualifications surpass the minimum requirements of the job, which may include internal and/or external experience performing the job duties and responsibilities of the job.
Pay Range Minimum	The least amount paid to employees whose job titles are assigned to the pay grade. The pay range minimum is intended to reflect the rate paid to employees whose qualifications align with the minimum requirements of the job.
Pay Range Target	The pay range target is typically the midpoint of the pay range and is intended to reflect the market rate for the job. The pay range target aligns to employees whose qualifications surpass the minimum requirements of the job and may include internal and/or external experience performing the job duties and responsibilities of the job.
Percentile	A point on a rank-ordered scale, found by arranging a group of data points in order of magnitude from lowest to highest. The first percentile approximates the very lowest number found, while the 100th percentile is the very highest.

Compensation Administration Guidelines

Revised Month, Day, 2023

Implemented TBD

Contents

Pay Philosophy and Strategy

CalOptima Health's pay philosophy is intended to attract, retain, and motivate employees through market competitive, internally equitable, and merit-based pay practices. CalOptima Health's labor market is where we compete to hire employees and may include private, public, governmental, and/or non-profit healthcare and related industries. CalOptima Heath's salary structure is intended to be competitive in the labor market. Availability to fund and stewardship of public funds are also considered when determining the competitiveness of our salary structure and pay practices.

Administration Guidelines

These Compensation Administration Guidelines (Guidelines) are intended to support consistent, competitive, equitable, and merit-based pay practices to be administered by HR under the direction of the Chief Executive Officer (CEO). These Guidelines and CalOptima Health's pay practices are merit-based and do not discriminate based on political affiliation, race, color, creed, ancestry, national origin, sex (pregnancy or gender), sexual orientation, gender identity and expression, medical condition, genetic information, marital status, age (40 and over), mental or physical disability, military or veteran status, or other protected characteristics or activities. Except as permissible by law, CalOptima Health will not seek an applicant's salary history information, nor will it rely on an applicant's salary history information as a factor in determining an offer of employment or in determining what salary amount to offer.

The CalOptima Health Salary Schedule, which includes, but is not limited to job titles, pay grades, job codes, and pay ranges is approved by the CalOptima Health Board of Directors (Board) and posted publicly on www.CalOptima.org and on the employee intranet. The minimum and maximum of the pay ranges will be included on all job postings and announcements and provided to an applicant applying for employment or to an employee upon their request. Human Resources (HR) will maintain records of job titles and salary rate history for every employee during the duration of the employee's tenure.

Compensation Authorization

The compensation of the CEO will be determined and approved by the Board.

The compensation of Executive Level Positions, which includes positions of executive director and above, will be recommended by the Chief Human Resources Officer (CHRO), approved by the CEO, and reported to the Board. Medical Director is not considered Executive Level Positions. Additional Executive Level Positions require Board approval.

The compensation of all other positions will be recommended by HR and approved by the CHRO or the CHRO's designee.

Salary Structure

The structure of the Salary Schedule establishes the spread between the minimums and maximums of the pay range for each pay grade, the difference between the pay range minimums, midpoints, and maximums from one pay grade to another, and the number of pay grades to be utilized, to support recruiting and retention of talent with competitive base pay.

The salary structure should be reviewed as needed and on a regular basis, such as annually or every other year, to assess current market competitiveness. A comparison of CalOptima Health's pay grade midpoints to the market benchmark job titles is used to determine market competitiveness. The following criteria may be used to determine market benchmarks:

- Job titles with benchmarks commonly found in the marketplace
- Job titles with above average separation rates (high turnover not due to promotion)
- Job titles with above average recruiting efforts and expenses
- Job titles with above average time to fill
- Job titles with job offer rejections and candidate counter offers
- The top ten (10) highest populated jobs
- Market-sensitive jobs
- Two (2) job titles from every pay grade where available

Any jobs for which market data is not available can be slotted into the salary structure based on internal pay equity considerations to peer positions. Based on market findings and internal pay equity considerations, the CHRO may recommend to the CEO that the pay grades, pay ranges, job titles, and/or pay grade assignments captured in the Salary Schedule be adjusted. A recommendation from the CEO to the Board and Board approval is required to make any revisions to the Salary Schedule.

Pay Grades, Ranges and Levels

Pay Grade: An identifier of a pay range in the Salary Schedule. Each job classification (job title) is assigned to a pay grade. Jobs with similar pay range targets are assigned the same pay grade, with the same pay range.

Pay Range: A pay range is the minimum and maximum of the pay grade and every amount between minimum and maximum.

Pay Range Target: The pay range target is the midpoint of the pay range and is intended to reflect the market rate paid to employees whose qualifications surpass the minimum requirements of the job, which may include internal and/or external experience performing the job duties and responsibilities of the job.

Table 1.

Pay Grade	Minimum	Midpoint (Target)	Maximum
A	$41,600	$46,100	$50,600
B	$42,432	$48,716	$55,000
Market Median Base Salary:		$47,000	

Example: Market Median for a Data Entry Tech is $47,000. The Range Target of $46,100 is closest to Market Median of $47,000; job title would be assigned to Pay Range A.

Note Pay Grades A and B overlap across their pay ranges by design. An employee in pay grade A may have a higher base pay than an employee in pay grade B. For example, a staff member with extensive experience and/or education can earn more than their supervisor when their supervisor is new to the role.

Data Entry Tech would display on the Salary Schedule as such:

Table 2.

Job Title	Pay Grade	Minimum	Midpoint (Target)	Maximum
Data Entry Tech	A	$41,600	$46,100	$50,600

Pay Range Minimum: The pay range minimum is the least amount paid to employees whose job titles are assigned to the pay grade.* The pay range minimum is intended to reflect the rate paid to employees whose qualifications align with the minimum requirements of the job.

All employees should have a pay rate equal to or greater than the pay range minimum. When the minimum of the pay range is increased and employees' pay rates fall below the minimum of the adjusted pay range, the employees' pay rates will be brought to the minimum of the new pay range in the pay period the new pay range is effective. Adjustments to pay range minimums occur prior to merit pay calculations.

- HR may post a recruitment as a training position, allowing candidates to meet the minimum requirements within twelve (12) months of hire.

- *A training rate equal to ten percent (10%) below the minimum of the pay grade range may be used until the incumbent meets the minimum experience requirements within the twelve (12) month period.

Pay Range Maximum: The pay range maximum is the greatest amount paid to employees whose job titles are assigned to the pay grade. The pay range maximum is intended to reflect the rate paid to employees whose qualifications significantly surpass the minimum job requirements and typically include internal and/or external experience performing the job duties and responsibilities of the job.

Base pay is capped at the pay range maximum; therefore, employee base pay is not increased beyond the pay range maximum of the assigned pay grade.

Pay Above Range Maximum: Employees are not assigned pay above the pay range maximum. In rare cases where employees' pay becomes above the pay range maximum, typically due to an adjustment made to the pay grade that resulted in a decrease to the pay range maximum, the following applies:

- Employees whose current pay becomes at or above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.

- As the pay structures and pay ranges increase, employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases again, as appropriate.

Employee Base Pay Adjustments

Market Adjustment: An increase or decrease to an employee's base pay due to internal pay equity and/or market competitiveness.

Upon recommendation from the CHRO and approval of the CEO, a market adjustment up to the maximum of the employee's pay range may be granted to maintain market competitiveness and internal pay equity.

A market adjustment may result in base pay increases for full-time, part-time, and some as-needed and limited term staff. When the salary schedule is adjusted, employees will be paid a base pay rate at least equal to the new pay range minimum when the employee meets all the minimum requirements of the position.

Employees paid below the pay range minimum will receive an increase in their base pay to ensure it is at least equal to the pay range minimum of their grade. Move to pay range minimum occurs before any other adjustment to base pay such as merit pay or cost of living adjustment (COLA). Market adjustments are made prior to determining merit pay. Market adjustment effective dates are not delayed based on an employee's leave status.

Merit Pay Adjustment: Merit pay recognizes employees' job proficiency and performance. All regular employees who achieve a satisfactory level or higher of performance will be eligible for a merit pay adjustment.

Merit pay is applicable to full-time and part-time employees, including employees in temporary assignments paid anywhere in the pay range. Limited term, as needed, paid interns, extra help, and temporary agency employees are not eligible for merit pay.

An employee must have started employment at CalOptima Health on or before March 31 to be eligible for a merit pay increase in July of the same year and achieved an overall satisfactory or higher rating on the annual performance review.

Merit pay will typically be an increase to base pay; however, it may also be delivered as lump sum bonus for individuals paid at or above the pay range maximum. Merit lump sum bonuses are not considered regular or special compensation under CalPERS regulations (Gov. Code section 20636). CalOptima Health is not able to report lump sum bonuses as compensation earnable.

The budgeted amount for merit pay, if any, is based on 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and 4) recruiting and retention issues.

Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked during the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year. When prorating merit pay for employees who leave and are rehired within the same review year, the rehire date is used. Service prior to rehire date is not included in merit proration.

Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and receive a lump sum amount for the remaining portion of the merit pay. Employees paid at or over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in two (2) incremental amounts - the first half when merit pay is normally distributed; and the second half six (6) months later. Incumbents must be employed with CalOptima Health at time of distribution to receive the merit lump sum.

Employees who did not achieve an overall satisfactory level of performance are not eligible for merit pay. Merit pay may be withheld altogether or delayed for ninety (90) days if the employee is not in good standing as of March 31. On or before the conclusion of the ninety (90) days, the supervisor must notify HR as to whether the employee should be granted a merit pay increase to be processed at the start of the next applicable pay period.

Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment in the same pay period.

Merit pay is typically effective the beginning of the start of the pay period that includes July 1.

Employees on a leave of absence who are eligible for merit pay will receive the adjustment effective the beginning of the start of the pay period that includes July 1. Merit pay is not delayed based on an employee's leave status.

Executive Directors and Chiefs must approve merit pay increases for all areas for which they are responsible before submitting to HR. HR has final approval of all merit increases.

A Merit Pay Matrix similar to the one shown below** [displaying a three and a half percent (3.5%) merit increase budget] is used to provide supervisors with a sample of what merit pay increase may be awarded based upon performance and an employee's pay within the pay range.

Performance Score Low	-	Performance Score High	Q1	Q2	Q3	Q4	Above Max
4.30	-	5.00	5.55%	4.95%	4.60%	4.50%	4.50%
4.00	-	4.29	5.30%	4.70%	4.35%	4.25%	4.25%
3.61	-	3.99	4.65%	4.35%	4.10%	4.00%	4.00%
3.31	-	3.60	4.40%	4.10%	3.85%	3.75%	3.75%
3.00	-	3.30	4.15%	3.85%	3.60%	3.50%	3.50%
2.90	-	2.99	3.30%	3.20%	3.10%	3.00%	3.00%
2.51	-	2.89	1.50%	1.25%	1.00%	0.75%	0.75%
0.00	-	2.50	0.00%	0.00%	0.00%	0.00%	0.00%

***This Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

Cost of Living Adjustment: Annually, HR will identify the over-the-year percent change in the Consumer Price Index (CPI) from a blend of regional metropolitan areas (e.g., Los Angeles-Long Beach-Anaheim and Riverside-San Bernardino-Ontario). Availability to fund a cost-of-living adjustment (COLA) and competitiveness of our salary structure and pay practices are also reviewed and considered. Upon which, HR may recommend a COLA to base pay for evaluation by the Chief Financial Officer (CFO) and recommendation to the Board by the CEO. COLA adjustments are typically provided to all employees in the pay period following approval by the Board and are not retroactive. Employees at or above pay range maximum will not receive a COLA base pay adjustment. They may receive COLA adjustment as a lump sum bonus. COLA adjustment to base pay is not delayed based on an employee's leave status, lump sum bonus is paid upon return from leave of absence.

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruitment and retention challenging.

Premium pay is built into the pay range targets for these jobs.

- Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.

The desired market target rate is established on a job-by-job basis to reflect specific market conditions. Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:

- Time to fill the position – statistics will suggest the average amount of time required to fill a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.

- Job offer rejections – statistics will illustrate an increase in the number of job offers rejected by candidates.

- Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to eighteen (18) months. Turnover for the job will be compared to historical results for the same job and/or to other similarly situated jobs.

- Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:

    - A year-to-year market rate increase significantly greater than the average year-to-year increase for other jobs analyzed.

    - A competitive market rate significantly higher [typically ten percent (10%) than its current midpoint] or a competitive market rate with significantly higher pay practices [typically ten percent (10%)] in the labor market than the average of current internal pay practices.

Jobs classified as market-sensitive are reviewed at least annually to determine if this status still applies.

Once a job is classified as market-sensitive, it typically remains classified as market-sensitive for not less than one (1) year or until the recruiting and retention challenges subside and/or the market pay rates adjust themselves. When a job is no longer considered market-sensitive, the job's premium pay is no longer applicable; however, no change is typically made to the employees' base pay rates at this time.

Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are monitored. If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

Special One-time Pay Considerations

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, the CEO may award a retention incentive consistent with CalOptima Health Policy GA.8042: Supplemental Compensation.

Recruitment Incentive: Recruitment incentives may be utilized to entice a candidate to join CalOptima Health. The CHRO may present the circumstances and recommendation for a recruitment incentive to the CEO for approval consistent with CalOptima Health Policy GA.8042: Supplemental Compensation.

Pay Upon Hire/Rehire

Compensation is merit-based in consideration of the job requirements and responsibilities, market conditions, the applicant's qualifications, and internal pay equity. Factors to be considered in determining pay for new hires and re-hires include:

- The pay grade and pay range of the job.
- The candidate's job-related qualifications (knowledge, skills, and abilities), such as in-position experience, related experience, and education, including degrees, licenses, and certifications. At hire, external service is typically valued comparable to internal service.
    - For example, three (3) years of prior job experience is viewed comparable to three (3) years of job experience at CalOptima Health.
- Job designation as Market Sensitive, as described in these Guidelines.
- Internal pay equity – compensation of incumbents performing substantially similar work.

Starting pay rates cannot be below the minimum of the pay range (unless it is viewed as a training rate).

Pay rates for all positions are prepared by HR before a job offer is extended. HR will review internal and external equity to support CalOptima Health's pay philosophy and strategy.

Pay Upon Promotion

An employee receives a promotion when the employee is selected for a job with a higher pay grade. Selection for a job with a higher pay grade may occur through a recruitment or when reclassified into a job with a higher pay grade through a job re-evaluation.

An employee who has been promoted will be paid at least the minimum of the new pay range. In addition to performance, pay upon promotion will be determined based on the following:

- The pay grade and pay range of the job.

- The employee's job-related qualifications (knowledge, skills, and abilities), such as in-position experience, related experience, and education, including degrees, licenses, and certifications.

- Job designation as Market Sensitive, as described in these Guidelines.

- Internal pay equity – compensation of incumbents performing substantially similar work.

The pay determination may result in an increase or no change to the pay of an employee who is promoted. In rare cases, the pay determination may result in a decrease to the pay of an employee who is promoted, to ensure internal pay equity.

Employees who are promoted after March 31, but prior to receiving their merit pay increase, will have their merit pay increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance review rating and therefore merit pay increase amount is not known and/or approved at the time the promotional pay is being calculated, a merit increase equivalent to an "Exceeds Expectations" performance rating will be included in the base pay used to calculate their promotional pay. The merit matrix from the prior fiscal year will be referenced when determining the merit increase percentage.

The pay rate adjustment, if any, will be effective on the first day in which the promotion takes effect.

Pay Upon Lateral Transfer

An employee receives a lateral transfer when the employee is selected for a different job with the same pay grade through a recruitment or when placed into a job with the same pay grade through a job re-classification, organizational restructure, reasonable accommodation, or corrective action.

An employee who has been laterally transferred will be paid at least the minimum of the pay range. In addition to performance, pay upon transfer will be determined based on the following:

- The pay grade and pay range of the job.

- The employee's job-related qualifications (knowledge, skills, and abilities), such as in position experience, related experience, and education, including degrees, licenses, and certifications.

- Job designation as Market Sensitive, as described in these Guidelines.

- Internal pay equity – compensation of incumbents performing substantially similar work.

The pay determination may result in a decrease, increase, or no change to the pay of an employee who is transferred.

A transfer does not affect how future merit pay increases and/or market adjustments are awarded. The pay rate adjustment, if any, will be effective on the first day of the pay period in which the transfer takes effect.

Pay Upon Demotion

An employee receives a demotion when the employee is selected for a job with a lower pay grade through a recruitment or when placed into a job with a lower pay grade through a job re-classification, organizational restructure, reasonable accommodation, or corrective action.

An employee who has been voluntarily or involuntarily demoted will be paid at least the minimum of the new pay range. In addition to performance, pay upon demotion will be determined based on the following:

- The pay grade and pay range of the job.
- The employee's job-related qualifications (knowledge, skills, and abilities), such as in position experience, related experience, and education, including degrees, licenses, and certifications.
- Job designation as Market Sensitive, as described in these Guidelines.
- Internal pay equity – compensation of incumbents performing substantially similar work.

The pay determination may result in a decrease or no change to the pay of an employee who is demoted. In rare cases, the pay determination may result in an increase to the pay of an employee who is demoted, to ensure internal pay equity.

A demotion does not directly affect how future merit pay increases and/or market adjustments are awarded. The pay rate adjustment, if any, will be effective on the first day in which the demotion takes effect.

Temporary Upgrade Appointments

An employee who is appointed to a job having a higher pay grade for limited duration 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.

1. Temporary Upgrade Pay:

    a. An employee in a temporary upgrade assignment will maintain their regular base pay. Temporary upgrade pay will be a separate premium amount paid in a lump

sum based on regular hours worked per pay period (excluding overtime).

b. Temporary upgrade pay will be the minimum of the new pay range or a five percent (5%) of base pay increase, whichever is greater. The premium will be effective on the first day of the pay period in which the temporary upgrade appointment takes effect.

c. Temporary upgrade pay is supplemental compensation above regular base pay to compensate for business needs under CalOptima Health Policy GA.8042 (Supplemental Compensation).

d. Temporary Upgrade Pay is considered premium pay pursuant to Title 2 California Code of Regulations (CCR) Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS classic members.

e. Temporary Upgrade Pay is eliminated when the temporary appointment ends.

2. Duration of Temporary Upgrade Appointments:

a. Temporary upgrade appointments shall not exceed 960-hours.

Training/Transition Overlap

To provide for a transition and/or training period, CalOptima Health may fill a regular position with a replacement in advance of the separation of a terminating employee or in advance of returning an employee from a temporary assignment to their former position. For the transition and/or training period, two employees may fill the same budgeted position for up to thirty (30) calendar days during the period of overlap. The immediate supervisor will determine which employee will be designated for decision-making, timesheet approval, and regulatory reporting purposes, if applicable.

Job Re-Evaluations

A job re-evaluation is the study of an employee's current job duties and responsibilities in comparison to the job description of their current job classification. The results of a job re-evaluation may be a job re-classification to a new job title with a higher, lower or same pay grade, reassignment of duties, or other administrative actions to resolve substantive discrepancies between the employee's job duties and those described in the job description. A job re-evaluation study may be appropriate when a position's job duties and responsibilities have changed over time as to become out of alignment with the current job classification.

- Re-classification to a higher pay grade must require a higher level of skills, abilities, scope of authority, autonomy, and/or minimum qualifications for a period of one (1) year to be eligible for a re-evaluation.

- A change in job duties and responsibilities of thirty-five percent (35%) or more is typical in considering whether a job re-evaluation is to be conducted.

- Employee can only be re-evaluated into a job title that currently exists on the Salary Schedule.

- Employee must meet the minimum requirements of the re-classified position as stated in the job description.

- Employee has worked in their current position for at least one (1) year prior to the re-evaluation request date.

- Re-evaluations cannot be used to fill a job vacancy.

- The proposed position exists in a similar job series, hierarchy, or growth progression.

- All requests for job re-evaluations must be signed by the department director; department Chief must sign if request to be re-classified to management classifications.

- The request must also include justification that the job re-evaluation supports a business need.

- The request must include the incumbent's current job description and revised job description with the change in responsibilities highlighted and percentage of time spent performing the change in responsibilities assigned (total responsibilities not to exceed 100%).

Salary Schedule Revisions

Outside of the cyclical market studies performed by HR, department directors may request a review to add, remove, or revise a job title, and/or reassign the pay grade of an existing job title.

All requests must be approved by the by the department executive prior to submission to HR. Submissions must include a business justification and supporting documentation e.g., reorganization plan, strategic plan, or specific recruitment/retention concerns.

After review and study of the request and in the event that a revision is approved by HR and requires a change to the Salary Schedule, HR will inform the director. It will be held by HR until such time that the Salary Schedule is scheduled to be presented to the Board of Directors.

Compensation Terms

Term	Definition
Base Pay	Base pay is a fixed amount paid to an employee in exchange for time and services most often expressed as an hourly rate or annual salary. It does not include benefits, allowances, or other supplemental compensation.

Term	Definition
Internal Pay Equity	The compensation of employees performing the same work is paid consistently based on qualifications and performance.
Merit Pay	A performance-based increase to an employee's base pay or lump sum bonus.
Pay Grade	An identifier of a pay range in the Salary Schedule. Each job classification (job title) is assigned to a pay grade. Jobs with similar pay range targets are assigned the same pay grade with the same pay range.
Pay Range	The minimum and maximum of the pay grade and every amount between minimum and maximum.
Pay Range Maximum	The pay range maximum is the greatest amount paid to employees whose job titles are assigned to the pay grade. The pay range maximum is intended to reflect the rate paid to employees whose qualifications significantly surpass the minimum job requirements and typically include internal and/or external experience performing the job duties and responsibilities of the job.
Pay Range Midpoint	Typically, the middle amount of the pay range, equidistant to the range minimum and range maximum and aligned to the market value for the job classification. The pay range target is intended to reflect the market rate paid to employees whose qualifications surpass the minimum requirements of the job, which may include internal and/or external experience performing the job duties and responsibilities of the job.
Pay Range Minimum	The least amount paid to employees whose job titles are assigned to the pay grade. The pay range minimum is intended to reflect the rate paid to employees whose qualifications align with the minimum requirements of the job.
Pay Range Target	The pay range target is typically the midpoint of the pay range and is intended to reflect the market rate for the job. The pay range target aligns to employees whose qualifications surpass the minimum requirements of the job and may include internal and/or external experience performing the job duties and responsibilities of the job.
Percentile	A point on a rank-ordered scale, found by arranging a group of data points in order of magnitude from lowest to highest. The first percentile approximates the very lowest number found, while the 100th percentile is the very highest.

1

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

12. Adopt Resolution No. 23-1207-02 Authorizing the Adoption of the Public Agency Retirement Services (PARS) Trust Agreement and the Appointment of a Plan Administrator

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405

Recommended Actions

1. Adopt Resolution No. 23-1207-02 Authorizing the Adoption of the Public Agency Retirement Services (PARS) Trust Agreement and the Appointment of a Plan Administrator

Background

On January 5, 1999, the CalOptima Health Board of Directors (Board) approved the establishment of a supplemental retirement benefit (SRP) for CalOptima Health employees, appointed members to a 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 System (PARS) to implement and administer the SRP, a 401(a) tax-qualified multiple employer trust.

The original PARS Trust document was initially developed when the PARS Trust was formed in 1991. The PARS Trust Agreement, adopted by CalOptima Health in 1999, did not require a Board resolution for adopting the PARS Trust Agreement and appointing a plan administrator. At the January 5, 1999 Board meeting, the Board appointed the Director of Human Resources as the plan administrator without a resolution. In accordance with the January 5, 1999 Board action, subsequent PARS Trust Agreements and amendments were approved by the plan administrator.

In 2000, the PARS Trust Agreement was amended and included new language requiring “a certified copy of the Member Agency governing body resolution authorizing the adoption of the PARS Trust Agreement and the appointment of an individual designated by position of employment at the Member Agency to act on its behalf in all matters relating to the Member Agency’s participation in the PARS Trust Program and Agency Trust (Plan Administrator).” The most recent change to the PARS Trust Agreement in 2008 included similar language regarding the appointment of a Plan Administrator by resolution.

In order to formalize the current PARS Trust Agreement, Staff recommends the Board adopt a resolution and appoint the Chief Human Resources Officer (CHRO) or the CEO’s designee, in the absence of the CHRO as the Plan Administrator according to the terms of the PARS Trust Agreement.

Back to Agenda

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
This Board action formalizes the adoption of the current PARS Trust Agreement for Participant Directed Investment Program and appoints the CHRO or the CEO's designee, in the absence of the CHRO as the Plan Administrator according to the terms of the PARS Trust Agreement.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Resolution No. 23-1207-02, Authorizing the Adoption of the Public Agency Retirement Services (PARS) Trust Agreement and the Appointment of a Plan Administrator
2. Board Action Dated January 5, 1999, "Establishment of a Supplemental Retirement Plan"
3. PARS Trust Agreement, September 1991
4. PARS Trust Agreement, January 2000
5. PARS Trust Agreement for Participant Directed Investment Program, June 2008

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

RESOLUTION NO. 23-1207-02

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

ADOPTING THE PARS TRUST AGREEMENT FOR PARTICIPANT DIRECTED INVESTMENT PROGRAM AND APPOINTING A PLAN ADMINISTRATOR

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

WHEREAS, at the January 5, 1999, Board of Directors ("**Board**") meeting, the Board took actions regarding a supplemental employee benefit plan, including (i) authorizing the establishment of a supplemental retirement benefit plan for CalOptima Health employees effective January 1, 1999; (ii) establishing a supplemental retirement plan committee and appointing the initial members; (iii) directing and authorizing the committee to take necessary actions to adopt and implement a plan document in compliance with applicable laws and regulations; and (iv) appointed the Director of Human Resources as the plan administrator with authorization to take necessary actions to implement and administer the plan in compliance with the plan and applicable legal requirements;

WHEREAS, the Board was not required to, and did not, adopt a resolution to appoint a plan administrator and the committee was empowered to take actions related to the supplemental retirement benefit plan;

WHEREAS, the Public Agency Retirement System ("**PARS**") was selected as the vendor to provide the supplemental retirement benefit plan;

WHEREAS, the CalOptima Public Agency Retirement System (PARS) Defined Contribution Plan was adopted effective January 1, 1999, and outlines the terms of the supplemental benefit plan authorized by the Board, last amended and restated January 1, 2011, (the "**Plan**");

WHEREAS, Plan funds are held in a trust established to hold the assets of the Plan for the exclusive benefits of Plan participants or their beneficiaries as authorized by law;

WHEREAS, the Plan's trust is governed by the PARS Trust Agreement for the Participant Directed Investment Program effective August 1, 2008 ("**PARS Trust Agreement**") allowing individual Plan participants to direct their own account balance;

WHEREAS, after the January 5, 1999, Board of Directors action, the PARS Trust Agreement requires that the Board of Directors adopt a resolution appointing a plan administrator who is designated by position of employment to act on behalf of CalOptima Health in all matters relating to CalOptima Health's participation the PARS trust;

WHEREAS, the Board wishes to formalize the adoption of the PARS Trust Agreement; and

Back to Item

Back to Agenda

WHEREAS, the Board wishes to appoint the plan administrator in accordance to the terms of the PARS Trust Agreement.

NOW, THEREFORE, BE IT RESOLVED:

I. That the CalOptima Health Board of Directors ratifies and adopts the PARS Trust Agreement.

II. That the CalOptima Health Board of Directors appoints the Chief Human Resources Officer (CHRO) or the Chief Executive Officer's designee, in the absence of the CHRO, as the plan administrator vested with the powers to administer the Plan according to terms of the Plan and the PARS Trust Agreement.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 7th day of December, 2023.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

/s/_____
Printed Name and Title: Clayton Corwin, Chair, CalOptima Health Board of Directors

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

Back to Item

Back to Agenda

CalOPTIMA Board Action Agenda Referral

Action to Be Taken January 5, 1999
Regular Meeting of the CalOPTIMA Board of Directors

Report Item
VIII. A. Establishment of a Supplemental Retirement Plan

Contact
Sharon Tucker, Director, Human Resources
(714) 246-8400

Recommended Action
A. Approve the establishment of a Supplemental Retirement Plan (SRP) for CalOPTIMA Employees effective January 1, 1999; and
B. Establish a Supplemental Retirement Plan Committee and appoint as its initial members the Chief Financial Officer, the Director of Human Resources and a designee of the Director of Facilities and Procurement; and
C. Direct and authorize this Committee to take necessary actions, including obtaining legal review, to adopt and implement a Plan Document in compliance with applicable laws and regulations pertaining thereto, including requirements of the Internal Revenue Service (IRS), and that includes flexible, optional funding; and
D. Appoint the Director of Human Resources as the Plan Administrator with authorization to take necessary actions to implement and administer the Plan in compliance with the Plan and applicable legal requirements; and
E. Authorize the Chairman of the Board and/or the Chief Executive Officer (CEO) to appoint and/or remove members of the Committee; and
F. Authorize the CEO to determine the employer contribution to the SRP in keeping with the previous authority given to her to set employee compensation and benefits within the limits of the budget.

Background on Issue
CalOPTIMA participates in the California Public Employees Retirement System (CalPERS), and CalOPTIMA makes an employer's contribution toward this benefit. Our employees' participation in CalPERS is in lieu of participating in Social Security.

Earlier this year, the services of the Hay Group were enlisted to review the benefits provided to CalOPTIMA employees. Their report indicated that CalOPTIMA was in the lower tenth percentile in its contribution towards employee benefits. They recommended that an area in which we could particularly improve was in employer's contribution toward retirement.

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Back to Item

Back to Agenda

In approving the budget for this year, the Board included funding for enhancing employee benefits, including the implementation of a Supplemental Retirement Benefit (SRB) funded by an employer contribution of approximately three to four percent (3-4%) of payroll. In follow-up to this action, staff sent out a Request for Quotes (RFQ) to solicit proposals for assisting CalOPTIMA in developing and implementing a Supplemental Retirement Benefit. The selected vendor was the Public Agency Retirement System (PARS). Staff is in the process of working with PARS in the development and implementation of a Plan.

Discussion

The only actions required by the Board are those to establish the Plan, appoint the Committee and Plan Administrator, and authorize them to act on the Board's behalf. The Board has already budgeted funds for the Plan for this year and will maintain funding authorization for future years. By appointing and authorizing a Committee to act, flexibility is allowed for the design and implementation of a Plan which best meets the needs of CalOPTIMA employees.

Fiscal Impact of Action

Funding will not exceed the budget amount.

Rationale for Recommendation

A Supplemental Retirement Plan will be an enhancement to employee benefits in keeping with the recommendations of the Hay Group and with the Board's stated interest in recognizing and maintaining a strong and motivated work force.

Concurrence

Foley & Lardner
Board of Directors' Personnel Ad Hoc Workgroup

Attachments

None

Authorized Signature

12/16/95
Date

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Back to Item

Back to Agenda

P A R S

Public Agency Retirement System

TRUST AGREEMENT

Version 3
November 25, 1991

Back to Item

Back to Agenda

PUBLIC AGENCY RETIREMENT SYSTEM TRUST

Huntington Beach City School District and State Center Community College District (hereinafter referred to as "Employer") do hereby adopt the following Retirement Plan Trust.

ARTICLE I

ELECTIVE PROVISIONS

1.1 Initial Deposit

In establishment of this Trust, the Employer has paid to Trustee the sum of at least One Thousand Dollars ($1,000.00) as its initial contribution.

1.2 Effective Date

The effective date of this Trust is July 1, 1991.

1.3 Trustee

The Trustee is Imperial Trust Company or any successor(s) as named in any amendment hereto.

Back to Item

Back to Agenda

ARTICLE II

PRELIMINARY MATTERS

2.1 The Trust

This trust and the related Public Agency Retirement Pension System Pension Plan are all parts of a single, integrated employee benefit system. The Trust's fiscal year shall be the Plan Year as the same may be changed from time to time.

2.2 Definition of Terms

In construing the terms of this Trust, words and terms defined in the Plan shall, when used herein, have the same meaning as in the Plan, unless the context of this Trust clearly indicates otherwise.

2.3 Purpose

This Trust is created for the purpose of receiving contributions made under the Plan; accumulating, managing and investing those contributions; and providing benefits to the Participants of the Plan or their Beneficiaries. This Trust may also be a complete amendment and restatement of its predecessor, if any, pursuant to Section 3.

This Trust is intended to evidence the Trust portion of an employee's retirement plan(s) and trust, established by the adopting Employer for the benefit of eligible employees and to qualify as a qualified employees' retirement trust under the appropriate provisions of the Internal Revenue Code.

2.4 Reversion

In the event the Plan is terminated, the vested interest of any participant shall not be diminished or adversely affected. Except as may be provided in this Trust or the Plan, such termination shall not vest in the adopting Employer any corpus or income under the Trust, nor permit the Plan to discriminate as to coverage, or as to allocation of contributions or earnings, in favor of employees who are officers, shareholders, or highly compensated, nor cause the Trust to lose its exemption pursuant to Code Section 501(a). No modification, amendment or termination of the Plan shall be construed a termination of the Trust so as to require the Trustee to make a distribution of any of the Trust assets to any Participant, unless otherwise expressly provided pursuant to written instructions from the Administrator.

If any Employer participating in this Trust adopts a retirement plan whose assets are maintained in this trust and makes application to the Internal Revenue Service, within one year from the date of adoption of such Plan, for a determination that such plan is a qualified plan under Section 401(a) of the Internal Revenue Code, and if such plan is determined by the Internal Revenue Service not to be a qualified plan, then all contributions and investment income attributable to such plan shall be returned to the Employer upon application to the Trustee.

2.5 Adoption by Other Employers

Notwithstanding anything to the contrary, any other Employer whether an affiliate or subsidiary or not, may adopt this Trust and all of the provisions hereof, and participate herein and be known as an adopting Employer, by a properly executed document evidencing said intent.

Back to Item

Back to Agenda

ARTICLE III

GENERAL ADMINISTRATION

3.1 Selection of Trustee

The initial two adopting Employers, by a unanimous vote, may appoint any individual, individuals, institution or combination thereof to serve as Trustee. The Trustee so appointed, or any successor Trustee appointed pursuant to a two-thirds vote of the Participating Employers, shall be deemed to have accepted this Trust and to have agreed to carry out all of the provisions hereof.

3.2 Conflict with Plan

If the provisions of this Trust conflict with the provisions of the Plan, the Plan provisions shall be followed.

3.3 The Administrator

Each adopting Employer shall designate an individual or a position to serve as the Administrator. The Administrator shall act on behalf of the Employer in all matters relating to this Plan and Trust. The Employer shall keep accurate books and records with respect to its Employees, their service with the Employer and their Compensation and shall certify the same to the Administrator.

3.4 Directions to Trustee

All directions to the Trustee from the Administrator must be in writing and need be signed by only one Administrator. For all purposes of this Trust, "direction" shall include any certification, notice, authorization, application or instruction of the Administrator and/or Trustee appropriately communicated. Direction shall be implied if the Administrator, having knowledge of the Trustee's intentions, fails to file written objection at least 30 days prior to the completion of procedures contemplated.

The Trustee may request directions or clarification of directions received and may delay acting until clarification is received. In the absence of timely received direction or clarification, or if the Trustee considers any direction to be a violation of the Trust, the Employees Retirement Security Act, the Code, or any local law, the Trustee shall in its sole discretion take appropriate action, or refuse to act upon a direction, without incurring liability to the Administrator or participants for such action or failure to act.

3.5 Resignation or Removal of Trustee

The Trustee may resign at any time by giving at least thirty (30) days prior written notice to the Administrator. The adopting Employer may remove the Trustee by giving at least thirty (30) days prior written notice to the Trustee and withdrawing from the PARS Trust. In either case, the Employer's appointment of a successor Trustee will vest the successor Trustee with title to the withdrawing participating employer's Trust Fund Assets upon acceptance of such appointment.

Back to Item

Back to Agenda

3.6 Co-Trustees

Where there is more than one Trustee, a majority of such Trustees shall be vested with the right to make any decision, undertake any action or execute any documents affecting this Trust without the approval of the dissenting Trustees. In the event there are co-Trustees, any directions (as defined in Section 3.4) need be executed by only one of the co-Trustees.

3.7 Trust Administrator

The Trust shall appoint a Trust Administrator to perform such administrative services as deemed necessary by the Trustee, on behalf of, and at the direction of the Trustee.

3.8 Resignation or Removal of Trust Administrator

The Trust Administrator may resign at any time by giving at least one hundred twenty (120) days written notice. The adopting Employers, by a two-thirds majority vote, may remove the Trust Administrator by giving at least one hundred twenty (120) days written notice to the Trust Administrator and to the Trustee.

3.9 Trust Fund

The contributions received by the Trustee from each adopting Employer shall be held and administered pursuant to the terms hereof without distinction between income and principal and without liability for the payment of interest thereon except as expressly provided herein.

Back to Item

Back to Agenda

ARTICLE IV

THE TRUSTEE

4.1 Investments

a) Fiduciary with Respect to Investments

Except as herein provided, the Administrator shall be the Fiduciary with respect to the authority and duty to direct the investment and management (including the power to direct the acquisition and disposition) of the Trust Assets:

1) The adopting Employer may, by resolution of its governing body, terminate the Administrator's right to direct the investment and management of all or any portion of the Trust Assets by transferring to the Trustee or an Investment Manager the authority and duty to direct the investment and management of all or any portion of the Trust Assets, as the case may be.

2) The Employer may, but need not, by appropriate Administrator action appoint the Trustee or an Investment Manager to direct the investment and management (including the power to acquire and dispose of) of all or any portion of the Trust Assets.

b) A certified copy of any such Governing Body resolution or Administrator action pursuant to Section 4.1 b) of this Trust shall be delivered to the Trustee, whereupon the Trustee or Investment Manager, as the case may be, shall assume fiduciary responsibility with respect to the investment and management of such Trust Assets. Any transfer of investment authority to the Trustee or to an Investment Manager may be revoked upon receipt by the Trustee of a notice from either the adopting Employer through its governing body or the Administrator, as the case may be. The appointment, selection and retention of a qualified Investment manager shall be solely the responsibility of the Administrator or the adopting Employer, as the case may be. The Trustee is to rely upon the fact that said Investment Manager is authorized to direct the investment and management of the assets of the aforesaid Trust until such time as the adopting Employer, or Administrator, as the case may be, shall notify the Trustee in writing that another Investment Manager has been appointed in the place and stead of the Investment Manager named, or, in the alternative, that the Investment Manager named has been removed.

c) When Trustee is not Directing Investments

During such period or periods of time, if any, as the Administrator or an Investment Manager is authorized to direct the investment and management of the Trust Assets, the Trustee shall (subject to the overriding limitations hereinafter set forth) effect and change investment of the Trust Fund as directed in writing by the Administrator, or Investment Manager, as the case may be, and shall neither effect nor change any such investments without such direction and shall have no right, duty or responsibility to recommend investments or investment changes. The following provision shall govern the Trustee during such period or periods:

1) So long as the Administrator retains or reacquires full power and responsibility to direct the Trustee with respect to the investment and management of all or any portion of the assets of the Trust Fund, the Trustee shall not be liable nor responsible for losses or

Back to Item

Back to Agenda

unfavorable results arising from the Trustee's compliance with proper directions of the Administrator which are made in accordance with the terms of the Plan and this Trust and which are not contrary to the provisions of any applicable federal or state statute regulating such investment and management of the assets of an employee benefit trust.

2) In the event that an Investment Manager is given full authority and responsibility with respect to the investment and management of the Trust Assets, the Trustee or the Administrator shall not be liable or responsible in any way for any losses or other unfavorable results arising from the Trustee's compliance with investment or management directions received by the Trustee from the Investment Manager.

3) All directions concerning investments made by the Administrator or the Investment Manager shall be signed by the authorized person or persons acting on behalf of the Administrator or the Investment Manager, as the case may be.

4) The Trustee shall be entitled to rely upon directions which the Trustee receives. The Trustee shall be under no duty to question any directions of the Investment Manager or Administrator nor to review any securities or other property of the Trust constituting assets thereof with respect to which an Investment Manager has investment responsibility, nor to make any suggestions to such Investment Manager in connection therewith. The Trustee shall, as promptly as possible, comply with any written directions given by the Administrator or an Investment Manager hereunder. The Trustee shall not be liable, in any manner nor for any reason, for the making or retention of any investment pursuant to such directions, nor shall the Trustee be liable for its failure to invest any or all of the Trust Funds in the absence of such written directions.

5) During such period of time, if any, as the Administrator or an Investment Manager is authorized to direct the Trustee, the Trustee shall have no obligation to determine the existence of any conversion, redemption, exchange, subscription or other right relating to any securities purchased of which notice was given prior to the purchase of such securities, and shall have no obligation to exercise any such right unless the Trustee is informed of the existence of the right and is instructed to exercise such right, in writing, by the Administrator or the Investment Manager, as the case may be, within a reasonable time prior to the expiration of such right.

Back to Item

Back to Agenda

6) In any event, neither the Administrator nor any Investment Manager referred to above shall direct the purchase, sale or retention of any assets of the Trust Fund if such directions are not in compliance with the applicable provisions of the Act and any regulations or rulings issued thereunder.

4.2 Trustee Fees

As may be agreed upon from time to time by the adopting Employer and Trustee, the Trustee will be paid reasonable compensation for services rendered or reimbursed for expenses properly and actually incurred in the performance of duties with respect to the Trust.

In the absence of specific arrangement for such payments, any fee or other compensation or reimbursed expenses shall be withdrawn by the Trustee from the Trust, unless paid by the adopting Employer. Such compensation shall include accounting, legal and administrative services rendered by or to the Trustee unless specifically excluded by appropriate written agreement.

To the extent that the Trustee fees are to be charged against Participant contributions, the adopting Employer shall so advise each Participant.

4.3 Contributions

The adopting Employer shall make all of its contributions to the Trustee, and shall also transmit all contributions of its Participants, as may be required or allowed by the Plan. Such contributions shall be in cash. All contributions shall be paid to the Trustee for investment and reinvestment pursuant to the terms of this Trust Agreement. The Trustee shall not have any duty to determine or inquire whether any contributions to the Trust made to the Trustee by any adopting Employer are in compliance with the Plan; nor shall the Trustee have any duty or authority to compute any amount to be paid to the Trustee by any adopting Employer; nor shall the Trustee be responsible for the collection or adequacy of the Trust to meet and discharge liabilities under the Plan.

4.4 Directing Investments

Except as provided in Section 4.1 a), the Administrator shall have the power to direct the investments of all monies held by Trustee and constituting part of the Trust Fund hereunder. However, pending any investment directions, such cash in the Trust Fund in an amount as is reasonable in the discretion of the Trustee shall be deposited in an interest-bearing account, which may be an interest-bearing account of Trustee.

4.5 Purchase of Contracts

The Trustee shall purchase individual or group insurance, annuity, preliminary term, group pension, and variable annuity contracts in accordance with the directions of the Administrator.

Back to Item

Back to Agenda

4.6 Records

The Trustee shall maintain accurate records and detailed accounts of all investments, receipts, disbursements and other transactions hereunder. Such records shall be available at all reasonable times for inspection by the Administrator or its designated consultants and the Employer or its authorized representative. The Trustee shall, at the direction of the Administrator, submit to the Administrator or its designated consultants such valuations, reports or other information as the Administrator or its designated consultants may reasonably require.

4.7 Statements

The Trustee shall render to the Administrator, as soon as practicable after each Plan Year, a statement of its accounts pursuant to this Section 4.7 on the basis of the Trust's established accounting period. If Trustee is a bank, it shall render the statement within sixty (60) days after the Plan Year end. If the Trustee maintains separate accounts for each Participant, it shall also render to each Participant an annual statement of his Participant Account.

The Administrator may approve such statements either by written notice or by failure to express objections to such statement by written notice delivered to the Trustee within 90 days from the date the statement is delivered to the Administrator. Upon approval, the Trustee shall be released and discharged as to all matters and items set forth in such statement as if such account had been settled and allowed by a decree from a court of competent jurisdiction.

4.8 Pooled Funds

The assets of this Trust may be pooled in a fund for employee benefit plans maintained by the Trustee for any other retirement plan or may be pooled with the assets of any other retirement plan maintained by an adopting Employer, or both.

4.9 Delegation of Duties

The adopting Employer, or the Administrator, or both, may at any time retain the Trustee as their agent to perform any act, keep any records or accounts and make any computations which are required of the Employer, or the Administrator by this Trust or the Plan. The Trustee may be compensated for such retention and such retention shall not be deemed to be contrary to this Trust.

4.10 General Authority

Subject to the Fiduciary provisions of this Trust, the Fiduciary responsible for investment and management of the Trust Assets shall have full power and authority to invest and reinvest all or any portion of the Trust Fund in any investment permitted by the laws of the State in which the Trustee administers this Trust, including, without limiting the generality of the terms thereof, the power:

a) To invest in bonds, notes, mortgages, commercial paper, preferred stock and common stock; other securities (including puts, calls and stock options), rights and obligations; any real or personal property; insurance company contracts; shares or certificates of participation issued

Back to Item

Back to Agenda

by investment companies, investment trusts and mutual funds; grant options to purchase any real or personal property upon such terms and conditions as Trustee deems proper.

b) To agree with an insurer for the insurer's investment of any part or all of the trust fund or for the investment in one or more of the insurer's separate Accounts or other funds, and to deposit with such insurer all amounts so agreed upon.

c) To agree with an insurer for the conversion of any part or all of the trust fund annuities for the benefit of the trust fund into annuities for the benefit of Participants upon their retirement.

d) To retain any investment for such period of time as Fiduciary deems appropriate and to sell the same, at either public or private sale, at such time or times and on such terms and conditions as to credit or otherwise as the Fiduciary may deem appropriate.

e) To renew or extend the time of payment of any obligation due or becoming due.

f) To borrow money, with or without giving security; and to borrow on contracts.

g) To consent to or participate in any plan for the reorganization, consolidation or merger of any corporation of which any security is held for the Trust; to pay any and all calls and assessments imposed upon the owners of such securities as a condition of their participation therein; and to consent to any contract, lease, mortgage, purchase or sale of property by or between such corporation and any other corporation or person.

h) To compromise, arbitrate or otherwise adjust or settle claims in favor of or against the Trust and to deliver or accept in either total or partial satisfaction of any indebtedness or other obligation any property; and to continue to hold for such period of time as the Trustee deems appropriate any property so received.

i) To vote any stock or other security held for the Trust and to execute and deliver any proxies or powers of attorney to such person or persons as the Trustee deems proper, granting to such person or persons such power and authority with relation to any property or securities at any time held for the Trust, provided, however, that, irrespective of whether the Trustee has been designated as the fiduciary responsible for investment and management of the Trust Assets, the powers enumerated in this subparagraph (j) shall be exercised by the Trustee unless the Trustee shall receive written notice to the contrary from the Administrator or other Fiduciary responsible for directing the investments.

j) To sue or defend in connection with any and all securities or property at any time received or held for the Trust, and all costs and attorney's fees in connection therewith shall be charged against the Trust.

k) To lease real and/or personal property held for the Trust for such term or terms, and upon such conditions, as the Trustee deems appropriate.

l) To cause any securities held for the Trustee to be registered and to carry any such securities in the name of a nominee or nominees.

Back to Item

Back to Agenda

m) To hold in cash such portion of the Trust Fund as it may deem necessary for the ordinary administration of the Trust and the disbursement of funds as directed from time to time by the Administrator, and for the temporary investment of such cash pending the receipt thereto, by depositing such cash immediately upon receipt in any type of interest bearing account, including, but not limited to, bank savings accounts and/or Time Certificates of Deposit maintained at any commercial and/or savings department of any bank (including the Trustee if the Trustee also is a banking institution), subject to the rules and regulations governing such deposits and without regard to the amount of such deposit.

n) To effect any agreement with an Insurer which the Trustee deems necessary to carry out the purposes of this Trust and to pay all premiums on contracts held hereunder.

4.11 Distributions

a) All benefits payable pursuant to the Plan shall be paid out of the assets of this Trust by the Trustee pursuant to the direction of the Administrator. The Trustee shall, from time to time, upon the written direction of the Administrator, make distributions from the Trust Fund to or for the benefit of such persons, in such manner, in such form(s), in such amounts and for such purposes as may be specified in such directions. The Trustee at the direction of the Administrator may make any distribution required to be made by it hereunder by delivering to the Administrator or its authorized designee:

1) Its check payable to the person to whom such distribution is to be made, for delivery to such person; or

2) Its check payable to an insurer for the benefit of such person, for delivery by such insurer; or

3) Insurance Contracts held on the life of the Participant to whom or with respect to whom the distribution is being made, for redelivery to the person to whom such distribution is to be made; provided that any contract distributed shall be endorsed as non-transferable.

b) In directing the Trustee to make distributions, the Administrator shall follow the provisions of the Plan and shall not direct that any distribution be made either during the existence or upon discontinuance of the Plan, which would cause any part of the Trust Fund to be used for or diverted to purposes other than as provided in the Plan and this Trust. In no event shall the Trustee have any responsibility respecting the application of such distributions, nor for determining or inquiring into whether such distributions are in accordance with the Plan.

Back to Item

Back to Agenda

ARTICLE V

FIDUCIARY RESPONSIBILITIES

5.1 More Than One Fiduciary Capacity

Any one or more of the named or identified Fiduciaries with respect to this Trust and the Plan may, to the extent required thereby or as directed by the Employer and/or Administrator pursuant to this Trust and the Plan, serve in more than one Fiduciary capacity with respect to this Trust and the Plan.

5.2 Fiduciary Discharge of Duties

Except as otherwise provided in the Code, each Fiduciary shall discharge such Fiduciary's duties with respect to this Trust and the Plan solely in the interest of the Participants and Beneficiaries:

a) For the exclusive purpose of:

1) providing benefits to Participants and their Beneficiaries, and

2) defraying reasonable expenses of administering the Plan.

b) With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

c) By diversifying the investments of the Plan and this Trust so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so.

5.3 Prohibited Transactions

Except as hereinafter set forth, each Fiduciary with respect to this Trust shall not cause this Trust to engage in any or all of the prohibited transactions set forth in Section 406(a) of the ERISA retirement security act ("Act"). However, the foregoing limitations shall not apply with respect to any conditional or unconditional exemption or variance granted under Section 408 of the Act and/or Section 4975 of the Code (whichever shall be relevant) and/or under any regulation promulgated thereunder and/or any proper interpretation of the Congressional Conference Committee Joint Explanation of the Pension Reform Act of 1974 as applicable to governmental plans and/or any administrative pronouncement so long as the same shall not be abrogated by subsequent legislation, regulations, court decisions, rulings and procedures.

5.4 No Foreign Situs

Except as authorized by applicable Labor Regulations, no Fiduciary shall maintain the indicia of ownership on any Trust Assets of the Plan or this Trust outside the jurisdiction of the district courts of the United States.

Back to Item

Back to Agenda

5.5 Limitations on Fiduciary Responsibility

To the extent permitted by the Act:

a) No Fiduciary shall be liable with respect to a breach of fiduciary duty by any other fiduciary if such breach was committed before such person became a fiduciary or after such person ceased to be a fiduciary.

b) Each Fiduciary shall bear only such liability for breach of any fiduciary responsibility as is imposed by the Act; and the inclusion in this Trust and the Plan of provisions comparable to those in the Act and/or the Code is intended for the information and guidance of the parties hereto and all fiduciaries and not to increase such fiduciaries' liabilities, responsibilities, duties and obligations by reason of such inclusion, except as required by the Act or the Code.

c) The Employer shall indemnify and hold harmless the members of the governing body, the Administrator, the Trustee (except if Trustee is a bank, trust company or similar institution) and any other persons to whom any fiduciary responsibility with respect to this Trust and the Plan is allocated or delegated from, and against any and all liabilities, costs and expenses incurred by such persons as a result of any act, or omission to act, in connection with the performance of such person' duties, responsibilities and obligations under this Trust, the Plan and under the Act, other than such liabilities, costs and expenses as may result from the negligence, gross negligence, bad faith, willful misconduct and/or criminal acts of such persons.

5.6 Indemnification of Trustee

The adopting Employer agrees to indemnify the Trustee against, and to hold the Trustee harmless from, all liabilities and claims (including reasonable attorney's fees and expenses in defending against such liabilities and claims) against the Trustee as a result of any breach of fiduciary responsibility by a Fiduciary other than the Trustee unless the Trustee participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take reasonable remedial action to remedy such breach or, through its gross negligence in performing its own specific fiduciary responsibilities, has enabled such other fiduciary to commit a breach of the latter's fiduciary responsibilities.

Back to Item

Back to Agenda

ARTICLE VI

AMENDMENT, TERMINATION & MERGER

6.1 Permanency

It is the expectation of the Employer that this Trust, and the permanency of contributions hereunder, will be continued indefinitely, but continuance of this Trust and of the Plan is not assumed as a contractual obligation of the Employer. This Trust may be amended or terminated only as provided in this Trust.

6.2 Amendments

a) A two-thirds majority of the Employers acting through the Administrators shall have the right to amend this Trust from time to time, and to similarly amend or cancel any amendments. A copy of all amendments shall be delivered to the Trustee and Administrators promptly as each is made.

b) Such amendments shall be set forth in an instrument in writing executed by the amending party and the Trustee. Any amendment may be current, retroactive or prospective, provided, however, that no amendment shall:

1) Cause any of the assets of this Trust to be used for or diverted to purposes other than for the exclusive benefit of Participants, retired Participants or their joint annuitants and their Beneficiaries who have an interest in this Trust or for the purpose of defraying the reasonable expenses of administering this Trust.

2) Have any retroactive effect so as to reduce the Benefits of any Participant under this Trust to the date the amendment is adopted, except that such changes may be made as may be required to permit this Trust to meet the requirements of the Act and Code.

3) Create or effect any discrimination prohibited by the Code in favor of Participants who are highly compensated, who are officers of the Employer.

4) Change or modify the duties, powers or liabilities of the Trustee hereunder without its consent

5) Permit the assets of this Trust to be used for the benefit of any other Plan of the Employer unless the Employer agrees to such use.

6.3 Termination

The Employers shall have the right to terminate this Trust by a unanimous vote of all members acting through the Administrators and by delivering written notice of termination to Trustee. A termination by the Employer of its Plan shall not, in itself, effect a termination of this Trust. Upon any termination of the Plan, the Trust Fund shall be distributed by the Trustee as and when directed by the Administrator. From and after the date of such termination of the Plan and until final distribution of the Trust Fund, the Trustee shall continue to have all the powers provided herein as are necessary or expedient for the orderly liquidation and distribution of the Trust Fund and this Trust shall continue until all Participants' Accounts have been completely distributed to or for the benefit of the Participants or their Beneficiaries in accordance with the Plan.

Back to Item

Back to Agenda

6.4 Fund Recovery

Except as hereinafter provided, the assets of the Plan and this Trust shall never inure to the benefit of the Employer and the same shall be held for the exclusive purposes of providing benefits to Participants in this Trust and their beneficiaries and defraying reasonable expenses of administering this Trust. The sole exception to the foregoing is as follows:

a) Mistake of Fact
In the case of a contribution which is made by the Employer by a mistake of fact, that portion of the contribution relating to the mistake of fact (exclusive of any earnings or less any trust losses attributable thereto) may be returned to the Employer, provided such return occurs within one (1) year after discovery by the Employer of the mistake.

If any repayment is payable to the Employer, then, as a condition to such repayment, and only if requested by Trustee, the Employer shall execute, acknowledge and deliver to the Trustee its written undertaking, in form satisfactory to the Trustee, to indemnify, defend and hold the Trustee harmless from all claims, actions, demands or liabilities arising in connection with such repayment.

6.5 Transfers from Other Qualified Plans

Notwithstanding any other provision hereof, there may be transferred to the Trustee, upon direction of the Administrator, all or any of the assets held (whether by a Trustee, custodian or otherwise) on behalf of any other plan which satisfied the applicable requirements of Section 401 of the Code, and which is maintained for the benefit of any persons who are or are about to become Participants in the Employer's Plan.

Back to Item

Back to Agenda

ARTICLE VII

MISCELLANEOUS PROVISIONS

7.1 Third Persons

All persons dealing with the Trustee are released from inquiring into the decisions or authority of the Trustee and from seeing to the application of any securities or other property paid or delivered to the Trustee.

7.2 Nonalienation

The balances in a Participant's Employer Contribution Account may not be assigned or alienated, except that he may voluntarily and revocably assign up to ten percent (10%) of the balances in his Accounts once he is receiving distribution, so long as the assignment or alienation is not for the purpose of defraying Plan administration costs. For purposes of this Section, a garnishment or levy is not considered to be a voluntary assignment, and a loan to the Participant, or his Beneficiary in the event of the Participant's death, shall not be treated as an assignment or alienation if such loan is secured by the Participant's nonforfeitable Employer Contribution Account, and is not a prohibited transaction within the meaning of Section 4975 of the Code.

7.3 Saving Clause

In the event any provision of this Trust is held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining parts of the Trust Agreement, but this instrument shall be construed and enforced as if said provision had never been included.

7.4 Applicable Law

This Trust shall be construed, administered and governed under the Act and the Code; and to the extent any of the provisions of this Trust and/or the Plan are inconsistent with the Act and/or the Code, the provisions of the Act and/or Code shall control. This Trust shall be construed, administered and governed by the laws of the State in which the Trustee administers this Trust, but only to the extent the laws of such State have not been superseded, or are not inconsistent with the Act and the Code. In the event, however, that any provision is susceptible to more than one interpretation, such interpretation shall be given thereto as is consistent with this Trust and the Plan being a qualified retirement Trust and Plan within the meaning of the Act and the Code.

7.5 Joinder of Parties

In any action or other judicial proceedings affecting this Trust, it shall be necessary to join as parties only the Trustee, the Administrator, and the Employer. No Participant or other persons having any interest in this Trust shall be entitled to any Notice or service of process unless otherwise required by law. Any judgment entered in such a proceeding or action shall be binding on all persons claiming under this Trust, provided, however, that nothing in this Trust shall be construed as to deprive a Participant of such Participant's right to seek adjudication of such Participant's rights under the Act.

Back to Item

Back to Agenda

7.6 Employment of Counsel

The Trustee may consult with legal counsel (who may be counsel for the Trustee or Employer).

7.7 Gender and Number

Words used in the masculine, feminine or neuter gender shall each be deemed to refer to the other whenever the context so requires; and words used in the singular or plural number shall each be deemed to refer to the other whenever the context so requires.

7.8 Headings

Headings used in this Trust are inserted for convenience of reference only and any conflict between such headings and the text shall be resolved in favor of the text.

7.9 Counterparts

This Trust may be executed in an original and any number of counterparts by the Employer and the Trustee, each of which shall be deemed to be an original of the one and the same instrument.

IN WITNESS WHEREOF, the Employer and Trustee have executed this Trust by their duly authorized agents on this 26th day of September 1991.

Huntington Beach City School District
EMPLOYER

By: _____
Gary Burgner

ACKNOWLEDGED AND ACCEPTED this 26th day of September 1991.

State Center Community College District
EMPLOYER

By: _____
Henry Padden

ACKNOWLEDGED AND ACCEPTED this 26th day of September 1991.

Imperial Trust Company
TRUSTEE

By: _____
John C. Henry, Vice President/Manager

Back to Item

Back to Agenda

PUBLIC AGENCY

RETIREMENT SYSTEM (PARS)

TRUST AGREEMENT

ACCOUNT IS ENTERED INTO BY CLIENT
AND U.S. BANK NATIONAL ASSOCIATION, AS TRUSTEE

This document is entered into by U.S. Bank National Association ("U.S. Bank"), as trustee. U.S. Bank succeeded Union Bank, N.A. as the trustee on February 1, 2012. All references in this document and all account related documents to Union Bank of California, N.A. and/or Union Bank, N.A. ("Union Bank"), are replaced with U.S. Bank.

Back to Item

Back to Agenda

PREAMBLE

The Huntington Beach City School District and State Center Community College District formed and adopted the Public Agency Retirement System Trust ("PARS Trust") on July 1,1991 ("Effective Date"). Subsequent to the Effective Date other California public agencies adopted the PARS Trust as the funding vehicle for tax qualified retirement plans for employees. Subsequent to the Effective Date the PARS Trust was amended. Effective as of July 1, 1999 ("Amended Effective Date") the PARS Trust was amended and restated in its entirety as contained herein. This amended and restated Trust shall supersede all prior versions of the PARS Trust as of the Amended Effective Date.

Back to Item

Back to Agenda

TABLE OF CONTENTS

Article I

DEFINITIONS

1.1 "Act" shall mean California Government Code Sections 53215 - 53224, or their successor sections.

1.2 "Agreement for Administrative Services" shall mean the agreement executed between the Member Agency and the Trust Administrator which authorizes the Trust Administrator to perform specific duties of administering the Member Agency Plan and related Agency Trust.

1.3 "Amended Effective Date" shall mean July 1, 1999, the date the PARS Trust Agreement was amended and restated in its entirety.

1.4 "Assets" shall mean all contributions and transfers of assets received by an Agency Trust on behalf of a Member Agency's Plan, together with the income and earnings from such contributions and transfers and any increments accruing to them.

1.5 "Agency Trust" shall mean the legally separate and individual trust, whose provisions are identical to those of the PARS Trust Agreement, that is established by a Member Agency when it adopts the PARS Trust by executing an Adoption Agreement.

1.6 "Alternate Trustee" shall mean a trustee, other than the Trustee of the PARS Trust Program, appointed by a Member Agency to serve as a trustee of a portion of such Agency Trust's assets as to which the Trustee serves as custodian.

1.7 "Code" shall mean the Internal Revenue Code of 1986 as amended from time to time.

1.8 "Custodian" shall mean Union Bank of California, N.A. whose duties are limited to those specified in Section 4.3.

1.9 "Delegatee" shall mean an individual or entity, appointed by the Plan Administrator or Member Agency to act in such matters as are specified in the appointment.

1.10 "Effective Date" shall mean July 1, 1991, the date the PARS Trust Program was established.

1.11 "Investment Fiduciary" shall mean the fiduciary with the authority and duty to direct the investment and management (including the power to direct the

acquisition and disposition) of some or all of the Assets of the Agency Trust appointed by a Member Agency for its Agency Trust.

1.12 "Omnibus Account" shall mean an account, established for record keeping purposes only, to commingle the Assets of the Agency Trust.

1.13 "Member Agency" shall mean a California public agency that adopts the provisions of the PARS Trust Agreement.

1.14 "Plan" shall mean the tax qualified plan whose assets the Agency Trust holds.

1.15 "Plan Administrator" shall mean the individual designated by position of employment at the Member Agency to act on its behalf in all matters relating to the Member Agency's participation in the PARS Trust Program and Agency Trust.

1.16 "PARS Trust Agreement" or "Trust Agreement" shall mean the pro forma Public Agency Retirement System trust document adopted by each Member Agency upon execution of an Adoption Agreement, as amended from time to time.

1.17 "PARS Trust Program" shall mean the Public Agency Retirement System trust arrangement.

1.18 "Participant" shall mean individual participating in a Member Agency Plan or that individual's beneficiary.

1.19 "Trust Administrator" shall mean Phase II Systems.

1.20 "Trustee" shall mean the entity appointed as trustee of the PARS Trust that shall also serve as trustee of each Agency Trust established pursuant to the provisions of this trust agreement except where an Alternate Trustee has been appointed.

Article II

THE PARS TRUST PROGRAM

2.1 Multiple Employer Trust

The PARS Trust Program is a multiple employer trust arrangement established to provide economies of scale and efficiency of administration to public agencies that adopt it to hold the assets of their Member Agency Plans maintained for the benefit of their employees. The PARS Trust Program consists of the Agency Trusts adopted and not terminated by Member Agencies.

2.2 Qualified Governmental Retirement Trust

The PARS Trust Program is established pursuant to the provisions of Section 501 of the Internal Revenue Code of 1986, as amended (the "Code"), and California Government Code Sections 53215 through 53224 providing for pension trusts established by public agencies.

2.3 Date of Adoption

The date as of which each Member Agency adopts the PARS Trust Program shall be the "Effective Date" of the PARS Trust Agreement and the Agency Trust, as defined in Section 2.5, as to that Member Agency.

2.4 Member Agencies

Any California public agency may, by action of its governing body in a writing accepted by the Trustee, adopt the provisions of the PARS Trust Agreement as the trust portion of a qualified governmental retirement plan established for the benefit of its employees. Executing an adoption instrument for the PARS Trust Program ("Adoption Agreement"), attached hereto as Exhibit "A", shall constitute such adoption, unless the Trustee requires additional evidence of adoption. In order for such adoption to be effective, the public agency must also execute an Agreement for Administrative Services with Phase II Systems, the Trust Administrator, pursuant to section 3.6 of this PARS Trust Agreement. Such adopting employer shall then become a Member Agency of the PARS Trust Program.

Each such Member Agency shall, at a minimum, furnish the Trust Administrator with the following documents to support its adoption of the PARS Trust Program:

(a) a certified copy of the Member Agency governing body resolution authorizing the adoption of the PARS Trust Agreement and the appointment of an individual designated by position of employment at the Member Agency to act on its behalf in all matters relating to the Member Agency's participation in the PARS Trust Program and Agency Trust ("Plan Administrator");

(b) an original of the Adoption Agreement executed by the Plan Administrator or other duly authorized Member Agency employee;

(c) an original of the Agreement for Administrative Services with Phase II Systems executed by the Plan Administrator or other duly authorized Member Agency employee and Phase II Systems;

(d) an address notice; and

(e) such other documents as the Trustee may reasonably request.

2.5 Agency Trust

By adopting the PARS Trust Agreement, as provided in Section 2.4, a Member Agency shall be deemed to have adopted a legally separate and individual Agency Trust whose provisions are identical to those of the PARS Trust Agreement. The Assets of an Agency Trust shall be available only to pay benefits pursuant to the provisions of the Plan to participants and beneficiaries of the Member Agency entitled to receive benefits under the provisions of the Plan. The Agency Trust is created for the purpose of receiving contributions made to fund the Member Agency's Plan; accumulating, managing and investing those contributions; and providing benefits to active or retired participants of the Plan, their joint annuitants, or their beneficiaries. Each Agency Trust shall be used to fund only a single Plan maintained by the Member Agency. A Member Agency may establish additional Agency Trusts to fund the assets of additional Plans by executing one or more additional Adoption Agreement(s).

2.6 Assets of Agency Trust

The assets of the Agency Trust shall consist of all contributions and transfers received by the Agency Trust on behalf of the Member Agency's Plan, together with the income and earnings from such contributions and transfers, and any increments accruing to them ("Assets"). All contributions or transfers shall be received by the Trustee in cash or in other property acceptable to the Trustee. The Trustee shall manage and administer the Assets of the Agency Trust without distinction between principal and income. The Trustee and the Trust Administrator shall have no duty to compute any amount to be transferred or paid to the Agency Trust by the Member Agency and the Trustee and the Trust Administrator shall not be responsible for the collection of any contributions or transfers to the Agency Trust.

2.7 Commingling for Investment and Administration

The Assets of more than one Agency Trust may be commingled by the Trustee or Investment Fiduciary in one or more Omnibus Accounts for investment and administrative purposes, to provide economies of scale and efficiency of administration to the Agency Trusts. The responsibility for Plan level accounting within this Omnibus Account(s) shall be that of the Trust Administrator.

2.8 Trustee Accounting

The Trustee shall be responsible only for maintaining records and maintaining accounts for the aggregate assets of the PARS Trust Program. The

responsibility for Plan level accounting for each Agency Trust, based upon the Omnibus Account(s), shall be that of the Trust Administrator.

2.9 No Diversion of Assets

The Assets in each Agency Trust shall be held in trust for the exclusive purpose of providing benefits to the Participants of the Plan for which the Agency Trust is holding assets and defraying the reasonable expenses of such Plan. The Assets shall not be used for or diverted to, any other purpose.

2.10 Type and Nature of Trust

Neither the full faith and credit nor the taxing power of each Member Agency, the State of California or any political subdivision thereof other than each Member Agency is pledged to the distribution of benefits hereunder. Except for contributions and other amounts hereunder, no other amounts are pledged to the distribution of benefits hereunder. Distributions of benefits are neither general nor special obligations of any Member Agency, but are payable solely from the Assets of each Agency Trust, as more fully described herein. No employee of any Member Agency or beneficiary may compel the exercise of the taxing power by any Member Agency.

Distributions of Assets under any Agency Trust are not debts of any Member Agency, the State of California or any of its political subdivisions within the meaning of any constitutional or statutory limitation or restriction. Such distributions are not legal or equitable pledges, charges, liens or encumbrances, upon any of a Member Agency's property, or upon any of its income, receipts, or revenues, except amounts in the accounts which are, under the terms of each Plan, Agency Trust and the Act, set aside for distributions. Neither the members of the legislative body of any Member Agency nor its officers, employees, agents or volunteers are liable hereunder.

Article III

ADMINISTRATIVE MATTERS

3.1 Appointment of Trustee

Two thirds or more of the Member Agencies acting jointly, may by a two-thirds or greater vote, act to appoint a bank, trust company, retirement board, insurer, committee or such other entity as permitted by California law, to serve as the trustee of the PARS Trust Program ("Trustee"). Such action must be in writing. Upon the written acceptance of such entity it shall become the Trustee of the PARS Trust Program and, subject to the provisions of Section 3.10, the trustee of each Agency Trust. By executing an Adoption Agreement, the adopting Member

Agency hereby appoints the Union Bank of California, N.A. as the Trustee as of the Amended Effective Date.

3.2 Removal of Trustee

Two thirds or more of the Member Agencies acting jointly, may by a vote of two - thirds or greater, act to remove the Trustee. Such action must be in writing and delivered to the Trustee and the Trust Administrator. Upon such removal from the PARS Trust the Trustee shall also be removed as trustee of each of the Agency Trusts. The Plan Administrator may remove the Trustee as trustee of an Agency Trust by giving at least ninety (90) days prior written notice to the Trustee and the Trust Administrator and withdrawing from the PARS Trust Program.

3.3 Resignation of Trustee

The Trustee may resign as trustee of the PARS Trust Program at any time by giving at least ninety (90) days prior written notice to the Trust Administrator and to each Plan Administrator of each Member Agency that has adopted the PARS Trust Agreement and not terminated its participation in the PARS Trust Program. Such resignation shall also be deemed a resignation as trustee of each of the Agency Trusts. The Trustee may resign as trustee of an Agency Trust by giving at least ninety (90) days written notice to the Plan Administrator of such Agency Trust and to the Trust Administrator. The Member Agency's appointment of a successor trustee to the Agency Trust will vest the successor trustee with title to the Assets of its Agency Trust upon the successor trustee's acceptance of such appointment.

3.4 The Plan Administrator

The governing body of each Member Agency shall have plenary authority for the administration and investment of the Agency Trust pursuant to the laws and Constitution of the State of California and applicable federal laws and regulations. Each Member Agency shall by resolution designate a Plan Administrator. Unless otherwise specified in the instrument the Plan Administrator shall be deemed to have authority to act on behalf of the Member Agency in all matters pertaining to the Member Agency's participation in the PARS Trust Program and in regard to the Agency Trust of the Member Agency. Such appointment of a Plan Administrator shall be effective upon receipt and acknowledgment by the Trustee and the Trust Administrator and shall be effective until the Trustee and Trust Administrator are furnished with a resolution of the Member Agency that the appointment has been modified or terminated.

3.5 Failure to Appoint Plan Administrator

If a Plan Administrator is not appointed, or such appointment lapses, the Member Agency shall be deemed to be the Plan Administrator. As used in this document

Plan Administrator shall be deemed to mean Member Agency when a Plan Administrator has not been appointed.

3.6 Delegatee

The Plan Administrator, acting on behalf of the Member Agency, may delegate certain authority, powers and duties to an entity to act in those matters specified in the delegation ("Delegatee"). Any such delegation must be in a writing that names and identifies the Delegatee, states the effective date of the delegation, specifies the authority and duties delegated, is executed by the Plan Administrator and is acknowledged in writing by the Delegatee, the Trust Administrator (if not the Delegatee) and the Trustee. Such delegation shall be effective until the Trustee and the Trust Administrator are directed in writing by the Plan Administrator that the delegation has been rescinded or modified.

3.7 Certification to Trustee

The governing body of each Member Agency, or other duly authorized official, shall certify in writing to the Trustee and the Trust Administrator the names and specimen signatures of the Plan Administrator and Delegatee, if any, and all others authorized to act on behalf of the Member Agency whose names and specimen signatures shall be kept accurate by the Member Agency acting through a duly authorized official or governing body of the Member Agency. The Trustee and the Trust Administrator shall have no liability if it acts upon the direction of a Plan Administrator or Delegatee that has been duly authorized, as provided in Section 3.6, if that Plan Administrator or Delegatee is no longer authorized to act, unless the Member Agency has informed the Trustee and the Trust Administrator of such change.

3.8 Directions to Trustee

Except as provided in Section 5.18 of this Trust Agreement, all directions to the Trustee from the Plan Administrator or Delegatee must be in writing and must be signed by the Plan Administrator or Delegatee, as the case may be. For all purposes of this Trust Agreement, direction shall include any certification, notice, authorization, application or instruction of the Plan Administrator, Delegatee or Trustee appropriately communicated. The above notwithstanding direction may be implied if the Plan Administrator or Delegatee has knowledge of the Trustee's intentions and fails to file written objection.

The Trustee shall have the power and duty to comply promptly with all proper direction of the Plan Administrator, or Delegatee, appointed in accordance with the provisions of this PARS Trust Agreement. In the case of any direction deemed by the Trustee to be unclear or ambiguous the Trustee may seek written instructions from the Plan Administrator, the Agency or the Delegatee on such

matter and await their written instructions without incurring any liability. If at any time the Plan Administrator or the Delegatee should fail to give directions to the Trustee, the Trustee may act in the manner that in its discretion seems advisable under the circumstances for carrying out the purposes of the PARS Trust Program and/or any Agency Trust which may include not taking any action. The Trustee may request directions or clarification of directions received and may delay acting until clarification is received. In the absence of timely direction or clarification, or if the Trustee considers any direction to be a violation of the PARS Trust Agreement or any applicable law, the Trustee shall in its sole discretion take appropriate action, or refuse to act upon a direction.

3.9 Alternate Trustee

A Member Agency may appoint a trustee, other than the Trustee, as to a portion of the assets in the Agency Trust by designating such person or entity as an Alternate Trustee on the Adoption Agreement and by specifying which assets shall be subject to the fiduciary management of the Alternate Trustee. Such appointment shall not be effective unless it is in writing, specifies clearly the assets as to which the Alternate Trustee is to have trustee powers, is acknowledged in writing by the Alternate Trustee, is delivered to and acknowledged by the Trustee and the Trust Administrator. Only a bank, trust company, retirement board, insurer, the Member Agency or such entity as permitted by California law to be a trustee may be appointed an Alternate Trustee. Such appointment will become effective upon acceptance by the Alternate Trustee.

3.10 Powers Of Alternate Trustee

The Alternate Trustee shall be deemed to have all of the powers and duties and responsibilities specified in the PARS Trust Agreement for the PARS Trustee in Article IV unless otherwise specified in the Adoption Agreement.

3.11 Responsibility of Trustee Upon Appointment of Alternate Trustee

Upon the appointment of an Alternate Trustee, the Trustee shall have no liability or responsibility for any matters relating to the management, investment or administration of those assets as to which the Alternate Trustee has been appointed and shall only have the duties set forth in Section 4.3.

3.12 Trust Administrator

The Member Agencies have appointed Phase II Systems as the Trust Administrator. The Trust Administrator has accepted its appointment subject to each Member Agency's delegation of authority, to act as such, pursuant to Section 3.6 of this PARS Trust Agreement. The Trust Administrator's duties

involve the performance of the following services pursuant to the provisions of this trust agreement and the Agreement for Administrative Services:

(a) Performing periodic accounting of the Agency Trust;

(b) Directing the Trustee to make distributions from the Agency Trust to Participants pursuant to the provisions of the Member Agency's Plan and liquidate assets in order to make such distributions;

(c) Notifying the Investment Fiduciary of the amount of Assets in the Agency Trust available for further investment and management by the Investment Fiduciary;

(d) Allocating contributions, earnings and expenses to each Agency Trust;

(e) Directing the Trustee to pay insurance premiums, to pay the fees of the Trust Administrator and to do such other acts as shall be appropriate to carry out the intent of the Agency Trusts.

(f) Such other services as the Member Agency and the Trust Administrator may agree in the Agreement for Administrative Services pursuant to Section 2.4.

3.13 The Trust Administrator shall be entitled to rely on, and shall be under no duty to question, direction and/or data received from the Plan Administrator, or other duly authorized entity, in order to perform its authorized duties under this trust agreement. The Trust Administrator shall not have any duty to compute contributions made to the Agency Trust, determine or inquire whether contributions made to the Agency Trust by the Plan Administrator or other duly authorized entity are adequate to meet and discharge liabilities under the Plan; or determine or inquire whether contributions made to the Agency Trust are in compliance with the Plan; The Trust Administrator shall not be liable for non performance of duties if such non performance is directly caused by erroneous, and/or late delivery of, directions or data from the Plan Administrator, or other duly authorized entity.

3.14 Additional Trust Administrator Services

The Plan Administrator may at any time retain the Trust Administrator as its agent to perform any act, keep any records or accounts and make any computations which are required of the Member Agency or the Plan Administrator by this PARS Trust Agreement or by the Member Agency's Plan. The Trust Administrator shall be separately compensated for such service and such services shall not be deemed to be contrary to the PARS Trust Agreement.

3.15 Trust Administrator's Compensation

As may be agreed upon from time to time by the Member Agency and Trust Administrator, the Trust Administrator will be paid reasonable compensation for services rendered or reimbursed for expenses properly and actually incurred in the performance of duties with respect to the Agency Trust and to the PARS Trust Program in accordance with Section 53217 of the Act.

3.16 Resignation or Removal of Trust Administrator

The Trust Administrator may resign at any time by giving at least one hundred twenty (120) days written notice to each Member Agency of the PARS Trust Program and the Trustee. The Member Agencies, by a two-thirds or greater vote, may remove the Trust Administrator by delivering, at least one hundred twenty (120) days prior to the effective date of such removal, written notice to the Trust Administrator and to the Trustee.

Article IV

THE TRUSTEE

4.1 Powers and Duties of the Trustee

Except as otherwise provided in Article V and subject to Article VI, the Trustee shall have full power and authority with respect to property held in the Agency Trust to do all such acts, take all proceedings, and exercise all such rights and privileges, whether specifically referred to or not in this document, as could be done, taken or exercised by the absolute owner, including, without limitation, the following:

(a) To invest and reinvest the Assets or any part hereof in any one or more kind, type, class, item or parcel of property, real, personal or mixed, tangible or intangible; or in any one or more kind, type, class, item or issue of investment or security; or in any one or more kind, type, class or item of obligation, secured or unsecured; or in any combination of them. To retain the property for the period of time that the Trustee deems appropriate;

(b) To acquire and sell options to buy securities ("call" options) and to acquire and sell options to sell securities ("put" options);

(c) To buy, sell, assign, transfer, acquire, loan, lease (for any purpose, including mineral leases), exchange and in any other manner to acquire, manage, deal with and dispose of all or any part of the Agency Trust

property, for cash or credit and upon any reasonable terms and conditions;

(d) To make deposits, with any bank or savings and loan institution, including any such facility of the Trustee or an affiliate thereof provided that the deposit bears a reasonable rate of interest;

(e) To invest and reinvest the Assets, or any part thereof in any one or more collective investment trust funds, including common and group trust funds that consist exclusively of assets of exempt pension and profit sharing trusts and individual retirement accounts qualified and tax exempt under the Code, that are maintained by the Trustee or an affiliate thereof. The declaration of trust or plan of operations for any such common or collective fund is hereby incorporated herein and adopted into this PARS Trust Agreement by this reference. The combining of money and other assets of the Agency Trust with money and other assets of other qualified trusts in such fund or funds is specifically authorized. Notwithstanding anything to the contrary in this trust agreement, the Trustee shall have full investment responsibility over assets of the trust invested in such commingled funds. If the plan and trust for any reason lose their tax exempt status, and the Assets have been commingled with assets of other tax exempt trusts in Trustee's collective investment funds, the Trustee shall within 30 days of notice of such loss of tax exempt status, liquidate the Agency Trust's units of the collective investment fund(s) and invest the proceeds in a money market fund pending investment or other instructions from the Plan Administrator. The Trustee shall not be liable for any loss or gain or taxes, if any, resulting from said liquidation;

(f) To place uninvested cash and cash awaiting distribution in one or more mutual funds and/or commingled investment funds maintained by or made available by the Trustee, and to receive compensation from the sponsor of such fund(s) for services rendered, separate and apart from any Trustee's fees hereunder. Trustee or Trustee's affiliate may also be compensated for providing investment advisory services to any mutual fund or commingled investment funds;

(g) To borrow money for the purposes of the Agency Trust from any source with or without giving security; to pay interest; to issue promissory notes and to secure the repayment thereof by pledging all or any part of the Assets;

(h) To take all of the following actions as directed by the Investment Fiduciary or other person with investment discretion over the trust assets: to vote proxies of any stocks, bonds or other securities; to give general or special proxies or powers of attorney with or without power of substitution; to exercise any conversion privileges, subscription rights or other options,

and to make any payments incidental thereto; to consent to or otherwise participate in corporate reorganizations or other changes affecting corporate securities and to delegate discretionary powers and to pay any assessments or charges in connection therewith; and generally to exercise any of the powers of an owner with respect to stocks, bonds, securities or other property held in the Agency Trust;

(i) To make, execute, acknowledge and deliver any and all documents of transfer and conveyance and any and all other instruments that may be necessary or appropriate to carry out the powers herein granted;

(j) To raze or move existing buildings; to make ordinary or extraordinary repairs, alterations or additions in and to buildings; to construct buildings and other structures and to install fixtures and equipment therein;

(k) To pay or cause to be paid from the Agency Trust any and all real or personal property taxes, income taxes or other taxes or assessments of any or all kinds levied or assessed upon or with respect to the Agency Trust or the Plan;

(l) As directed by the Trust Administrator, to hold term or ordinary life insurance contracts on the lives of Participants (but in the case of conflict between any such contract and the Plan, the terms of the Plan shall prevail); to pay from the Agency Trust the premiums on such contracts; to distribute, surrender or otherwise dispose of such contracts; to pay the proceeds, if any, of such contracts to the proper persons in the event of the death of the insured Participant; to enter into, modify, renew and terminate annuity contracts of deposit administration of immediate participation or other group or individual type with one or more insurance companies and to pay or deposit all or any part of the Agency Trust Assets thereunder; to provide in any such contract for the investment of all or any part of funds so deposited with the insurance company in securities under separate accounts; to exercise and claim all rights and benefits granted to the contract holder by any such contracts;

(m) To exercise all the further rights, powers, options and privileges granted, provided for, or vested in trustees generally under applicable federal or California laws, as amended from time to time, it being intended that, except as herein otherwise provided, the powers conferred upon the Trustee herein shall not be construed as being in limitation of any authority conferred by law, but shall be construed as consistent or in addition thereto.

4.2 Additional Trustee Powers

In addition to the other powers enumerated above, and whether or not the Member Agency has retained investment authority or delegated it to an Investment Fiduciary or Participants in Participant Directed Accounts, the Trustee in any and all events is authorized and empowered:

(a) To invest funds pending required directions in any type of interest-bearing account including without limitation, time certificates of deposit or interest-bearing accounts issued by Union Bank of California N.A., or any mutual fund or short term investment fund ("Fund"), whether sponsored or advised by Union Bank of California or any affiliate thereof; Union Bank of California, N.A. or its affiliate may be compensated for providing such investment advice and providing other services to such Fund, in addition to any Trustee's fees received pursuant to this Trust Agreement;

(b) To cause all or any part of the Agency Trust to be held in the name of the Trustee (which in such instance need not disclose its fiduciary capacity) or, as permitted by law, in the name of any nominee, and to acquire for the Agency Trust any investment in bearer form, but the books and records of the Agency Trust shall at all times show that all such investments are a part of the Agency Trust and the Trustee shall hold evidences of title to all such investments;

(c) To serve as sole custodian with respect to the Agency Trust Assets;

(d) To employ such agents and counsel as may be reasonably necessary in managing and protecting the Assets and to pay them reasonable compensation; to employ any broker-dealer, including a broker-dealer affiliated with the Trustee, and pay to such broker-dealer at the expense of the Agency Trust, its standard commissions; to settle, compromise or abandon all claims and demands in favor of or against the Agency Trust; and to charge any premium on bonds purchased at par value to the principal of the Agency Trust without amortization from the Agency Trust, regardless of any law relating thereto;

(e) In addition to the powers listed herein, to do all other acts necessary or desirable for the proper administration of the Agency Trust, as though the absolute owner thereof;

(f) To abandon, compromise, contest, arbitrate or settle claims or demands; to prosecute, compromise and defend lawsuits, but without obligation to do so, all at the risk and expense of the Agency Trust;

(g) To exercise and perform any and all of the other powers and duties specified in this Trust Agreement or the Plan;

(h) To permit such inspections of documents at the principal office of the Trustee as are required by law, subpoena or demand by United States agency;

(i) To comply with all requirements imposed by applicable provisions of law;

(j) To seek written instructions from the Plan Administrator or other fiduciary on any matter and await their written instructions without incurring any liability. If at any time the Plan Administrator or the fiduciary should fail to give directions to the Trustee, the Trustee may act in the manner that in its discretion seems advisable under the circumstances for carrying out the purposes of this Agency Trust;

(k) As directed by the Plan Administrator or Delegatee if duly authorized, to cause the benefits provided under the Plan to be paid directly to the persons entitled thereto under the Plan, and in the amounts and in the manner specified, and to charge such payments against the Agency Trust with respect to which such benefits are payable;

(l) To compensate such executive, consultant, actuarial, accounting, investment, appraisal, administrative, clerical, secretarial, medical, custodial, depository and legal firms, personnel and other employees or assistants as are engaged by the Plan Administrator in connection with the administration of the Plan and to pay from the Agency Trust the necessary expenses of such firms, personnel and assistants, to the extent not paid by the Plan Administrator;

(m) To act upon proper written directions of the Plan Administrator or Delegatee, including directions given by photostatic transmissions using facsimile signature;

(n) To pay from the Agency Trust the expenses reasonably incurred in the administration of the Agency Trust as provided in the Plan;

(o) To maintain insurance for such purposes, in such amounts and with such companies as the Plan Administrator shall elect, including insurance to cover liability or losses occurring by reason of the acts or omissions of fiduciaries but only if such insurance permits recourse by the insurer against the fiduciary in the case of a breach of a fiduciary obligation by such fiduciary.

4.3 Custodial Powers

If an Alternate Trustee has been appointed pursuant to Section 3.9, Union Bank of California, N.A., ("Bank") as Custodian, shall only have the following responsibilities:

(a) Keep records of all transactions entered into for the Agency Trust and furnish to Alternate Trustee statements no less frequently than quarterly showing all principal and income transactions and Agency Trust Assets, which shall be deemed ratified and approved by Alternate Trustee unless Custodian is advised to the contrary within ninety (90) days of Custodian's mailing thereof by first class mail to Alternate Trustee;

(b) Receive payments of income and principal on Agency Trust Assets, and retain or remit in accordance with Alternate Trustee's written instructions;

(c) Hold Agency Trust Assets in Bank's name as Custodian for Alternate Trustee or in Bank's nominee name, or, as to securities eligible to be held by the depository trust company or other depository, in its nominee name;

(d) Purchase and sell securities, attend to the exchange of securities, deposit or exchange securities of companies in reorganization, and tender securities on redemption or tender offer solely upon direction of Alternate Trustee;

(e) Sign the name of Alternate Trustee to stock and bond powers and any other instruments required for the proper exercise of Bank's duties, and Bank is appointed Alternate Trustee's attorney-in-fact for these purposes;

(f) Forward all proxies and accompanying materials to Alternate Trustee to be voted unless directed in writing to the contrary. Disclose Alternate Trustee's name and address in response to requests from issuers of securities and others to facilitate direct communication for proxy and tender offer response;

(g) Sell all fractional shares of stock received as a result of stock dividends or other corporate action;

(h) Notify Alternate Trustee of any inability to collect income or principal if the securities or other property constituting Assets upon which such amount is payable is in default, or if payment is refused after due demand. Bank shall be under no obligation or duty to take any action to effect collection of defaulted payments, or to file or pursue any bankruptcy or class action claims with respect to Agency Trust.

(i) Perform a telephonic verification to Alternate Trustee or Alternate Trustee's authorized representative or such other security procedure selected by Alternate Trustee prior to wiring funds or following facsimile directions as Bank may require. Alternate Trustee assumes all risk of delay of transfer if Bank is unable to reach Alternate Trustee or Alternate Trustee's authorized representative, or in the event of delay as a result of attempts to comply with any other security procedure selected by Alternate Trustee.

Article V

INVESTMENTS

5.1 Investment Fiduciary

Except as herein provided, the Plan Administrator shall be the Investment Fiduciary.

5.2 Appointment of Trustee or an Investment Manager as Investment Fiduciary

The Plan Administrator may appoint the Trustee or an investment manager as the Investment Fiduciary, with the authority and duty to direct the investment and management of all or any portion of the Assets of the Agency Trust.

5.3 Appointment of Investment Fiduciary

No action of the Plan Administrator pursuant to 5.2 shall be effective until a certified copy of the revised Adoption Agreement and, if required, any such resolution of the governing body of the Member Agency or Plan Administrator action is delivered to the Trustee. Upon receipt and acceptance, the Trustee or investment manager, as the case may be, shall assume fiduciary responsibility with respect to the investment and management of such assets of the Agency Trust as are specified in the resolution or action. Any transfer of investment authority to the Trustee or to an investment manager may be revoked by delivering to the Trustee or the investment manager a written notice from either the Member Agency governing body or the Plan Administrator, as the case may be.

5.4 Reliance by Trustee on Investment Fiduciary

The appointment, selection and retention of an Investment Fiduciary shall be solely the responsibility of the Member Agency acting through its governing body or the Plan Administrator. The Trustee may rely upon the fact that the

Investment Fiduciary is authorized to direct the investment and management of the Assets of the Agency Trust until such time as the Plan Administrator shall notify the Trustee in writing that another Investment Fiduciary has been appointed to replace the Investment Fiduciary named, or, in the alternative, that the Investment Fiduciary named has been removed.

5.5 When Trustee is not Investment Fiduciary

The Trustee shall not be the Investment Fiduciary and shall have no responsibility or authority for the investment and management of assets unless specifically designated as the Investment Fiduciary as to some or all of the assets in the Agency Trust and accepts such designation.

(a) During such period or periods of time, if any, as the Plan Administrator or an Investment Fiduciary is authorized to direct the investment and management of the Assets of the Agency Trust, the Trustee shall (subject to the overriding limitations hereinafter set forth) effect and change investment of the Assets of the Agency Trust as directed in writing by the Plan Administrator, or Investment Fiduciary, as the case may be, and shall neither effect nor change any such investments without such direction and shall have no right, duty or responsibility to recommend investments or investment changes. The following provisions shall govern the Trustee during such period or periods of time, if any, during which the Plan Administrator or an Investment Fiduciary is authorized to direct the investment and management of the Assets of any Agency Trust:

(b) So long as the Plan Administrator retains or reacquires full power and responsibility to direct the Trustee with respect to the investment and management of all or any portion of the Assets of the Agency Trust, the Trustee shall not be liable nor responsible for losses or unfavorable results arising from the Trustee's compliance with proper directions of the Plan Administrator which are made in accordance with the terms of this Trust Agreement and which are not contrary to the provisions of any applicable federal or state statute regulating such investment.

(c) In the event an Investment Fiduciary is given authority and responsibility with respect to the investment and management of the Assets of the Agency Trust, neither the Trustee nor the Plan Administrator shall be liable or responsible in any way for any losses or other unfavorable results arising from the Trustee's compliance with investment or management directions received by the Trustee from the Investment Fiduciary.

5.6 Investment Directions Must be in Writing

Subject to the provisions of Section 5.18, in order to be valid all directions concerning investments made by the Plan Administrator, or the Investment

Fiduciary, or PARS Trustee must be signed by the authorized person or persons acting on behalf of the Plan Administrator, Investment Fiduciary or Trustee, as the case may be.

5.7 Trustee Reliance On Directions

(a) The Trustee shall be entitled to rely upon directions which the Trustee receives. The Trustee shall be under no duty to question any directions of the Investment Fiduciary or Plan Administrator nor to review any securities or other property of the PARS Trust or Agency Trust constituting assets thereof with respect to which an Investment Fiduciary or the Plan Administrator has investment responsibility, nor to make any suggestions to the Investment Fiduciary or Plan Administrator in connection therewith. The Trustee shall, as promptly as possible, comply with any written directions given by the Plan Administrator or an Investment Fiduciary hereunder. The Trustee shall not be liable, in any manner nor for any reason, for the making or retention of any investment pursuant to such directions, nor shall the Trustee be liable for its failure to invest any or all of the Assets of the Agency Trust in the absence of such written directions. The Trustee shall be under no obligation to seek written clarification in the event of ambiguity.

(b) During such period of time, if any, as the Plan Administrator, or an Investment Fiduciary, is authorized to direct the Trustee, the Trustee shall have no obligation to determine the existence of any conversion, redemption, exchange, subscription or other right relating to any securities purchased of which notice was given prior to the purchase of such securities, and shall have no obligation to exercise any such right unless the Trustee is informed of the existence of the right and is instructed to exercise such right, in writing, by the Plan Administrator or the Investment Fiduciary, as the case may be, within a reasonable time prior to the expiration of such right.

(c) In any event, neither the Plan Administrator nor any Investment Fiduciary referred to above shall direct the purchase, sale or retention of any Assets of the Agency Trust if such directions are not in compliance with applicable law.

5.8 Trustee Fees

As may be agreed upon, in writing, between the Plan Administrator and Trustee, the Trustee will be paid reasonable compensation for services rendered or reimbursed for expenses properly and actually incurred in the performance of duties with respect to the Agency Trust or the PARS Trust.

5.9 Contributions

The Plan Administrator shall make all of its contributions to the Trustee, and shall also transmit all contributions of Plan participants, as may be required or allowed by the Plan, to the Trustee. Such contributions shall be in cash unless the Trustee agrees to accept a contribution that is not in cash. All contributions shall be paid to the Trustee for investment and reinvestment pursuant to the terms of this Trust Agreement. The Trustee shall not have any duty to determine or inquire whether any contributions to the Agency Trust made to the Trustee by any Plan Administrator are in compliance with the Plan; nor shall the Trustee have any duty or authority to compute any amount to be paid to the Trustee by any Plan Administrator; nor shall the Trustee be responsible for the collection or adequacy of the contributions to meet and discharge liabilities under the Plan. The contributions received by the Trustee from each Member Agency shall be held and administered pursuant to the terms hereof without distinction between income and principal.

5.10 Money Market Fund

Pending any investment directions, such cash in the Agency Trust in an amount as is reasonable in the discretion of the Trustee, may be deposited in a money market fund selected by the Trustee or the Member Agency.

5.11 Purchase of Contracts

The Trustee shall have the authority to purchase individual or group insurance, annuity, preliminary term, group pension, and variable annuity contracts in accordance with the directions of the Plan Administrator or other insurance contracts at the direction of the Plan Administrator or Investment Fiduciary if such contracts are acceptable to the Trustee. The Trustee shall act as custodian of such contracts if an Alternate Trustee is appointed as to such contracts.

5.12 Records

(a) The Trustee shall maintain accurate records and detailed accounts of all investments, receipts, disbursements and other transactions hereunder at the PARS Trust level. Such records shall be available at all reasonable times for inspection by the Trust Administrator. The Trustee shall, at the direction of the Trust Administrator, submit such valuations, reports or other information as the Trust Administrator may reasonably require.

(b) Valuation. The assets of the Agency Trust shall be valued at their fair market value on the date of valuation, as determined by the Trustee based upon such sources of information as it may deem reliable; provided, however, that the Plan Administrator shall instruct the Trustee as to valuation of assets which are not readily determinable on an established

market. The Trustee may rely conclusively on such valuations provided by the Plan Administrator and shall be indemnified and held harmless by the Plan Administrator with respect to such reliance. If the Plan Administrator fails to provide such values, the Trustee may take whatever action it deems reasonable, including employment of attorneys, appraisers or other professionals, the expense of which will be an expense of administration of the Agency Trust. Transactions in the account involving such hard to value assets may be postponed until appropriate valuations have been received and Trustee shall have no liability therefore.

5.13 Statements

(a) Periodically as specified, and within sixty days after June 30, or the end of the PARS Trust's fiscal year if different, Trustee shall render to the Trust Administrator as directed, a written account showing in reasonable summary the investments, receipts, disbursements and other transactions engaged in by the Trustee during the preceding fiscal year or period with respect to the PARS Trust. Such account shall set forth the assets and liabilities of the PARS Trust valued as of the end of the accounting period.

(b) The Trust Administrator may approve such statements either by written notice or by failure to express objections to such statements by written notice delivered to the Trustee within 90 days from the date the statement is delivered to the Trust Administrator. Upon approval, the Trustee shall be released and discharged as to all matters and items set forth in such statement as if such account had been settled and allowed by a decree from a court of competent jurisdiction.

5.14 Wire Transfers

The Trustee shall follow the Plan Administrator's, Delegatee's, or Trust Administrator's wire transfer instructions in compliance with the written security procedures provided by the party providing the wire transfers. The Trustee shall perform a telephonic verification to the Plan Administrator, Trust Administrator, or Delegatee, of such other security procedure, as selected by the party providing wire transfer directions, prior to wiring funds or following facsimile directions as Trustee may require. The Plan Administrator assumes the risk of delay of transfer if Trustee is unable to reach the Plan Administrator, or in the event of delay as a result of attempts to comply with any other security procedure selected by the directing party.

5.15 Exclusive Benefit

The Assets of the Agency Trust shall be held in trust for the exclusive purpose of providing benefits to the participants and their beneficiaries of the Member Agency Plan, and defraying reasonable expenses of the Plan, and shall not be

used for or diverted to any other purpose. No party shall have authority to use or divert such Plan's Assets for the payment of benefits or expenses of any other Member Agency's Plan.

5.16 Delegation of Duties

The Plan Administrator, Delegatee, or Trust Administrator, may at any time retain the Trustee as its agent to perform any act, keep any records or accounts and make any computations that are required of the Plan Administrator, Delegatee or Trust Administrator by this Trust Agreement or by the Plan. The Trustee may be compensated for such retention and such retention shall not be deemed to be contrary to this Trust Agreement.

5.17 Distributions

All benefits payable pursuant to the Plan shall be paid out of the Assets of the Agency Trust by the Trustee pursuant to the direction of the Plan Administrator or Delegatee. The Trustee shall, from time to time, upon the written direction of the Plan Administrator or Delegatee, make distributions from the Assets of the Agency Trust to or for the benefit of such persons, in such manner in such form(s), in such amounts and for such purposes as may be specified in such directions. The Trustee at the direction of the Plan Administrator or Delegatee may make any distribution required to be made by it hereunder by delivering to the Plan Administrator or Delegatee:

Its check payable to the person to whom such distribution is to be made, for delivery to such person; or

Its check payable to an insurer for the benefit of such person, for delivery by such insurer; or insurance contracts held on the life of the Participant to whom or with respect to whom the distribution is being made, for redelivery to the person to whom such distribution is to be made; provided that any contract distributed shall be endorsed as non-transferable.

In directing the Trustee to make distributions, the Plan Administrator or Delegatee shall follow the provisions of the Plan and shall not direct that any distribution be made either during the existence or upon discontinuance of the Plan, which would cause any part of the Assets of the Agency Trust to be used for or diverted to purposes other than as provided in the Plan and this PARS Trust. In no event shall the Trustee have any responsibility respecting the application of such distributions, nor for determining or inquiring into whether such distributions are in accordance with the Plan.

5.18 Participant Directed Accounts

The Member Agency may, by written resolution and execution of the Adoption Agreement, terminate the Plan Administrator's right to direct the investment and management of all or any portion of the Assets of the Agency Trust and allow Participants to direct their own account balances ("Participant Directed Accounts"). Notwithstanding any other provision of this Trust Agreement, for Participant Directed Accounts, the Trustee shall be entitled to act upon proper directions of the Plan Administrator, Trust Administrator, and Participants including directions in writing, or oral instructions which Trustee in its discretion may follow without receipt of written instructions, instruction given by photostatic teletransmission using facsimile signature, or those instructions which are digitally recorded on the UBOC Voice Response Unit ("VRU") or internet website. Trustee is hereby authorized to record conversations and transmissions made in connection with the Agency Trust. Trustee's recording or lack of recording of any such oral, internet or digital instructions, and/or receipt or lack of receipt of facsimile transmissions, as reflected in the Trustee's records maintained in the ordinary course of business shall constitute conclusive proof of Trustee's receipt or non-receipt of such instructions.

The Trustee and/or Trust Administrator shall not be liable in any manner for investment or other losses or other liability attributable to Participant's directions, or lack thereof, or exercise of control over the investments of their Participant Directed Accounts. Likewise, the Trustee and/or Trust Administrator shall have no duty or responsibility to review, monitor or make recommendations regarding investments made at the direction of the Participants or the Plan Administrator. In order for Member Agency to be relieved of investment fiduciary liability, the requirements of California law including Section 53213.5 of the California Government Code must be met. The Plan Administrator shall establish uniform and nondiscriminatory rules for the operation of the Participant Directed Accounts, including whether the Participant shall direct the Trustee or direct the Plan Administrator who directs the Trust Administrator who forwards such directions to the Trustee. Member Agency shall designate whether Participant Directed Accounts are to be established pursuant to the provisions of section 5.18(a) or 5.18(b), below:

(a) Participant Direction in Individually Directed Accounts. If the Member Agency has so elected, Participants may have investment direction power over their own segregated account balances ("Individually Directed Account" or "IDA"). Investments may be directed by Participants into assets administratively acceptable to Trustee, as limited by guidelines developed by the Plan Administrator (the "Permissible Investment Guidelines"). Plan Administrator shall notify Participants of the Plan's Permissible Investment Guidelines as in effect from time to time. In the absence of directions from a Participant, the Plan Administrator may direct the investment of the IDA. The Trustee may refuse to comply with the

directions of the Participant to invest in assets other than those listed in its Permissible Investments Guidelines or with directions which the Trustee deems to be improper or contrary to the provisions of the Plan and Agency Trust or the Internal Revenue Code and shall have no liability for such refusal.

(b) Participant Directed Account within Plan Administrator Selected Investment Options ("Select*BENEFIT* Accounts"): If the Member Agency so elects, the Participant's Account Balance shall be segregated into a Participant Directed Account ("SelectBENEFIT Account"), over which the Participant may direct investment into one or more investment alternatives ("Investment Options"). The Plan Administrator or its appointed Investment Fiduciary shall have full responsibility for designating the Investment Options under the Plan and for selecting the underlying investment vehicle(s) for each designated Investment Option into which a Participant may direct investment of his or her Select*BENEFIT* Account. To the extent allowed by law, neither the Member Agency, the Plan Administrator, the Trust Administrator nor the Trustee shall have any responsibility for monitoring the directions of the Participant nor shall the Member Agency, the Plan Administrator, the Trust Administrator or the Trustee be liable in any manner for investment or other losses or other liability for following directions of a Participant.

(c) If Select*BENEFIT* Accounts are established, notwithstanding any other provision of this Trust Agreement, the Member Agency may appoint the Trustee to provide ministerial services as recordkeeper for such accounts by so indicating in the Member Agency's Adoption Agreement, provided that an acceptable service agreement has been executed by and between the Member Agency, the Plan Administrator, the Trustee and the Trust Administrator.

Article VI

FIDUCIARY RESPONSIBILITIES

6.1 More Than One Fiduciary Capacity

Any one or more of the fiduciaries with respect to the PARS Trust Agreement or the Agency Trust may, to the extent required thereby or as directed by the Plan Administrator pursuant to this PARS Trust Agreement and the Plan, serve in more than one fiduciary capacity with respect to the PARS Trust Agreement, the Agency Trust and the Plan.

6.2 Fiduciary Discharge of Duties

Except as otherwise provided in the Code and applicable law each fiduciary shall discharge such fiduciary's duties with respect to the PARS Trust Agreement and the Plan:

Solely in the interest of the Participants and for the exclusive purpose of providing benefits to Participants, and defraying reasonable expenses of administering the Plan. With the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims. By diversifying the investments of the Plan and the Agency Trust so as to minimize the risk of loss and to maximize the rate of return, unless under the circumstances it is clearly prudent not to do so.

6.3 Limitations on Fiduciary Responsibility

To the extent permitted by applicable law:

No fiduciary shall be liable with respect to a breach of fiduciary duty by any other fiduciary if such breach was committed before such party became a fiduciary or after such party ceased to be a fiduciary.

No fiduciary shall be liable for a breach by another fiduciary unless the non-breaching fiduciary knowingly participates in such a breach, knowingly undertakes to conceal such breach, or has actual knowledge of such breach and fails to take reasonable steps to remedy such breach.

No fiduciary shall be liable for carrying out a proper direction from another fiduciary, including refraining from taking an action in the absence of a proper direction from the other fiduciary possessing the authority and responsibility to make such a direction, which direction the fiduciary in good faith believes to be authorized and appropriate.

6.4 Indemnification of Trustee by Member Agency

The Trustee shall not be liable for, and Member Agency shall indemnify, defend (as set out in 6.8 of this Trust Agreement), and hold the Trustee (including its officers, agents, employees and attorneys) and other Member Agencies and Alternate Trustees, harmless from and against any claims, demands, loss, costs, expense or liability imposed on the indemnified party, including reasonable attorneys' fees and costs incurred by the indemnified party, arising as a result of Member Agency's active or passive negligent act or omission or willful misconduct in the execution or performance of its duties under this Trust Agreement.

6.5 Indemnification of Member Agency by Trustee

The Member Agency shall not be liable for, and Trustee shall indemnify, defend (as set out in 6.8 of this Trust Agreement), and hold the Member Agency (including its officers, agents, employees and attorneys) and other Member Agencies and Alternate Trustees, harmless from and against any claims, demands, loss, costs, expense or liability imposed on the indemnified party, including reasonable attorneys' fees and costs incurred by the indemnified party, arising as a result of Trustee's active or passive negligent act or omission or willful misconduct in the execution or performance of its duties under this Trust Agreement.

6.6 Indemnification of Trustee by Trust Administrator

The Trustee shall not be liable for, and Trust Administrator shall indemnify and hold the Trustee (including its officers, agents, employees and attorneys) harmless from and against any claims, demands, loss, costs, expense or liability imposed on the indemnified party, including reasonable attorneys' fees and costs incurred by the indemnified party, arising as a result of Trust Administrator's active or passive negligent act or omission or willful misconduct in the execution or performance of its duties under this Trust Agreement.

6.7 Indemnification of Trust Administrator by Trustee

The Trust Administrator shall not be liable for, and Trustee shall indemnify and hold the Trust Administrator (including its officers, agents, employees and attorneys) harmless from and against any claims, demands, loss, costs, expense or liability imposed on the indemnified party, including reasonable attorneys' fees and costs incurred by the indemnified party, arising as a result of Trustee's active or passive negligent act or omission or willful misconduct in the execution or performance of its duties under this Trust Agreement.

6.8 Indemnification Procedures

Promptly after receipt by an indemnified party of notice or receipt of a claim or the commencement of any action for which indemnification may be sought, the indemnified party will notify the indemnifying party in writing of the receipt or commencement thereof. When the indemnifying party has agreed to provide a defense as set out above that party shall assume the defense of such action (including the employment of counsel, who shall be counsel satisfactory to such indemnitee) and the payment of expenses, insofar as such action shall relate to any alleged liability in respect of which indemnity may be sought against the indemnifying party. Any indemnified party shall have the right to employ separate counsel in any such action and to participate in the defense thereof, but the fees and expenses of such counsel shall not be at the expense of the

indemnifying party unless (i) the employment of such counsel has been specifically authorized by the indemnifying party or (ii) the named parties to any such action (including any impleaded parties) include both the indemnifying party and the indemnified party and representation of both parties by the same counsel would be inappropriate due to actual or potential differing interest between them. The indemnifying party shall not be liable to indemnify any person for any settlement of any such action effected without the indemnifying party's consent.

6.9 No Joint and Several Liability

This document is not intended to and does not create any joint powers agreement or any joint and several liability. No Member Agency shall be responsible for any contributions, costs or distributions of any other Member Agency.

Article VII

AMENDMENT, TERMINATION AND MERGER

7.1 No Obligation to Continue Plan and Trust

Continuance of the Agency Trust, participation in the PARS Trust Program and continuation of the Plan are not assumed as a contractual obligation of the Member Agency.

7.2 Amendments

(a) The PARS Trust Agreement may only be amended or terminated as provided herein. A two-thirds majority or greater of the Member Agencies shall have the right to amend this Trust Agreement from time to time, and to similarly amend or cancel any amendments. A copy of all amendments shall be delivered to the Trustee, the Trust Administrator and Plan Administrators promptly as each is made.

(b) Such amendments shall be set forth in an instrument in writing executed by the amending party, the Trust Administrator and the Trustee. Any amendment may be current, retroactive or prospective, provided, however, that no amendment shall:

(1) Cause the Assets of any Agency Trust to be used for or diverted to purposes other than for the exclusive benefit of Participants who have an interest in such Agency Trust or for the purpose of defraying the reasonable expenses of administering such Agency Trust.

(2) Have any retroactive effect so as to reduce the benefits of any Participant having an interest in the Agency Trust as of the date the amendment is adopted, except that such changes may be made as may be required to permit this PARS Trust Agreement to meet the requirements of applicable law.

(3) Change or modify the duties, powers or liabilities of the Trustee or the Trust Administrator hereunder without its consent.

(4) Permit the Assets of any Agency Trust to be used for the benefit of any other Plan of the Member Agency unless the Member Agency agrees to such use.

7.3 Termination of Plan

A termination of the Plan for which the Agency Trust was established shall not, in itself, effect a termination of an Agency Trust. Upon any termination of the Plan, the Assets of the Agency Trust shall be distributed by the Trustee as and when directed by the Plan Administrator. From and after the date of such termination of the Plan and until final distribution of the Assets the Trustee shall continue to have all the powers provided herein as are necessary or expedient for the orderly liquidation and distribution of such assets and the Agency Trust shall continue until the interests of all Participants have been completely distributed to or for the benefit of the Participants in accordance with the Plan.

7.4 Reversion

In the event a Member Agency's Plan is terminated, the vested interest of any Participant shall not be diminished or adversely affected. Except as may be provided in this Trust Agreement or the Plan, such termination shall not vest in the Member Agency any corpus or income under the Agency Trust, nor permit the Plan to discriminate as to coverage, or as to allocation of contributions or earnings, in favor of employees who are officers, shareholders, or highly compensated, nor cause the Agency Trust to lose its exemption pursuant to 501(a) of the Code. No modification, amendment or termination of the Plan shall be construed to be a termination of the Agency Trust so as to require the Trustee to make a distribution of any of the Assets of the Agency Trust to any Participant. In order to make such distribution the Trustee must receive written instructions from the Plan Administrator or Delegatee in a form acceptable to the Trustee.

If any Member Agency adopts a Plan whose assets are maintained in an Agency Trust and makes application to the Internal Revenue Service, within one year from the date of adoption of such Plan, for a determination that such Plan is a qualified plan under Section 401 (a) of the Code, and if such Plan is determined by the Internal Revenue Service not to be a qualified Plan, then all contributions

and investment income attributable to such Plan shall be returned to the Member Agency upon application to the Trustee.

7.5 Fund Recovery Based on Mistake of Fact

Except as hereinafter provided, the Assets of the Agency Trust shall never inure to the benefit of the Member Agency. The Assets shall be held for the exclusive purposes of providing benefits to Participants having an interest in the Plan and defraying reasonable expenses of administering the Agency Trust. The sole exception to the foregoing is as follows:

Mistake of Fact. In the case of a contribution which is made by the Plan Administrator because of a mistake of fact, that portion of the contribution relating to the mistake of fact (exclusive of any earnings or losses attributable thereto) may be returned to the Plan Administrator, provided such return occurs within one (1) year after discovery by the Plan Administrator of the mistake. If any repayment is payable to the Plan Administrator, then, as a condition to such repayment, and only if requested by Trustee, the Plan Administrator shall execute, acknowledge and deliver to the Trustee its written undertaking, in a form satisfactory to the Trustee, to indemnify, defend and hold the Trustee harmless from all claims, actions, demands or liabilities arising in connection with such repayment.

7.6 Transfers from Other Qualified Plans

Notwithstanding any other provision hereof, there may be transferred to the Trustee, upon direction of the Plan Administrator, all or any of the assets held (whether by a trustee, custodian or otherwise) on behalf of any other plan which satisfies the applicable requirements of Section 401 of the Code, and which is maintained for the benefit of any persons who are or will become Participants in the Plan.

7.7 Termination

The PARS Trust Agreement may be terminated only by a unanimous agreement of all Member Agencies. Such action must be in writing and delivered to the Trustee and Trust Administrator.

Article VIII

MISCELLANEOUS PROVISIONS

8.1 Nonalienation

To the maximum extent permitted by law, a Participant's interest in the Agency Trust shall not in any way be liable to attachment, garnishment, assignment or

other process, or be seized, taken, appropriated or applied by any legal or equitable process, to pay any debt or liability of the Participant or any other party. Agency Trust Assets shall not be subject to the claims of the Member Agency or the claims of its creditors.

8.2 Saving Clause

In the event any provision of this PARS Trust Agreement and each Agency Trust is held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining parts of the PARS Trust and/or Agency Trust, but this instrument shall be construed and enforced as if said provision had never been included.

8.3 Applicable Law

This PARS Trust Agreement and each Agency Trust shall be construed, administered and governed under the Code and the applicable provisions of California law. To the extent any of the provisions of this Trust Agreement or the Plan are inconsistent with the Code or applicable California law, the provisions of the Code or California law shall control. In the event, however, that any provision is susceptible to more than one interpretation, such interpretation shall be given thereto as is consistent with the Trust Agreement and the Plan being a qualified governmental retirement trust and plan within the meaning of the Code.

8.4 Joinder of Parties

In any action or other judicial proceedings affecting this Trust Agreement, it shall be necessary to join as parties only the Trustee, the Plan Administrator or Delegatee. No participant or other persons having an interest in any Agency Trust shall be entitled to any notice or service of process unless otherwise required by law. Any judgment entered in such a proceeding or action shall be binding on all persons claiming under this Trust Agreement, provided, however, that nothing in this Trust Agreement shall be construed as to deprive a participant of such participant's right to seek adjudication of such participant's rights under applicable law.

8.5 Employment of Counsel

The Trustee may consult with legal counsel (who may be counsel for the Trustee or Member Agency Plan Administrator) and charge the Agency Trust.

8.6 Gender and Number

Words used in the masculine, feminine or neuter gender shall each be deemed to refer to the other whenever the context so requires; and words used in the singular or plural number shall each be deemed to refer to the other whenever the context so requires.

8.7 Headings

Headings used in this Trust Agreement are inserted for convenience of reference only and any conflict between such headings and the text shall be resolved in favor of the text.

8.8 Counterparts

The Adoption Agreement of this Trust Agreement may be executed in an original and any number of counterparts by the Plan Administrator (executing an Adoption Agreement), the Trust Administrator and the Trustee, each of which shall be deemed to be an original of the one and the same instrument.

Article IX

ACKNOWLEDGMENT AND ACCEPTANCE

The provisions of the PARS Trust Agreement as contained herein are hereby amended and restated as of July 1, 1999 (the "Amended Effective Date")

IN WITNESS WHEREOF, the Plan Administrator (by executing the Adoption Agreement) the Trust Administrator and Trustee have executed this Trust Agreement by their duly authorized agents on this19th day of January, 2000.

ACKNOWLEDGED AND ACCEPTED this 19th day of January, 2000.

THE TRUSTEE

UNION BANK OF CALIFORNIA, N.A.

By: _____

Title: Senior Vice President

THE TRUST ADMINISTRATOR

PHASE II SYSTEMS

By: _____

Title: President

PUBLIC AGENCY

RETIREMENT SYSTEM

(PARS)

TRUST AGREEMENT

for

PARTICIPANT DIRECTED INVESTMENT PROGRAM

ACCOUNT IS ENTERED INTO BY CLIENT
AND U.S. BANK NATIONAL ASSOCIATION, AS TRUSTEE

This document is entered into by U.S. Bank National Association ("U.S. Bank"), as trustee. U.S. Bank succeeded Union Bank, N.A. as the trustee on February 1, 2012. All references in this document and all account related documents to Union Bank of California, N.A. and/or Union Bank, N.A. ("Union Bank"), are replaced with U.S. Bank.

Back to Item

Back to Agenda

TABLE OF CONTENTS

Article I

DEFINITIONS

1.1 “Agreement for Administrative Services” shall mean the agreement executed between the Member Agency and the Trust Administrator which authorizes the Trust Administrator to perform specific duties of administering the Member Agency Plan and related Agency Trust.

1.2 "Assets" shall mean all contributions and transfers of assets received by an Agency Trust on behalf of a Member Agency's Plan, together with the income and earnings from such contributions and transfers and any increments accruing to them.

1.3 “Agency Trust" shall mean the legally separate and individual trust, whose provisions are identical to those of the PARS Trust Agreement, that is established by a Member Agency when it adopts the PARS Trust by executing an Adoption Agreement.

1.4 “Alternate Trustee" shall mean a trustee, other than the Trustee of the PARS Trust Program, appointed by a Member Agency to serve as a trustee of a portion of such Agency Trust's assets as to which the Trustee serves as custodian.

1.5 "Code" shall mean the Internal Revenue Code of 1986 as amended from time to time.

1.6 "Custodian" shall mean Union Bank of California, N.A. or such other entity specified in the Adoption Agreement whose duties are limited to those specified in Section 4.3.

1.7 "Delegatee" shall mean an individual or entity, appointed by the Plan Administrator or Member Agency to act in such matters as are specified in the appointment.

1.8 ”Effective Date" shall mean July 1, 2008, the date the PARS Trust Program was established.

1.9 "Investment Fiduciary" shall mean the fiduciary with the authority and duty to direct the investment and management (including the power to direct the acquisition and disposition) of some or all of the Assets of the Agency Trust appointed by a Member Agency for its Agency Trust.

1.10 "Omnibus Account" shall mean an account, established for record keeping purposes only, to commingle the Assets of the Agency Trust.

1.11 "Member Agency" shall mean a public agency that adopts the provisions of the PARS Trust Agreement.

1.12 "Plan" shall mean the tax qualified plan whose assets the Agency Trust holds.

1.13 "Plan Administrator" shall mean the individual designated by position of employment at the Member Agency to act on its behalf in all matters relating to the Member Agency's participation in the PARS Trust Program and Agency Trust.

1.14 "PARS Trust Agreement" or "Trust Agreement" shall mean the pro forma Public Agency Retirement System trust document adopted by each Member Agency upon execution of an Adoption Agreement, as amended from time to time.

1.15 "PARS Trust Program" shall mean the Public Agency Retirement System trust arrangement.

1.16 "Participant" shall mean an individual participating in a Member Agency Plan or that individual's beneficiary.

1.17 "Trust Administrator" shall mean Phase II Systems.

1.18 "Trustee" shall mean the entity appointed as trustee of the PARS Trust that shall also serve as trustee of each Agency Trust established pursuant to the provisions of this trust agreement except where an Alternate Trustee has been appointed.

Article II

THE PARS TRUST PROGRAM

2.1 Multiple Employer Trust

The PARS Trust Program is a multiple employer trust arrangement established to provide economies of scale and efficiency of administration to public agencies that adopt it to hold the assets of their Member Agency Plans maintained for the benefit of their employees. The PARS Trust Program consists of the Agency Trusts adopted and not terminated by Member Agencies.

2.2 Qualified Governmental Retirement Trust

The PARS Trust Program is established pursuant to the provisions of Section 501(a) of the Code, and the provisions of the relevant state's statutory provisions as designated by the Member Agency in the Adoption Agreement.

2.3 Date of Adoption

The date as of which each Member Agency adopts the PARS Trust Program shall be the "Effective Date" of the PARS Trust Agreement and the Agency Trust, as defined in Section 2.5, as to that Member Agency.

2.4 Member Agencies

Any public agency may, by action of its governing body in a writing accepted by the Trustee, adopt the provisions of the PARS Trust Agreement as the trust portion of a qualified governmental retirement plan established for the benefit of its employees. Executing an adoption instrument for the PARS Trust Program ("Adoption Agreement"), attached hereto as Exhibit "A", shall constitute such adoption, unless the Trustee requires additional evidence of adoption. In order for such adoption to be effective, the public agency must also execute an Agreement for Administrative Services with the Trust Administrator, pursuant to section 3.6 of this PARS Trust Agreement. Such adopting employer shall then become a Member Agency of the PARS Trust Program.

Each such Member Agency shall, at a minimum, furnish the Trust Administrator with the following documents to support its adoption of the PARS Trust Program:

(a) a certified copy of the Member Agency governing body resolution authorizing the adoption of the PARS Trust Agreement and the appointment of an individual designated by position of employment at the Member Agency to act on its behalf in all matters relating to the Member Agency's participation in the PARS Trust Program and Agency Trust ("Plan Administrator");

(b) an original of the Adoption Agreement executed by the Plan Administrator or other duly authorized Member Agency employee;

(c) an original of the Agreement for Administrative Services executed by the Plan Administrator or other duly authorized Member Agency employee and the Trust Administrator;

(d) an address notice; and

(e) such other documents as the Trustee may reasonably request.

2.5 Agency Trust

By adopting the PARS Trust Agreement, as provided in Section 2.4, a Member Agency shall be deemed to have adopted a legally separate and individual Agency Trust whose provisions are identical to those of the PARS Trust Agreement. The Assets of an Agency Trust shall be available only to pay benefits pursuant to the provisions of the Plan to participants and beneficiaries of the Member Agency entitled to receive benefits under the provisions of the Plan. The Agency Trust is created for the purpose of receiving contributions made to fund the Member Agency's Plan; accumulating, managing and investing those contributions; and providing benefits to active or retired participants of the Plan, their joint annuitants, or their beneficiaries. Each Agency Trust shall be used to fund only a single Plan maintained by the Member Agency. A Member Agency may establish additional Agency Trusts to fund the assets of additional Plans by executing one or more additional Adoption Agreement(s).

2.6 Assets of Agency Trust

The assets of the Agency Trust shall consist of all contributions and transfers received by the Agency Trust on behalf of the Member Agency's Plan, together with the income and earnings from such contributions and transfers, and any increments accruing to them ("Assets"). All contributions or transfers shall be received by the Trustee in cash or in other property acceptable to the Trustee. The Trustee shall manage and administer the Assets of the Agency Trust without distinction between principal and income. The Trustee and the Trust Administrator shall have no duty to compute any amount to be transferred or paid to the Agency Trust by the Member Agency and the Trustee and the Trust Administrator shall not be responsible for the collection of any contributions or transfers to the Agency Trust.

2.7 Commingling for Investment and Administration

The Assets of more than one Agency Trust may be commingled by the Trustee or Investment Fiduciary in one or more Omnibus Accounts for investment and administrative purposes, to provide economies of scale and efficiency of administration to the Agency Trusts. The responsibility for Plan level accounting within this Omnibus Account(s) shall be that of the Trust Administrator.

2.8 Trustee Accounting

The Trustee shall be responsible only for maintaining records and maintaining accounts for the aggregate assets of the PARS Trust Program. The responsibility for Plan level accounting for each Agency Trust, based upon the Omnibus Account(s), shall be that of the Trust Administrator. The Trust Administrator shall certify the accuracy of such Plan level accounting to the Trustee.

2.9 No Diversion of Assets

The Assets in each Agency Trust shall be held in trust for the exclusive purpose of providing benefits to the Participants of the Plan for which the Agency Trust is holding assets and defraying the reasonable expenses of such Plan. The Assets shall not be used for or diverted to, any other purpose.

2.10 Type and Nature of Trust

Neither the full faith and credit nor the taxing power of each Member Agency is pledged to the distribution of benefits hereunder. Except for contributions and other amounts hereunder, no other amounts are pledged to the distribution of benefits hereunder. Distributions of benefits are neither general nor special obligations of any Member Agency, but are payable solely from the Assets of each Agency Trust, as more fully described herein. No employee of any Member Agency or beneficiary may compel the exercise of the taxing power by any Member Agency.

Distributions of Assets under any Agency Trust are not debts of any Member Agency within the meaning of any constitutional or statutory limitation or restriction. Such distributions are not legal or equitable pledges, charges, liens or encumbrances, upon any of a Member Agency's property, or upon any of its income, receipts, or revenues, except amounts in the accounts which are, under the terms of each Plan and the Agency Trust set aside for distributions. Neither the members of the legislative body of any Member Agency nor its officers, employees, agents or volunteers are liable hereunder.

Article III

ADMINISTRATIVE MATTERS

3.1 Appointment of Trustee

Two thirds or more of the Member Agencies acting jointly, may by a two-thirds or greater vote, act to appoint a bank, trust company, retirement board, insurer, committee or such other entity as permitted by applicable law as designated in the Adoption Agreement, to serve as Trustee of the PARS Trust Program. Such action must be in writing. Upon the written acceptance of such entity it shall become the Trustee of the PARS Trust Program and, subject to the provisions of Section 3.10, the trustee of each Agency Trust. By executing an Adoption Agreement, the adopting Member Agency hereby appoints the Union Bank of California, N.A. as the Trustee as of the Effective Date.

3.2 Removal of Trustee

Two-thirds or more of the Member Agencies acting jointly, may by a vote of two - thirds or greater, act to remove the Trustee. Such action must be in writing and delivered to the Trustee and the Trust Administrator. Upon such removal from the PARS Trust, the Trustee shall also be removed as trustee of each of the Agency Trusts. The Plan Administrator may remove the Trustee as trustee of an Agency Trust by giving at least ninety (90) days prior written notice to the Trustee and the Trust Administrator and withdrawing from the PARS Trust Program.

3.3 Resignation of Trustee

The Trustee may resign as trustee of the PARS Trust Program at any time by giving at least ninety (90) days prior written notice to the Trust Administrator and to each Plan Administrator of each Member Agency that has adopted the PARS Trust Agreement and not terminated its participation in the PARS Trust Program. Such resignation shall also be deemed a resignation as trustee of each of the Agency Trusts. The Trustee may resign as trustee of an Agency Trust by giving at least ninety (90) written notice to the Plan Administrator of such Agency Trust and to the Trust Administrator. The Member Agency's appointment of a successor trustee to the Agency Trust will vest the successor trustee with title to the Assets of its Agency Trust upon the successor trustee's acceptance of such appointment.

3.4 The Plan Administrator

The governing body of each Member Agency shall have plenary authority for the administration and investment of the Agency Trust pursuant to any applicable state laws and applicable federal laws and regulations. Each Member Agency shall by resolution designate a Plan Administrator. Unless otherwise specified in the instrument the Plan Administrator shall be deemed to have authority to act on behalf of the Member Agency in all matters pertaining to the Member Agency's participation in the PARS Trust Program and in regard to the Agency Trust of the Member Agency. Such appointment of a Plan Administrator shall be effective upon receipt and acknowledgment by the Trustee and the Trust Administrator and shall be effective until the Trustee and Trust Administrator are furnished with a resolution of the Member Agency that the appointment has been modified or terminated.

3.5 Failure to Appoint Plan Administrator

If a Plan Administrator is not appointed, or such appointment lapses, the Member Agency shall be deemed to be the Plan Administrator. As used in this document Plan Administrator shall be deemed to mean Member Agency when a Plan Administrator has not been appointed.

3.6 Delegatee

The Plan Administrator, acting on behalf of the Member Agency, may delegate certain authority, powers and duties to a Delegatee to act in those matters specified in the delegation. Any such delegation must be in a writing that names and identifies the Delegatee, states the effective date of the delegation, specifies the authority and duties delegated, is executed by the Plan Administrator and is acknowledged in writing by the Delegatee, the Trust Administrator (if not the Delegatee) and the Trustee. Such delegation shall be effective until the Trustee and the Trust Administrator are directed in writing by the Plan Administrator that the delegation has been rescinded or modified.

3.7 Certification to Trustee

The governing body of each Member Agency, or other duly authorized official, shall certify in writing to the Trustee and the Trust Administrator the names and specimen signatures of the Plan Administrator and Delegatee, if any, and all others authorized to act on behalf of the Member Agency whose names and specimen signatures shall be kept accurate by the Member Agency acting through a duly authorized official or governing body of the Member Agency. The Trustee and the Trust Administrator shall have no liability if it acts upon the direction of a Plan Administrator or Delegatee that has been duly authorized, as provided in Section 3.6, if that Plan Administrator or Delegatee is no longer authorized to act, unless the Member Agency has informed the Trustee and the Trust Administrator of such change.

3.8 Directions to Trustee

Except as provided in Section 5.18 of this Trust Agreement, all directions to the Trustee from the Plan Administrator or Delegatee must be in writing and must be signed by the Plan Administrator or Delegatee, as the case may be. For all purposes of this Trust Agreement, direction shall include any certification, notice, authorization, application or instruction of the Plan Administrator, Delegatee or Trustee appropriately communicated. The above notwithstanding direction may be implied if the Plan Administrator or Delegatee has knowledge of the Trustee's intentions and fails to file written objection.

The Trustee shall have the power and duty to comply promptly with all proper direction of the Plan Administrator or Delegatee, appointed in accordance with the provisions of this PARS Trust Agreement. In the case of any direction deemed by the Trustee to be unclear or ambiguous the Trustee may seek written instructions from the Plan Administrator, the Agency or the Delegatee on such matter and await their written instructions without incurring any liability. If at any time the Plan Administrator or the Delegatee should fail to give directions to the Trustee, the Trustee may act in the manner that in its discretion seems advisable

under the circumstances for carrying out the purposes of the PARS Trust Program and/or any Agency Trust which may include not taking any action. The Trustee may request directions or clarification of directions received and may, in its sole discretion, delay acting until clarification is received. In the absence of timely direction or clarification, or if the Trustee considers any direction to be a violation of the PARS Trust Agreement or any applicable law, the Trustee shall in its sole discretion take appropriate action, or refuse to act upon a direction.

3.9 Alternate Trustee

A Member Agency may appoint a trustee, other than the Trustee, as to a portion of the assets in the Agency Trust by designating such person or entity as an Alternate Trustee on the Adoption Agreement and by specifying which assets shall be subject to the fiduciary management of the Alternate Trustee. Such appointment shall not be effective unless it is in writing, specifies clearly the assets as to which the Alternate Trustee is to have trustee powers, is acknowledged in writing by the Alternate Trustee, is delivered to and acknowledged by the Trustee and the Trust Administrator. Only a bank, trust company, retirement board, insurer, the Member Agency or such entity as permitted by Member Agency's applicable state law to be a trustee may be appointed an Alternate Trustee. Such appointment will become effective upon acceptance by the Alternate Trustee.

3.10 Powers Of Alternate Trustee

The Alternate Trustee shall be deemed to have all of the powers and duties and responsibilities specified in the PARS Trust Agreement for the PARS Trustee in Article IV unless otherwise specified in the Adoption Agreement.

3.11 Responsibility of Trustee Upon Appointment of Alternate Trustee

Upon the appointment of an Alternate Trustee, the Trustee shall have no liability or responsibility for any matters relating to the management, investment or administration of those assets as to which the Alternate Trustee has been appointed and shall only have the duties set forth in Section 4.3.

3.12 Trust Administrator

The Member Agencies have appointed Phase II Systems as the Trust Administrator. The Trust Administrator has accepted its appointment subject to each Member Agency's delegation of authority, to act as such, pursuant to Section 3.6 of this PARS Trust Agreement. The Trust Administrator's duties involve the performance of the following services pursuant to the provisions of this trust agreement and the Agreement for Administrative Services:

(a) Performing periodic accounting of the Agency Trust;

(b) Directing the Trustee to i) make distributions from the Agency Trust, as directed and authorized by the Plan Administrator pursuant to the Agreement for Administrative Services, to Participants pursuant to the provisions of the Member Agency's Plan and, ii) liquidate assets in order to make such distributions;

(c) Notifying the Investment Fiduciary of the amount of Assets in the Agency Trust available for further investment and management by the Investment Fiduciary;

(d) Allocating contributions, earnings and expenses to each Agency Trust;

(e) Directing the Trustee to pay insurance premiums, to pay the fees of the Trust Administrator and to do such other acts as shall be appropriate to carry out the intent of the Agency Trusts.

(f) Such other services as the Member Agency and the Trust Administrator may agree in the Agreement for Administrative Services pursuant to Section 2.4.

3.13 The Trust Administrator shall be entitled to rely on, and shall be under no duty to question, direction and/or data received from the Plan Administrator, or other duly authorized entity, in order to perform its authorized duties under this trust agreement. The Trust Administrator shall not have any duty to compute contributions made to the Agency Trust, determine or inquire whether contributions made to the Agency Trust by the Plan Administrator or other duly authorized entity are adequate to meet and discharge liabilities under the Plan; or determine or inquire whether contributions made to the Agency Trust are in compliance with the Plan; or make independent determination of Participant distribution eligibility. The Trust Administrator shall not be liable for non performance of duties if such non performance is directly caused by erroneous, and/or late delivery of, directions or data from the Plan Administrator, or other duly authorized entity.

3.14 Additional Trust Administrator Services

The Plan Administrator may at any time retain the Trust Administrator as its agent to perform any act, keep any records or accounts and make any computations which are required of the Member Agency or the Plan Administrator by this PARS Trust Agreement or by the Member Agency's Plan. The Trust Administrator shall be separately compensated for such service and such services shall not be deemed to be contrary to the PARS Trust Agreement.

3.15 Trust Administrator's Compensation

As may be agreed upon from time to time by the Member Agency and Trust Administrator, the Trust Administrator will be paid reasonable compensation for services rendered or reimbursed for expenses properly and actually incurred in the performance of duties with respect to the Agency Trust and to the PARS Trust Program.

3.16 Resignation or Removal of Trust Administrator

The Trust Administrator may resign at any time by giving at least one hundred twenty (120) days written notice to each Member Agency of the PARS Trust Program and the Trustee. The Member Agencies, by a two-thirds or greater vote, may remove the Trust Administrator by delivering, at least one hundred twenty (120) days prior to the effective date of such removal, written notice to the Trust Administrator and to the Trustee.

Article IV

THE TRUSTEE

4.1 Powers and Duties of the Trustee

Except as otherwise provided in Article V and subject to Article VI, the Trustee shall have full power and authority with respect to property held in the Agency Trust to do all such acts, take all proceedings, and exercise all such rights and privileges, whether specifically referred to or not in this document, as could be done, taken or exercised by the absolute owner, including, without limitation, the following:

(a) To invest and reinvest the Assets or any part hereof in any one or more kind, type, class, item or parcel of property, real, personal or mixed, tangible or intangible; or in any one or more kind, type, class, item or issue of investment or security; or in any one or more kind, type, class or item of obligation, secured or unsecured; or in any combination of them. To retain the property for the period of time that the Trustee deems appropriate;

(b) To acquire and sell options to buy securities ("call" options) and to acquire and sell options to sell securities ("put" options);

(c) To buy, sell, assign, transfer, acquire, loan, lease (for any purpose, including mineral leases), exchange and in any other manner to acquire, manage, deal with and dispose of all or any part of the Agency Trust property, for cash or credit and upon any reasonable terms and conditions;

(d) To make deposits, with any bank or savings and loan institution, including any such facility of the Trustee or an affiliate thereof provided that the deposit bears a reasonable rate of interest;

(e) To invest and reinvest the Assets, or any part thereof in any one or more guaranteed annuity contracts, collective investment trust funds, including common and group trust funds that consist exclusively of assets of exempt pension and profit sharing trusts and individual retirement accounts qualified and tax exempt under the Code, that are maintained by the Trustee or an affiliate thereof. The declaration of trust or plan of operations for any such common or collective fund is hereby incorporated herein and adopted into this PARS Trust Agreement by this reference. The combining of money and other assets of the Agency Trust with money and other assets of other qualified trusts in such fund or funds is specifically authorized. Notwithstanding anything to the contrary in this trust agreement, the Trustee shall have full investment responsibility over assets of the trust invested in such commingled funds. If the plan and trust for any reason lose their tax exempt status, and the Assets have been commingled with assets of other tax exempt trusts in Trustee's collective investment funds, the Trustee shall within 30 days of notice of such loss of tax exempt status, liquidate the Agency Trust's units of the collective investment fund(s) and invest the proceeds in a money market fund pending investment or other instructions from the Plan Administrator. The Trustee shall not be liable for any loss or gain or taxes, if any, resulting from said liquidation;

(f) To place uninvested cash and cash awaiting distribution in one or more mutual funds and/or commingled investment funds maintained by or made available by the Trustee, and to receive compensation from the sponsor of such fund(s) for services rendered, separate and apart from any Trustee's fees hereunder. Trustee or Trustee's affiliate may also be compensated for providing investment advisory services to any mutual fund or commingled investment funds;

(g) To borrow money for the purposes of the Agency Trust from any source with or without giving security; to pay interest; to issue promissory notes and to secure the repayment thereof by pledging all or any part of the Assets;

(h) To take all of the following actions as directed by the Investment Fiduciary or other person with investment discretion over the trust assets: to vote proxies of any stocks, bonds or other securities; to give general or special proxies or powers of attorney with or without power of substitution; to exercise any conversion privileges, subscription rights or other options, and to make any payments incidental thereto; to consent to or otherwise participate in corporate reorganizations or other changes affecting

corporate securities and to delegate discretionary powers and to pay any assessments or charges in connection therewith; and generally to exercise any of the powers of an owner with respect to stocks, bonds, securities or other property held in the Agency Trust;

(i) To make, execute, acknowledge and deliver any and all documents of transfer and conveyance and any and all other instruments that may be necessary or appropriate to carry out the powers herein granted;

(j) To raze or move existing buildings; to make ordinary or extraordinary repairs, alterations or additions in and to buildings; to construct buildings and other structures and to install fixtures and equipment therein;

(k) To pay or cause to be paid from the Agency Trust any and all real or personal property taxes, income taxes or other taxes or assessments of any or all kinds levied or assessed upon or with respect to the Agency Trust or the Plan;

(l) As directed by the Trust Administrator, to hold term or ordinary life insurance contracts on the lives of Participants (but in the case of conflict between any such contract and the Plan, the terms of the Plan shall prevail); to pay from the Agency Trust the premiums on such contracts; to distribute, surrender or otherwise dispose of such contracts; to pay the proceeds, if any, of such contracts to the proper persons in the event of the death of the insured Participant; to enter into, modify, renew and terminate annuity contracts of deposit administration or immediate participation or other group or individual type with one or more insurance companies and to pay or deposit all or any part of the Agency Trust Assets thereunder; to provide in any such contract for the investment of all or any part of funds so deposited with the insurance company in securities under separate accounts; to exercise and claim all rights and benefits granted to the contract holder by any such contracts;

(m) To exercise all the further rights, powers, options and privileges granted, provided for, or vested in trustees generally under applicable federal or California State laws, as amended from time to time, it being intended that, except as herein otherwise provided, the powers conferred upon the Trustee herein shall not be construed as being in limitation of any authority conferred by law, but shall be construed as consistent or in addition thereto.

4.2 Additional Trustee Powers

In addition to the other powers enumerated above, and whether or not the Member Agency has retained investment authority or delegated it to an Investment Fiduciary or Participants in Participant Directed Accounts, the Trustee in any and all events is authorized and empowered:

(a) To invest funds pending required directions in any type of interest-bearing account including without limitation, time certificates of deposit or interest-bearing accounts issued by Union Bank of California N.A., or any mutual fund or short term investment fund, whether sponsored or advised by Union Bank of California or any affiliate thereof; Union Bank of California, N.A. or its affiliate may be compensated for providing such investment advice and providing other services to such fund, in addition to any Trustee's fees received pursuant to this Trust Agreement;

(b) To cause all or any part of the Agency Trust to be held in the name of the Trustee (which in such instance need not disclose its fiduciary capacity) or, as permitted by law, in the name of any nominee, and to acquire for the Agency Trust any investment in bearer form, but the books and records of the Agency Trust shall at all times show that all such investments are a part of the Agency Trust and the Trustee shall hold evidences of title to all such investments;

(c) To serve as custodian with respect to the Agency Trust Assets and as directed by the Member Agency to engage another entity as Custodian of a portion of the Agency Trust Assets;

(d) To employ such agents and counsel as may be reasonably necessary in managing and protecting the Assets and to pay them reasonable compensation; to employ any broker-dealer, including a broker-dealer affiliated with the Trustee, and pay to such broker-dealer at the expense of the Agency Trust, its standard commissions; to settle, compromise or abandon all claims and demands in favor of or against the Agency Trust; and to charge any premium on bonds purchased at par value to the principal of the Agency Trust without amortization from the Agency Trust, regardless of any law relating thereto;

(e) In addition to the powers listed herein, to do all other acts necessary or desirable for the proper administration of the Agency Trust, as though the absolute owner thereof;

(f) To abandon, compromise, contest, arbitrate or settle claims or demands; to prosecute, compromise and defend lawsuits, but without obligation to do so, all at the risk and expense of the Agency Trust;

(g) To exercise and perform any and all of the other powers and duties specified in this Trust Agreement or the Plan;

(h) To permit such inspections of documents at the principal office of the Trustee as are required by law, subpoena or demand by a United States agency;

(i) To comply with all requirements imposed by applicable provisions of law;

(j) To seek written instructions from the Plan Administrator or other fiduciary on any matter and await their written instructions without incurring any liability. If at any time the Plan Administrator or the fiduciary should fail to give directions to the Trustee, the Trustee may act in the manner that in its discretion seems advisable under the circumstances for carrying out the purposes of this Agency Trust;

(k) As directed by the Plan Administrator or Delegatee if duly authorized, to cause the benefits provided under the Plan to be paid directly to the persons entitled thereto under the Plan, and in the amounts and in the manner specified, and to charge such payments against the Agency Trust with respect to which such benefits are payable;

(l) To compensate such executive, consultant, actuarial, accounting, investment, appraisal, administrative, clerical, secretarial, medical, custodial, depository and legal firms, personnel and other employees or assistants as are engaged by the Plan Administrator in connection with the administration of the Plan and to pay from the Agency Trust the necessary expenses of such firms, personnel and assistants, to the extent not paid by the Plan Administrator;

(m) To act upon proper written directions of the Plan Administrator or Delegatee, including directions given by photostatic transmissions using facsimile signature;

(n) To pay from the Agency Trust the expenses reasonably incurred in the administration of the Agency Trust as provided in the Plan;

(o) To maintain insurance for such purposes, in such amounts and with such companies as the Plan Administrator shall elect, including insurance to cover liability or losses occurring by reason of the acts or omissions of fiduciaries but only if such insurance permits recourse by the insurer against the fiduciary in the case of a breach of a fiduciary obligation by such fiduciary.

4.3 Custodial Powers

If an Alternate Trustee has been appointed pursuant to Section 3.9, Union Bank of California, N.A., ("Bank") as Custodian, shall only have the following responsibilities:

(a) Keep records of all transactions entered into for the Agency Trust and furnish to Alternate Trustee statements no less frequently than quarterly showing all principal and income transactions and Agency Trust Assets, which shall be deemed ratified and approved by Alternate Trustee unless Custodian is advised to the contrary within ninety (90) days of Custodian's mailing thereof by first class mail to Alternate Trustee;

(b) Receive payments of income and principal on Agency Trust Assets, and retain or remit in accordance with Alternate Trustee's written instructions;

(c) Hold Agency Trust Assets in Bank's name as Custodian for Alternate Trustee or in Bank's nominee name, or, as to securities eligible to be held by the depository trust company or other depository, in its nominee name;

(d) Purchase and sell securities, attend to the exchange of securities, deposit or exchange securities of companies in reorganization, and tender securities on redemption or tender offer solely upon direction of Alternate Trustee;

(e) Sign the name of Alternate Trustee to stock and bond powers and any other instruments required for the proper exercise of Bank's duties, and Bank is appointed Alternate Trustee's attorney-in-fact for these purposes;

(f) Forward all proxies and accompanying materials to Alternate Trustee to be voted unless directed in writing to the contrary. Disclose Alternate Trustee's name and address in response to requests from issuers of securities and others to facilitate direct communication for proxy and tender offer response;

(g) Sell all fractional shares of stock received as a result of stock dividends or other corporate action;

(h) Notify Alternate Trustee of any inability to collect income or principal if the securities or other property constituting Assets upon which such amount is payable is in default, or if payment is refused after due demand. Bank shall be under no obligation or duty to take any action to effect collection of defaulted payments, or to file or pursue any bankruptcy or class action claims with respect to Agency Trust.

(i) Perform a telephonic verification to Alternate Trustee or Alternate Trustee's authorized representative or such other security procedure selected by Alternate Trustee prior to wiring funds or following facsimile directions as Bank may require. Alternate Trustee assumes all risk of delay of transfer if Bank is unable to reach Alternate Trustee or Alternate Trustee's authorized representative, or in the event of delay as a result of attempts to comply with any other security procedure selected by Alternate Trustee.

Article V

INVESTMENTS

5.1 Investment Fiduciary

Except as herein provided, the Plan Administrator shall be the Investment Fiduciary.

5.2 Appointment of Trustee or an Investment Manager as Investment Fiduciary

The Plan Administrator may appoint the Trustee or an investment manager as the Investment Fiduciary, with the authority and duty to direct the investment and management of all or any portion of the Assets of the Agency Trust.

5.3 Appointment of Investment Fiduciary

No action of the Plan Administrator pursuant to 5.2 shall be effective until a certified copy of the revised Adoption Agreement and, if required, any such resolution of the governing body of the Member Agency or Plan Administrator action is delivered to the Trustee. Upon receipt and acceptance, the Trustee or investment manager, as the case may be, shall assume fiduciary responsibility with respect to the investment and management of such assets of the Agency Trust as are specified in the resolution or action. Any transfer of investment authority to the Trustee or to an investment manager may be revoked by delivering to the Trustee or the investment manager a written notice from either the Member Agency governing body or the Plan Administrator, as the case may be.

5.4 Reliance by Trustee on Investment Fiduciary

The appointment, selection and retention of an Investment Fiduciary shall be solely the responsibility of the Member Agency acting through its governing body or the Plan Administrator. The Trustee may rely upon the fact that the Investment Fiduciary is authorized to direct the investment and management of

the Assets of the Agency Trust until such time as the Plan Administrator shall notify the Trustee in writing that another Investment Fiduciary has been appointed to replace the Investment Fiduciary named, or, in the alternative, that the Investment Fiduciary named has been removed.

5.5 When Trustee is not Investment Fiduciary

The Trustee shall not be the Investment Fiduciary and shall have no responsibility or authority for the investment and management of assets unless specifically designated as the Investment Fiduciary as to some or all of the assets in the Agency Trust and accepts such designation.

(a) During such period or periods of time, if any, as the Plan Administrator or an Investment Fiduciary is authorized to direct the investment and management of the Assets of the Agency Trust, the Trustee shall (subject to the overriding limitations hereinafter set forth) effect and change investment of the Assets of the Agency Trust as directed in writing by the Plan Administrator, or Investment Fiduciary, as the case may be, and shall neither effect nor change any such investments without such direction and shall have no right, duty or responsibility to recommend investments or investment changes. The following provisions shall govern the Trustee during such period or periods of time, if any, during which the Plan Administrator or an Investment Fiduciary is authorized to direct the investment and management of the Assets of any Agency Trust:

(b) So long as the Plan Administrator retains or reacquires full power and responsibility to direct the Trustee with respect to the investment and management of all or any portion of the Assets of the Agency Trust, the Trustee shall not be liable nor responsible for losses or unfavorable results arising from the Trustee's compliance with proper directions of the Plan Administrator which are made in accordance with the terms of this Trust Agreement and which are not contrary to the provisions of any applicable federal or state statute regulating such investment.

(c) In the event an Investment Fiduciary is given authority and responsibility with respect to the investment and management of the Assets of the Agency Trust, neither the Trustee nor the Plan Administrator shall be liable or responsible in any way for any losses or other unfavorable results arising from the Trustee's compliance with investment or management directions received by the Trustee from the Investment Fiduciary.

5.6 Investment Directions Must be in Writing

Subject to the provisions of Section 5.18, in order to be valid all directions concerning investments made by the Plan Administrator, or the Investment Fiduciary, or PARS Trustee must be signed by the authorized person or persons

acting on behalf of the Plan Administrator, Investment Fiduciary or Trustee, as the case may be.

5.7 Trustee Reliance On Directions

(a) The Trustee shall be entitled to rely upon directions which the Trustee receives. The Trustee shall be under no duty to question any directions of the Investment Fiduciary or Plan Administrator nor to review any securities or other property of the PARS Trust or Agency Trust constituting assets thereof with respect to which an Investment Fiduciary or the Plan Administrator has investment responsibility, nor to make any suggestions to the Investment Fiduciary or Plan Administrator in connection therewith. The Trustee shall, as promptly as possible, comply with any written directions given by the Plan Administrator or an Investment Fiduciary hereunder. The Trustee shall not be liable, in any manner nor for any reason, for the making or retention of any investment pursuant to such directions, nor shall the Trustee be liable for its failure to invest any or all of the Assets of the Agency Trust in the absence of such written directions. The Trustee shall be under no obligation to seek written clarification in the event of ambiguity.

(b) During such period of time, if any, as the Plan Administrator, or an Investment Fiduciary, is authorized to direct the Trustee, the Trustee shall have no obligation to determine the existence of any conversion, redemption, exchange, subscription or other right relating to any securities purchased of which notice was given prior to the purchase of such securities, and shall have no obligation to exercise any such right unless the Trustee is informed of the existence of the right and is instructed to exercise such right, in writing, by the Plan Administrator or the Investment Fiduciary, as the case may be, within a reasonable time prior to the expiration of such right.

(c) In any event, neither the Plan Administrator nor any Investment Fiduciary referred to above shall direct the purchase, sale or retention of any Assets of the Agency Trust if such directions are not in compliance with applicable law.

5.8 Trustee Fees

As may be agreed upon, in writing, between the Plan Administrator and Trustee, the Trustee will be paid reasonable compensation for services rendered or reimbursed for expenses properly and actually incurred in the performance of duties with respect to the Agency Trust or the PARS Trust.

5.9 Contributions

The Plan Administrator shall make all of its contributions to the Trustee, and shall also transmit all contributions of Plan Participants, as may be required or allowed by the Plan, to the Trustee. In the event such contributions are designated for another Custodian, the contributions shall be transmitted directly to such Custodian. Such contributions shall be in cash unless the Trustee agrees to accept a contribution that is not in cash. All contributions shall be paid to the Trustee for investment and reinvestment pursuant to the terms of this Trust Agreement. Trustee shall have any duty to determine or inquire whether any contributions to the Agency Trust made to the Trustee by any Plan Administrator are in compliance with the Plan; nor shall the Trustee have any duty or authority to compute any amount to be paid to the Trustee by any Plan Administrator; nor shall the Trustee be responsible for the collection or adequacy of the contributions to meet and discharge liabilities under the Plan. The contributions received by the Trustee from each Member Agency shall be held and administered pursuant to the terms hereof without distinction between income and principal.

5.10 Money Market Fund

Pending any investment directions, such cash in the Agency Trust in an amount as is reasonable in the discretion of the Trustee, may be deposited in a money market fund selected by the Trustee or the Member Agency.

5.11 Purchase of Contracts

The Trustee shall have the authority to purchase individual or group insurance, annuity, preliminary term, group pension, and variable annuity contracts in accordance with the directions of the Plan Administrator or other insurance contracts at the direction of the Plan Administrator or Investment Fiduciary if such contracts are acceptable to the Trustee. The Trustee shall act as custodian of such contracts if an Alternate Trustee is appointed as to such contracts.

5.12 Records

(a) The Trustee shall maintain accurate records and detailed accounts of all investments, receipts, disbursements and other transactions hereunder at the PARS Trust level. The Trustee shall provide the Trust Administrator with statements showing summary investment totals per plan for investments held by Custodian. Such records shall be available at all reasonable times for inspection by the Trust Administrator. The Trustee shall, at the direction of the Trust Administrator, submit such valuations, reports or other information as the Trust Administrator may reasonably require.

(b) Valuation. The assets of the Agency Trust shall be valued at their fair market value on the date of valuation, as determined by the Trustee based upon such sources of information as it may deem reliable; provided, however, that the Plan Administrator shall instruct the Trustee as to valuation of assets which are not readily determinable on an established market. Custodian will provide the Trustee with a valuation of all assets held by the Custodian for the Agency Trust. The Trustee may rely conclusively on such valuations provided by the Plan Administrator and shall be indemnified and held harmless by the Plan Administrator with respect to such reliance. If the Plan Administrator fails to provide such values, the Trustee may take whatever action it deems reasonable, including employment of attorneys, appraisers or other professionals, the expense of which will be an expense of administration of the Agency Trust. Transactions in the account involving such hard to value assets may be postponed until appropriate valuations have been received and Trustee shall have no liability therefore.

5.13 Statements

(a) Periodically as specified, and within sixty days after June 30, or the end of the PARS Trust's fiscal year if different, Trustee shall render to the Trust Administrator as directed, a written account showing in reasonable summary the investments, receipts, disbursements and other transactions engaged in by the Trustee during the preceding fiscal year or period with respect to the PARS Trust. If an outside Custodian is engaged, the Trustee shall provide the Trust Administrator with summary account statements received from Custodian. Custodian shall provide statements directly to the Participant. Such account shall set forth the assets and liabilities of the PARS Trust valued as of the end of the accounting period.

(b) The Trust Administrator may approve such statements either by written notice or by failure to express objections to such statements by written notice delivered to the Trustee within 90 days from the date the statement is delivered to the Trust Administrator. Upon approval, the Trustee shall be released and discharged as to all matters and items set forth in such statement as if such account had been settled and allowed by a decree from a court of competent jurisdiction.

5.14 Wire Transfers

The Trustee or the Custodian shall follow the Plan Administrator's, Delegatee's, or Trust Administrator's wire transfer instructions in compliance with the written security procedures provided by the party providing the wire transfers. The Trustee shall perform a telephonic verification to the Plan Administrator, Trust Administrator, or Delegatee, of such other security procedure, as selected by the party providing wire transfer directions, prior to wiring funds or following facsimile

directions as Trustee may require. The Plan Administrator assumes the risk of delay of transfer if Trustee is unable to reach the Plan Administrator, or in the event of delay as a result of attempts to comply with any other security procedure selected by the directing party.

5.15 Exclusive Benefit

The Assets of the Agency Trust shall be held in trust for the exclusive purpose of providing benefits to the Participants of the Member Agency Plan, and defraying reasonable expenses of the Plan, and shall not be used for or diverted to any other purpose. No party shall have authority to use or divert such Plan's Assets for the payment of benefits or expenses of any other Member Agency's Plan.

5.16 Delegation of Duties

The Plan Administrator, Delegatee, or Trust Administrator, may at any time retain the Trustee or Custodian as its agent to perform any act, keep any records or accounts and make any computations that are required of the Plan Administrator, Delegatee or Trust Administrator by this Trust Agreement or by the Plan. The Trustee or Custodian may be compensated for such retention and such retention shall not be deemed to be contrary to this Trust Agreement.

5.17 Distributions

All benefits payable pursuant to the Plan shall be paid out of the Assets of the Agency Trust by the Trustee or by Custodian pursuant to the direction of the Plan Administrator or Delegatee. The Trustee or Custodian shall, from time to time, upon the written direction of the Plan Administrator or Delegatee, make distributions from the Assets of the Agency Trust to or for the benefit of such persons, in such manner in such form(s), in such amounts and for such purposes as may be specified in such directions. The Trustee or Custodian at the direction of the Plan Administrator or Delegatee may make any distribution required to be made by it hereunder by delivering to the Plan Administrator or Delegatee:

Its check payable to the person to whom such distribution is to be made, for delivery to such person; or

Its check payable to an insurer for the benefit of such person, for delivery by such insurer; or insurance contracts held on the life of the Participant to whom or with respect to whom the distribution is being made, for redelivery to the person to whom such distribution is to be made; provided that any contract distributed shall be endorsed as non-transferable.

In directing the Trustee to make distributions, the Plan Administrator or Delegatee shall follow the provisions of the Plan and shall not direct that any distribution be made either during the existence or upon discontinuance of the

Plan, which would cause any part of the Assets of the Agency Trust to be used for or diverted to purposes other than as provided in the Plan and this PARS Trust. In no event shall the Trustee have any responsibility respecting the application of such distributions, nor for determining or inquiring into whether such distributions are in accordance with the Plan.

5.18 Participant Directed Accounts

The Member Agency may, by signing the Adoption of Trust, Recordkeeping Agreement and Investment Direction, written resolution and execution of the Adoption Agreement, terminate the Plan Administrator's right to direct the investment and management of all or any portion of the Assets of the Agency Trust and allow Participants to direct their own account balances ("Participant Directed Accounts"). Notwithstanding any other provision of this Trust Agreement, for Participant Directed Accounts, the Trustee shall be entitled to act upon proper directions of the Plan Administrator, Trust Administrator, and Participants including directions in writing, or oral instructions which Trustee in its discretion may follow without receipt of written instructions, instruction given by photostatic teletransmission using facsimile signature, or those instructions which are digitally recorded on the UBOC Voice Response Unit ("VRU") or internet website. Trustee is hereby authorized to record conversations and transmissions made in connection with the Agency Trust. Trustee's recording or lack of recording of any such oral, internet or digital instructions, and/or receipt or lack of receipt of facsimile transmissions, as reflected in the Trustee's records maintained in the ordinary course of business shall constitute conclusive proof of Trustee's receipt or non-receipt of such instructions.

The Trustee and/or Trust Administrator shall not be liable in any manner for investment or other losses or other liability attributable to Participant's directions, or lack thereof, or exercise of control over the investments of their Participant Directed Accounts. Likewise, the Trustee and/or Trust Administrator shall have no duty or responsibility to review, monitor or make recommendations regarding investments made at the direction of the Participants or the Plan Administrator. The Plan Administrator shall establish uniform and nondiscriminatory rules for the operation of the Participant Directed Accounts, including whether the Participant shall direct the Trustee or direct the Plan Administrator who directs the Trust Administrator who forwards such directions to the Trustee. Member Agency shall designate whether Participant Directed Accounts are to be established pursuant to the provisions of section 5.18(a) or 5.18(b), below:

(a) Participant Direction in Participant Directed Accounts. If the Member Agency has so elected, Participant Directed Accounts may be directed by Participants into assets administratively acceptable to Trustee, as limited by guidelines developed by the Plan Administrator (the "Permissible Investment Guidelines"). The Plan Administrator shall notify Participants of the Plan's Permissible Investment Guidelines as in effect from time to

time. In the absence of directions from a Participant, the Plan Administrator may direct the investment of the Participant Directed Account. The Trustee may refuse to comply with the directions of the Participant or Plan Administrator to invest in assets other than those listed in its Permissible Investments Guidelines or with directions which the Trustee deems to be improper or contrary to the provisions of the Plan and Agency Trust or the Internal Revenue Code and shall have no liability for such refusal.

(b) Participant Directed Account within Plan Administrator Selected Investment Options: If the Member Agency so elects and directs the Trustee to execute appropriate legal agreements, the Participant's Account Balance shall be segregated into a Participant Directed Account ("Directed Account"), over which the Participant may direct investment into one or more investment alternatives ("Investment Options"). The Plan Administrator or its appointed Investment Fiduciary shall have full responsibility for designating the Investment Options under the Plan and for selecting the underlying investment vehicle(s) for each designated Investment Option into which a Participant may direct investment of his or her Directed Account. To the extent allowed by law, neither the Member Agency, the Plan Administrator, the Trust Administrator nor the Trustee shall have any responsibility for monitoring the directions of the Participant nor shall the Member Agency, the Plan Administrator, the Trust Administrator or the Trustee be liable in any manner for investment or other losses or other liability for following directions of a Participant.

(c) If Directed Accounts are established, notwithstanding any other provision of this Trust Agreement, the Member Agency directs the Trustee to execute appropriate legal documentation appointing the Custodian as the recordkeeper for such accounts.

Article VI

FIDUCIARY RESPONSIBILITIES

6.1 More Than One Fiduciary Capacity

Any one or more of the fiduciaries with respect to the PARS Trust Agreement or the Agency Trust may, to the extent required thereby or as directed by the Plan Administrator pursuant to this PARS Trust Agreement and the Plan, serve in more than one fiduciary capacity with respect to the PARS Trust Agreement, the Agency Trust and the Plan.

6.2 Fiduciary Discharge of Duties

Except as otherwise provided in the Code and applicable law each fiduciary shall discharge such fiduciary's duties with respect to the PARS Trust Agreement and the Plan:

(a) solely in the interest of the Participants and for the exclusive purpose of providing benefits to Participants, and defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims; and

(c) by diversifying the investments of the Plan and the Agency Trust so as to minimize the risk of loss and to maximize the rate of return, unless under the circumstances it is clearly prudent not to do so.

6.3 Limitations on Fiduciary Responsibility

To the extent permitted by applicable law:

No fiduciary shall be liable with respect to a breach of fiduciary duty by any other fiduciary if such breach was committed before such party became a fiduciary or after such party ceased to be a fiduciary.

No fiduciary shall be liable for a breach by another fiduciary unless the non-breaching fiduciary knowingly participates in such a breach, knowingly undertakes to conceal such breach, or has actual knowledge of such breach and fails to take reasonable steps to remedy such breach.

No fiduciary shall be liable for carrying out a proper direction from another fiduciary, including refraining from taking an action in the absence of a proper direction from the other fiduciary possessing the authority and responsibility to make such a direction, which direction the fiduciary in good faith believes to be authorized and appropriate.

6.4 Indemnification of Trustee by Member Agency

The Trustee shall not be liable for, and Member Agency shall indemnify, defend (as set out in 6.8 of this Trust Agreement), and hold the Trustee (including its officers, agents, employees and attorneys) and other Member Agencies and Alternate Trustees, harmless from and against any claims, demands, loss, costs, expense or liability imposed on the indemnified party, including reasonable

attorneys' fees and costs incurred by the indemnified party, arising as a result of Member Agency's active or passive negligent act or omission or willful misconduct in the execution or performance of its duties under this Trust Agreement.

6.5 Indemnification of Member Agency by Trustee

The Member Agency shall not be liable for, and Trustee shall indemnify, defend (as set out in 6.8 of this Trust Agreement), and hold the Member Agency (including its officers, agents, employees and attorneys) and other Member Agencies and Alternate Trustees, harmless from and against any claims, demands, loss, costs, expense or liability imposed on the indemnified party, including reasonable attorneys' fees and costs incurred by the indemnified party, arising as a result of Trustee's active or passive negligent act or omission or willful misconduct in the execution or performance of its duties under this Trust Agreement.

6.6 Indemnification of Trustee by Trust Administrator

The Trustee shall not be liable for, and Trust Administrator shall indemnify and hold the Trustee (including its officers, agents, employees and attorneys) harmless from and against any claims, demands, loss, costs, expense or liability imposed on the indemnified party, including reasonable attorneys' fees and costs incurred by the indemnified party, arising as a result of Trust Administrator's active or passive negligent act or omission or willful misconduct in the execution or performance of its duties under this Trust Agreement.

6.7 Indemnification of Trust Administrator by Trustee

The Trust Administrator shall not be liable for, and Trustee shall indemnify and hold the Trust Administrator (including its officers, agents, employees and attorneys) harmless from and against any claims, demands, loss, costs, expense or liability imposed on the indemnified party, including reasonable attorneys' fees and costs incurred by the indemnified party, arising as a result of Trustee's active or passive negligent act or omission or willful misconduct in the execution or performance of its duties under this Trust Agreement.

6.8 Indemnification of Trust Administrator by Member Agency

The Trust Administrator shall not be liable for, and Member Agency shall indemnify and hold the Trust Administrator (including its officers, agents, employees and attorneys) harmless from and against any claims, demands, loss, costs, expense or liability imposed on the indemnified party, including reasonable attorneys' fees and costs incurred by the indemnified party, arising as a result of Member Agency's active or passive negligent act or omission or willful

misconduct in the execution or performance of its duties under this Trust Agreement.

6.9 Indemnification of Member Agency by Trust Administrator

The Member Agency shall not be liable for, and Trust Administrator shall indemnify and hold the Member Agency (including its officers, agents, employees and attorneys) harmless from and against any claims, demands, loss, costs, expense or liability imposed on the indemnified party, including reasonable attorneys' fees and costs incurred by the indemnified party, arising as a result of Trust Administrator's active or passive negligent act or omission or willful misconduct in the execution or performance of its duties under this Trust Agreement.

6.10 Indemnification Procedures

Promptly after receipt by an indemnified party of notice or receipt of a claim or the commencement of any action for which indemnification may be sought, the indemnified party will notify the indemnifying party in writing of the receipt or commencement thereof. When the indemnifying party has agreed to provide a defense as set out above that party shall assume the defense of such action (including the employment of counsel, who shall be counsel satisfactory to such indemnitee) and the payment of expenses, insofar as such action shall relate to any alleged liability in respect of which indemnity may be sought against the indemnifying party. Any indemnified party shall have the right to employ separate counsel in any such action and to participate in the defense thereof, but the fees and expenses of such counsel shall not be at the expense of the indemnifying party unless (i) the employment of such counsel has been specifically authorized by the indemnifying party or (ii) the named parties to any such action (including any impleaded parties) include both the indemnifying party and the indemnified party and representation of both parties by the same counsel would be inappropriate due to actual or potential differing interest between them. The indemnifying party shall not be liable to indemnify any person for any settlement of any such action effected without the indemnifying party's consent.

6.11 No Joint and Several Liability

This document is not intended to and does not create any joint powers agreement or any joint and several liability. No Member Agency shall be responsible for any contributions, costs or distributions of any other Member Agency.

Article VII

AMENDMENT, TERMINATION AND MERGER

7.1 No Obligation to Continue Plan and Trust

Continuance of the Agency Trust, participation in the PARS Trust Program and continuation of the Plan are not assumed as a contractual obligation of the Member Agency.

7.2 Amendments

(a) The PARS Trust Agreement may only be amended or terminated as provided herein. A two-thirds majority or greater of the Member Agencies shall have the right to amend this Trust Agreement from time to time, and to similarly amend or cancel any amendments. A copy of all amendments shall be delivered to the Trustee, the Trust Administrator and Plan Administrators promptly as each is made.

(b) Such amendments shall be set forth in an instrument in writing executed by the amending party, the Trust Administrator and the Trustee. Any amendment may be current, retroactive or prospective, provided, however, that no amendment shall:

(1) Cause the Assets of any Agency Trust to be used for or diverted to purposes other than for the exclusive benefit of Participants who have an interest in such Agency Trust or for the purpose of defraying the reasonable expenses of administering such Agency Trust.

(2) Have any retroactive effect so as to reduce the benefits of any Participant having an interest in the Agency Trust as of the date the amendment is adopted, except that such changes may be made as may be required to permit this PARS Trust Agreement to meet the requirements of applicable law.

(3) Change or modify the duties, powers or liabilities of the Trustee or the Trust Administrator hereunder without its consent.

(4) Permit the Assets of any Agency Trust to be used for the benefit of any other Plan of the Member Agency unless the Member Agency agrees to such use.

7.3 Termination of Plan

A termination of the Plan for which the Agency Trust was established shall not, in itself, effect a termination of an Agency Trust. Upon any termination of the Plan, the Assets of the Agency Trust shall be distributed by the Trustee as and when directed by the Plan Administrator. From and after the date of such termination of the Plan and until final distribution of the Assets the Trustee shall continue to have all the powers provided herein as are necessary or expedient for the orderly liquidation and distribution of such assets and the Agency Trust shall continue until the interests of all Participants have been completely distributed to or for the benefit of the Participants in accordance with the Plan.

7.4 Reversion

In the event a Member Agency's Plan is terminated, the vested interest of any Participant shall not be diminished or adversely affected. Except as may be provided in this Trust Agreement or the Plan, such termination shall not vest in the Member Agency any corpus or income under the Agency Trust, nor permit the Plan to discriminate as to coverage, or as to allocation of contributions or earnings, in favor of employees who are officers, shareholders, or highly compensated, nor cause the Agency Trust to lose its exemption pursuant to 501(a) of the Code. No modification, amendment or termination of the Plan shall be construed to be a termination of the Agency Trust so as to require the Trustee to make a distribution of any of the Assets of the Agency Trust to any Participant. In order to make such distribution the Trustee must receive written instructions from the Plan Administrator or Delegatee in a form acceptable to the Trustee.

If any Member Agency adopts a Plan whose assets are maintained in an Agency Trust and makes application to the Internal Revenue Service, within one year from the date of adoption of such Plan, for a determination that such Plan is a qualified plan under Section 401 (a) of the Code, and if such Plan is determined by the Internal Revenue Service not to be a qualified Plan, then all contributions and investment income attributable to such Plan shall be returned to the Member Agency upon application to the Trustee.

7.5 Fund Recovery Based on Mistake of Fact

Except as hereinafter provided, the Assets of the Agency Trust shall never inure to the benefit of the Member Agency. The Assets shall be held for the exclusive purposes of providing benefits to Participants having an interest in the Plan and defraying reasonable expenses of administering the Agency Trust. The sole exception to the foregoing is as follows:

Mistake of Fact. In the case of a contribution which is made by the Plan Administrator because of a mistake of fact, that portion of the contribution relating to the mistake of fact (exclusive of any earnings or losses attributable thereto)

may be returned to the Plan Administrator, provided such return occurs within one (1) year after discovery by the Plan Administrator of the mistake. If any repayment is payable to the Plan Administrator, then, as a condition to such repayment, and only if requested by Trustee, the Plan Administrator shall execute, acknowledge and deliver to the Trustee its written undertaking, in a form satisfactory to the Trustee, to indemnify, defend and hold the Trustee harmless from all claims, actions, demands or liabilities arising in connection with such repayment.

7.6 Transfers from Other Qualified Plans

Notwithstanding any other provision hereof, there may be transferred to the Trustee, upon direction of the Plan Administrator, all or any of the assets held (whether by a trustee, custodian or otherwise) on behalf of any other plan which satisfies the applicable requirements of Section 401 of the Code, and which is maintained for the benefit of any persons who are or will become Participants in the Plan.

7.7 Termination

The PARS Trust Agreement may be terminated only by a unanimous agreement of all Member Agencies. Such action must be in writing and delivered to the Trustee and Trust Administrator.

Article VIII

MISCELLANEOUS PROVISIONS

8.1 Nonalienation

To the maximum extent permitted by law, a Participant's interest in the Agency Trust shall not in any way be liable to attachment, garnishment, assignment or other process, or be seized, taken, appropriated or applied by any legal or equitable process, to pay any debt or liability of the Participant or any other party. Agency Trust Assets shall not be subject to the claims of the Member Agency or the claims of its creditors.

8.2 Saving Clause

In the event any provision of this PARS Trust Agreement and each Agency Trust is held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining parts of the PARS Trust and/or Agency Trust, but this instrument shall be construed and enforced as if said provision had never been included.

8.3 Applicable Law

This PARS Trust Agreement and each Agency Trust shall be construed, administered and governed under the Code and the applicable provisions of California State law, except to the extent that the Member Agency's applicable state law limits or restricts investments in Member Agency's Plan and Trust, and to that extent, the Member Agency's state law shall control, as designated by Member Agency in the Adoption Agreement. To the extent any of the provisions of this Trust Agreement or the Plan are inconsistent with the Code or applicable state law, the provisions of the Code or state law shall control. In the event, however, that any provision is susceptible to more than one interpretation, such interpretation shall be given thereto as is consistent with the Trust Agreement and the Plan being a qualified governmental retirement trust and plan within the meaning of the Code.

8.4 Joinder of Parties

In any action or other judicial proceedings affecting this Trust Agreement, it shall be necessary to join as parties only the Trustee, the Plan Administrator or Delegatee. No participant or other persons having an interest in any Agency Trust shall be entitled to any notice or service of process unless otherwise required by law. Any judgment entered in such a proceeding or action shall be binding on all persons claiming under this Trust Agreement, provided, however, that nothing in this Trust Agreement shall be construed as to deprive a participant of such participant's right to seek adjudication of such participant's rights under applicable law.

8.5 Employment of Counsel

The Trustee may consult with legal counsel (who may be counsel for the Trustee or Member Agency Plan Administrator) and charge the Agency Trust.

8.6 Gender and Number

Words used in the masculine, feminine or neuter gender shall each be deemed to refer to the other whenever the context so requires; and words used in the singular or plural number shall each be deemed to refer to the other whenever the context so requires.

8.7 Headings

Headings used in this Trust Agreement are inserted for convenience of reference only and any conflict between such headings and the text shall be resolved in favor of the text.

8.8 Counterparts

The Adoption Agreement of this Trust Agreement may be executed in an original and any number of counterparts by the Plan Administrator (executing an Adoption Agreement), the Trust Administrator and the Trustee, each of which shall be deemed to be an original of the one and the same instrument.

Article IX

ACKNOWLEDGMENT AND ACCEPTANCE

IN WITNESS WHEREOF, the Plan Administrator (by executing the Adoption Agreement) the Trust Administrator and Trustee have executed this Trust Agreement by their duly authorized agents on this 19th day of June, 2008.

ACKNOWLEDGED AND ACCEPTED this 19th day of June, 2008.

THE TRUSTEE

UNION BANK OF CALIFORNIA, N.A.

By: _____

Title: VP

By: Pamela L. Uyehara

Title: VP

THE TRUST ADMINISTRATOR

PHASE II SYSTEMS

By: _____
Daniel Johnson

Title: President

Back to Item

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
13. Authorize Utilization of a Customized Contract

Contacts
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action
Authorize the Chief Executive Officer (CEO) to utilize a customized contract to execute an agreement with Automatic Data Processing, Inc. (ADP) for comprehensive human capital management (HCM) software.

Background
The CalOptima Health Board of Directors (Board) has authorized the use of a standard contract template; however, in cases where no vendors are willing to accept the standard contract template, Board authorization is required to enter into a customized contract with an otherwise responsive vendor.

Discussion
HCM software integrates multiple human resources systems, such as payroll, timekeeping and attendance, compensation, benefits, and more, using mobile and cloud-based technology to process data, run reports and create a smooth end-user experience. Currently, CalOptima Health contracts with Ceridian Dayforce for its HCM software. The initial contract with Ceridian Dayforce commenced in July 2008, for a three-year term. Since 2011, the contract with Ceridian Dayforce has been extended six times in various increments until 2014 when the contract was amended to be in effect until canceled. Current pricing is effective through January 9, 2024.

Having had the same vendor for over thirteen years, staff issued a request for proposal (RFP) in January 2022 for HCM software. ADP and Ceridian Dayforce responded to the RFP; however, both declined to use the CalOptima Health standard contract template and required use of their vendor-specific contract templates instead. For that reason, both proposals were disqualified. The RFP was then cancelled, and staff worked with legal counsel to update the CalOptima Health standard contract template to make it more suitable for a software agreement.

Staff updated the RFP scope of work as well. The revised RFP with the revised CalOptima Health standard contract template was used to re-issue the RFP in September 2022. Five responses were received. Two were disqualified for performance and three were disqualified for not agreeing to use the CalOptima Health standard contract template. The three bidders disqualified for not agreeing to use the standard contract template were Ceridian Dayforce, ADP, and Ultimate Kronos Group (UKG).

With guidance from legal counsel, staff revised the RFP again in February 2023 to allow the three vendors disqualified for not agreeing to use CalOptima Health standard contract template to submit their

Back to Agenda

vendor-specific contract templates, which they all did. In March 2023, the three vendor proposals were then reviewed by the RFP evaluation team. ADP and UKG had the highest results and were invited to provide product demonstrations that were also evaluated and scored by the RFP evaluation team.

After viewing and evaluating the two vendor demonstrations, the RFP evaluation team reviewed the overall combined scores and selected ADP with a score of 4.03 out of 5.00. UKG had a score of 3.65. ADP was selected as the preferred HCM software vendor based on cost, service model, and system functionality.

Staff recommends that the Board authorize the CEO to execute the agreement with ADP utilizing the vendor-specific contract template with revisions that reflect the negotiated and agreed-upon terms and conditions with ADP. The agreement has been reviewed and approved by staff and legal counsel.

Staff anticipate implementation of the new HCM software will commence in January 2024. The Ceridian Dayforce contract will remain in effect until the ADP implementation is complete.

Fiscal Impact
The recommended action is a budgeted item and is included in the Fiscal Year 2023-24 Digital Transformation Year Two Capital and Operating Budgets approved by the Board on June 1, 2023. Management will include this project in future budgets.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Global Master Services Agreement with ADP, INC.

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
ADP, INC.	One ADP Boulevard	Roseland	NJ	07068

Back to Item

Back to Agenda

GLOBAL MASTER SERVICES AGREEMENT

Effective Date:_____, 20___

As between:

ADP, INC.
(Referred to in this agreement as "**ADP**")
One ADP Boulevard
Roseland, NJ 07068

-and-

CalOptima
(Referred to in this agreement as "**Client**")
505 City Pkwy W
Orange, CA 92868-2924

ADP and Client agree that ADP shall provide Client with the following services in accordance with the terms set forth in this Global Master Services Agreement and the applicable Sales Order (as defined herein):

- ADP Payroll Services – delivered via ADP Workforce Now
- ADP Compliance on Demand
- ADP DataCloud
- ADP Document Cloud
- ADP Health Compliance Services
- ADP Marketplace
- ADP Time & Attendance Services
- Benefit Services – delivered via ADP Workforce Now
- Employment Verification Services
- ESS & MSS Technology
- History Conversion Services
- Human Resources Administration Services – delivered via ADP Workforce Now
- Talent Management Solutions – delivered via ADP Workforce Now

ADP, INC.

_____
Signature of Authorized Representative

_____
Name - Please Print

_____
Title

CalOptima

_____
Signature of Authorized Representative

_____
Name - Please Print

_____
Title

Appendices

Appendix: History Conversion Services
Appendix: Data Privacy
Appendix: Sales Order

Global Master Terms and Conditions

1 Definitions

1.1 **ADP HCM Services**. Only those Services, as defined below, that have been purchased by Client (as listed on the cover page, a Sales Order or otherwise) will be applicable.

1.1.1 **ADP Compliance on Demand**. A workforce management solution that provides clients with access to information and best practice guidance. ADP Compliance on Demand may include access to (1) a self-service library of human resources compliance information, (2) an online community to collaborate with other clients, (3) Tier 1 human resources professionals available to support and assist clients with their workforce management administration requirements, and (4) Tier 2compliance experts who are available for up to a total of four (4) contacts per year.

1.1.2 **ADP Data Cloud**. Provide tools to analyze and understand data.

1.1.2.1 **Analytics**. Enables an employer to gain insight from data for key Human Capital Management (HCM) metrics.

1.1.3 **ADP Document Cloud**. Integrated solution to support maintenance and retrieval of employee-specific documents via cloud-based technology.

1.1.4 **ADP Health Compliance Services.** A technology and software solution to assist Client in managing compliance needs related to the Affordable Care Act (ACA), including eligibility calculations and affordability determinations, preparation and electronic filing of Forms 1094-C and 1095-C forms, access to evidence of benefit offering information and benefit offering audit reports.

1.1.5 **ADP Marketplace.** Enable Client to build applications and/or purchase available applications via online store. Provide access to certain Client data stored in ADP systems via industry-standard Application Programming Interfaces (APIs).

1.1.6 **ADP Payroll Services.** Administration and processing of payroll including performing gross-to-net calculations and generating and/or transmitting of payment instructions, and also including:

1.1.6.1 **ADP Employment Tax Services.** Coordination of payroll-related tax and/or regulatory agency deposits, filings and reconciliations on behalf of employers.

1.1.6.2 **ADP Wage Garnishment Payment Services.** Garnishment payment processing and disbursement of payments to appropriate Payees as directed by Client.

1.1.6.3 **ADP Wage Payment Services.** Payment of wages, commissions, consulting fees, or similar compensation or work-related expenses in the employment context to employees and independent contractors via direct deposit, check or payroll debit cards, in each case only to the extent applicable.

1.1.6.4 **Print and Online Statement Services.** Print and distribution of payroll checks, pay statements, and/or year-end statements, as well as online posting of pay statements and/or year-end statements.

1.1.6.5 **State Unemployment Insurance (SUI) Management Services.** ADP becomes the unemployment insurance address of record. ADP requests the state to send unemployment insurance claims, charges, tax rates and related information to ADP and Client receives a quarterly summary of all claims.

1.1.7 **ADP Time & Attendance Services**. Support of time-related services, including time data collection, employee scheduling, timecard reviews and approvals, and consistent application of time-related policies.

1.1.8 **ADP Workforce Now.** ADP's web-based portal which provides a single point of access to ADP online solutions and employee-facing websites and resources related to payroll, HR, benefits, talent, and time and attendance.

1.1.9 **Benefit Services.** Technology to facilitate the administration of employee benefits, including applying eligibility rules, facilitating online enrollment and changes and calculating payroll deductions within a unified system, as well as providing data to carriers through ADP carrier connection services.

1.1.10 **Employment Verification Services.** Management of employment and income verification requests.

1.1.11 **ESS & MSS Technology.** Employee self-service (ESS) and Manager self-service (MSS) functionality provides all Client Users (practitioners, managers and employees) 24x7 online access to ADP Application Programs.

1.1.12 **History Conversion Services.** Conversion and loading of certain Client historical payroll or other human capital management data elements into ADP's systems or a standalone history viewer, as applicable.

1.1.13 **Human Resources Administration Services**. Administration of human resource functions using a unified system to process and audit employee lifecycle events, provide compliance tracking and reporting, including new hire reporting, and automate notification and approval processes via self-service/direct access, and also including:

1.1.13.1 **WFN EI-9 Services.** Electronic I-9 administration and onboarding services to help facilitate and manage I-9 and related employment eligibility verification processes.

1.1.14 **Talent Management Solutions**. Technology to facilitate the administration of talent management services, including:

1.1.14.1 **ADP Compensation Management**. Solutions and tools to administer the compensation planning process.

1.2.1.1 **ADP Performance Management**. Solutions and tools to facilitate the performance management process, including goal alignment and employee engagement.

1.2.1.2 **Succession Planning**. Solutions and tools to facilitate talent assessments and establish action plans for critical roles.

1.2 General

1.2.2 **"ADP"** has the meaning set forth on the cover page.

1.2.3 **"ADP Application Programs"** means the computer software programs and related Documentation, including any updates, modifications or enhancements thereto, that are either delivered or made accessible to Client through a hosted environment by ADP in connection with the Services.

1.2.4 **"ADPCheck"** means checks printed and distributed by ADP to Payees pursuant to Client's direction.

1.2.5 **"ADPCheck Services"** refers to ADP's payment of Client's Payees for Permitted Payments through ADPCheck.

1.2.6 **"ADP Direct Deposit Services"** means ADP's full service direct deposit services which includes ADP's payment of Client's Payees who have elected to receive Permitted Payments by direct deposit into an account at a financial institution of such Payee's selection.

1.2.7 **"Affiliate"** means, with respect to any entity, any other entity that controls, is controlled by or under control with such first entity. For purposes of this Agreement, "control" (or variants of it) means the ability, whether directly or indirectly, to direct the management and corporate policies and actions of an entity by means of ownership, contract or otherwise. Client's Affiliates do not include third parties for whom Client is a service provider or provides outsourcing services.

1.2.8 **"Agreement"** means this Global Master Services Agreement, consisting of the signature pages, the Global Master Terms and Conditions, all exhibits, annexes, appendices, addenda and schedules, and each Amendment, if any.

1.2.9 **"Amendment"** means a written amendment to this Agreement modifying, supplementing or amending the terms andconditions of this Agreement.

1.2.10 "**API**" means application programming interface.

1.2.11 **"Approved Country"** means each country in which, subject to the terms of this Agreement, Client is authorized to use or receive the Services. The following is the list of Approved Countries for the Services: United States.

1.2.12 **"Biometric Data"** includes the information collected by timeclocks and software that use finger and/or hand scan technology, which potentially may include Biometric Identifiers and Biometric Information.

1.2.13 **"Biometric Identifier"** means a retina or iris scan, fingerprint, voiceprint, or scan of hand or face geometry.

1.2.14 **"Biometric Information"** means any information, regardless of how it is captured, converted, stored, or shared, based on an individual's biometric identifier used to identify an individual.

1.2.15 **"Biometric Services"** means services provided by ADP to Client via the use of timeclocks and software in connection with ADP's provision of Time & Attendance Services, to the extent such timeclocks or software collect, store or use Biometric Data.

1.2.16 **"Biometric User"** means Client's employees or independent contractors who use Biometric Services to record their attendance, hours worked or other work-related data.

1.2.17 **"Business Day"** means any day, except a Saturday, Sunday or a day on which ADP's bank is not open for business in the applicable jurisdiction where services are provided by ADP.

1.2.18 **"Cardholder"** means the Payees of Client who receive a Pay Card.

1.2.19 **"Client"** has the meaning set forth on the cover page.

1.2.20 "**Client ACA Liaison**" means the Client's designated person who shall serve as ADP's principal contact for Health Compliance Services.

1.2.21 **"Client Content"** means all information and materials provided by Client, its agents or employees, regardless of form.

1.2.22 **"Client Group"** means Client and Client's Affiliates listed in the Sales Order who are authorized to receive the Services.

1.2.23 **"Client Infringement Event"** means (i) any change or enhancement in, or use of, the Services by Client or a third party on Client's behalf other than at the direction of, or as approved by, ADP or (ii) Client's failure to use the most current release or version of any computer software programs included in the ADP Application Programs or any corrections or enhancements provided by ADP thereto (to the extent ADP requires Client to use the most current release or version of any computer software programs, the implementation of such shall be at no charge to Client).

1.2.24 **"Confidential Information"** means all trade secrets, processes, proprietary data and documentation and any pricing and product information, Personal Data, the terms of this Agreement, and any other information that is confidential or proprietary provided by the disclosing party to the receiving party for use in connection with the Services or this Agreement, but does not include information that (i) the receiving party already knows prior to its disclosure by the disclosing party, (ii) becomes generally available to the public, except as a result of disclosure by the receiving party in violation of this Agreement or (iii) becomes known to the receiving party on a non-confidential basis from a source other than the disclosing party.

1.2.25 "**Data Security Breach"** means a security breach as defined by applicable law or any incident that compromises the confidentiality, integrity, or availability of Personal Data.

1.2.26 **"DHS"** means the U.S. Department of Homeland Security.

1.2.27 **"Documentation"** means all manuals, tutorials and related materials that may be provided or made available to Client by ADP in connection with the Services.

1.2.28 "**Early Termination Fee**" has the meaning set forth in Section 12.4.

1.2.29 **"Effective Date"** has the meaning set forth on the cover page.

1.2.30 **"ERISA"** means Employee Retirement Income Security Act of 1974, as amended.

1.2.31 **"E-Verify"** means the DHS's employment eligibility verification program which allows participating employers to electronically verify the employment eligibility of each newly hired employee and/or employee assigned to a covered federal contract.

1.2.32 **"Form I-9"** means the employment eligibility verification form issued by the DHS.

1.2.33 "**FCRA**" means the Fair Credit Reporting Act, 15 U.S.C. §1681 et seq.

1.2.34 **"Global Master Terms and Conditions"** means the terms and conditions contained in the main body of this document following the signature pages.

1.2.35 "**Go-Live Date**" means the date of commencement of the first live processing of any given Service.

1.2.36 **"Gross Negligence"** means (1) willful, wanton, careless or reckless conduct, misconduct, failures, omissions, or disregard of the duty of care towards others of a risk known or so obvious that the actor must be taken to have been aware of it, and with an intent to injure or so great as to make it highly probable that harm would follow and/or (2) failure to use even the slightest amount of care, or conduct so reckless, as to demonstrate a substantial lack of concern for the safety of others. For the avoidance of doubt, Gross Negligence must be more than any mere mistake resulting from inexperience, excitement, or confusion, and more than mere thoughtlessness or inadvertence or simple inattention.

1.2.37 **"I-9 Handbook"** means the current USCIS Handbook for Employers: Instructions for Completing Form I-9 (M-274).

1.2.38 **"Implementation Services"** means the Services to be performed in order to commence ongoing Services.

1.2.39 **"Improvements"** has the meaning set forth in Section 5.4.

1.2.40 **"Indemnitee"** has the meaning set forth in Section 6.3.

1.2.41 **"Indemnitor"** has the meaning set forth in Section 6.3.

1.2.42 **"Initial Term"** means the period beginning as of the Effective Date and ending five (5) years after the date of Client's first monthly invoice for Services.

1.2.43 **"Intellectual Property Rights"** means all rights, title and interest to or in patent, copyright, trademark, service mark, trade secret, business or trade name, know-how and rights of a similar or corresponding character.

1.2.44 **"Internal Business Purposes"** means the usage of the Services, including the ADP Application Programs, exclusively by the Client Group for its own internal business purposes, without the right to provide service bureau or other data processing services, or otherwise share or distribute the Services.

1.2.45 **"NACHA"** means the National Automated Clearing House Association.

1.2.46 "**Notice to Furnishers**" means with respect to Employment Verification Services, the notice provided to a furnisher of information pursuant to the Obligations of Furnishers of Information provided at the following URL: https://www.consumer.ftc.gov/articles/pdf-0092-notice-to-furnishers.pdf.

1.2.47 **"Payee"** means any intended recipient of payments under the Payment Services and may include Client's employees, taxing authorities, governmental agencies, suppliers, benefit carriers and/or other third parties; provided that in the case of ADP Wage Payment Services, Payee shall be limited to Client's employees and independent contractors.

1.2.48 **"Payment Services**" means Services that involve electronic or check payments being made by ADP to third parties on Client's behalf and at its direction.

1.2.49 **"Permitted Payment"** means the legal payment of wages, commissions, consulting fees or similar compensation or work-related expenses in the employment context.

1.2.50 **"Personal Data"** means any information relating to an identified or identifiable natural person. An identifiable person is one who can be identified, directly or indirectly, in particular by reference to an identification number or to one or more factors specific to such person's physical, physiological, mental, economic, cultural or social identity.

1.2.51 "**Sales Order(s)**" means the document(s) between the parties that lists the specific Services purchased by Client Group from ADP.

1.2.52 **"Services"** means the services listed on the cover page of this Agreement (including Implementation Services related thereto), and such other services as the parties may agree to be performed from time to time.

1.2.53 **"SOC 1 Reports"** has the meaning set forth in Section 9.1.

1.2.54 **"Strategic Carrier Partner"** means a carrier that participates in ADP's strategic carrier partner program.

1.2.55 **"Technology Credit"** means funds paid by a Strategic Carrier Partner and applied by ADP to Client's invoice for benefit administration fees.

1.2.56 **"Term"** means the Initial Term together with any other renewal periods thereafter.

1.2.57 "**Termination Event**" means with respect to any party, the occurrence of any of the following: (i) under the applicable bankruptcy laws or similar law regarding insolvency or relief for debtors, (A) a trustee, receiver, custodian or similar officer is appointed for a party's business or property, (B) a party seeks to liquidate, wind-up, dissolve, reorganize or otherwise obtain relief from its creditors, or (C) an involuntary proceeding is commenced against a party and the proceeding is not stayed, discharged or dismissed within thirty (30) days of its commencement, or (ii) a party's Standard and Poor's issuer credit rating falls to or below BB.

1.2.58 **"Time & Attendance Hardware"** means timeclocks and other time collection devices provided to Client by ADP in connection with the ADP Time & Attendance Services. Hardware may be purchased or provided on a subscription basis.

1.2.59 **"Transition Services"** has the meaning set forth in Section 13.1.

1.2.60 **"Unauthorized Third Party"** means any commercial third party or business that seeks to access or accesses ADPApplication Programs using the account credentials (e.g., username and password) of a User even if such User has provided consent.

1.2.61 **"USCIS"** means U.S. Citizenship and Immigration Services.

1.2.62 **"User"** means any single natural person who, subject to the terms of this Agreement, is an employee or independent contractor of Client authorized by Client to use, access or receive the Services.

1.2.63 **"Verification Agent"** means ADP and its subcontractors, as authorized by the Client, to perform Employment Verification Services.

1.2.64 **"Verification Data"** means employment and income information disclosed on the Client's behalf in connection with Employment Verification Services.

1.2.65 **"Verifiers"** means commercial, private, non-profit and government entities and their agents that wish to obtain or verify any Client's employees or former employees Verification Data in connection with Employment Verification Services.

2 Provision and Use of Services

2.1 **Provision of Services**. ADP, or one of its Affiliates, will provide the Services to Client Group in accordance with the terms of this Agreement. ADP will provide the Services in a good, diligent and professional manner in accordance with industry standards, utilizing personnel with a level of skill commensurate with the Services to be performed. ADP's performance of the Services (includingany applicable implementation activities) is dependent upon the timely completion of Client's responsibilities and obligations under this Agreement. Without limitation of the foregoing, Client will timely provide the Client Content necessary for ADP to provide the Services.

2.2 **Cooperation**. ADP and Client will work together to implement the Services. Client will cooperate with ADP and execute and deliver all documents, forms, or instruments necessary for ADP to implement and render the Services. Client will provide ADP with all reasonable and necessary Client Content in the format requested by ADP, and will otherwise provide all reasonable assistance required of Client in order for ADP to successfully implement the Services.

2.3 **Use of Services**. Client will use the Services in accordance with the terms of this Agreement and solely for its own Internal Business Purposes. Client will be responsible for the use of the Services by the Client Group and the Users in accordance with the terms of this Agreement. Client understands and agrees that only Users are permitted to access and use ADP Application Programs (and that access by Unauthorized Third Parties is not permitted) and will reasonably cooperate with ADP to limit access to such persons. Client is responsible for the accuracy and completeness of the Client Content provided to ADP. The Services are designed for use in the Approved Country only and Client understands that the Services have not been designed to assist Client in complying with the laws and regulations of any country other than the Approved Country. ADP makes no representation or warranty that access and use of the Services from outside the Approved Country by Client employee managers and/or other Users who are not physically located in an Approved Country comport with any local laws, regulations, or directives in any other country. Furthermore, if Client during the implementation process or as part of the ongoing Services configures the ADP Application Programs to process additional data elements beyond those data elements that are required by ADP to perform the Services, Client will remain solely responsible for such configurations, including the processing of Personal Data pursuant to applicable law.

2.4 **Errors**. Client will promptly review all documents and reports produced by ADP and provided or made available to Client in connection with the Services and promptly notify ADP of any error, omission, or discrepancy with Client's records. ADP will promptly correct such error, omission or discrepancy and, if such error, omission or discrepancy was caused by ADP, then such correction will be done at no additional charge to Client.

2.5 **Records**. Unless expressly included as a part of the Services, and without prejudice to ADP's obligation to retain the data necessary for the provision of the Services, ADP does not serve as Client's record keeper and Client will be responsible for retaining copies of all documentation received from or provided to ADP in connection with the Services to the extent required by law or Client's internal policies.

2.6 **Third Party Services Available through or Integrated with the Services.** At times, ADP may make available to Client through the Services, or integrate the Services with, the services of a third party, either through a link, integration, or otherwise. ADP reserves the right to terminate such links, services or integrations at any time for any reason. If Client uses any third party services that are integrated with or linked to the Services which require the transmission, use, sharing, access or exchange of Client Content or any other payroll or other data or information provided to ADP or the third party by Client, Client is expressly agreeing to the transmission,use, sharing, access and exchange of such data between ADP and the third party. Client's use of any third party services will be governed by any terms Client agrees to with the third party and in the event of any conflict between the terms of this Agreement and any third party terms, the terms of this Agreement will apply to the provision of the Services by ADP to Client.

3 Compliance

3.1 **Applicable Laws**. Each party will comply with laws and regulations that affect its business generally, including any applicable anti-bribery, export control, computer fraud and data protection laws.

3.2 **Design of the Services**. ADP will design the Services, including the functions and processes applicable to ADP's performance of the Services, to assist the Client in complying with its legal and regulatory requirements applicable to the Services, and ADP will be responsible for the accuracy of such design. Client and not ADP will be responsible for (i) how it uses the Services to comply with its legal and regulatory requirements and (ii) the consequences of any instructions that it gives to ADP, including as part of the implementation of the Services, provided ADP follows such instructions. Services do not include any legal, financial, regulatory, benefits, accounting or tax advice.

3.3 **Online Statements**. If Client instructs ADP to provide online pay statements, Forms W2, Forms 1099, or Forms 1095-C without physical copies thereof, Client will be exclusively responsible for determining if and to what extent Client's use of online pay statements, Forms W2, Forms 1099, or Forms 1095-C satisfies Client's obligations under applicable laws and the consequences resulting from such determinations.

3.4 **Data Protection Laws.** During the Term of the Agreement (i) Personal Data transferred by Client or at Client's direction to ADP has been collected by Client in accordance with applicable privacy laws; and (ii) Client has the authority to provide such Personal Data to ADP under applicable privacy laws. ADP may not retain, sell (as defined by applicable privacy laws), use or disclose the Personal Data for any purpose other than as needed to perform the Services, as permitted by the Agreement, or as required by law.

4 Confidentiality

4.1 **General**. All Confidential Information disclosed under this Agreement will remain the exclusive and confidential property of the disclosing party. The receiving party will not disclose to any third party the Confidential Information of the disclosing party and will use at least the same degree of care, discretion and diligence in protecting the Confidential Information of the disclosing party as it uses with respect to its own confidential information. The receiving party will limit access to Confidential Information to itsemployees and independent contractors with a need to know the Confidential Information and will instruct those employees and independent contractors to keep such information confidential. ADP may disclose Client's Confidential Information on a need to know basis to (i) ADP's subcontractors who are performing the Services, provided that ADP shall remain liable for any unauthorized disclosure of Client's Confidential Information by those subcontractors, (ii) employees of ADP's Affiliates, provided such employees are instructed to keep the information confidential as set forth in this Agreement and (iii) social security agencies, tax authorities and similar third parties, to the extent strictly necessary to perform the Services. ADP may use Client's and its employees' and other Services recipients' information in an aggregated, anonymized form, such that neither Client nor such person may be identified, and Client will have no ownership interest in such aggregated, anonymized data. Client authorizes ADP to release employee-related data, and such other data as required to perform the Services, to third party vendors of Client as designated by Client from time to time. Notwithstanding the foregoing, the receiving party may disclose Confidential Information (x) to the extent necessary to comply with any law, rule, regulation or ruling applicable to it, (y) as appropriate to respond to any summons or subpoena or in connection with any litigation and (z) to the extent necessary to enforce its rights under this Agreement. ADP acknowledges that Client is a public agency subject to the California Public Records Act (Government Code § 6250 *et seq.*) and regulated by the Centers for Medicare & Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care (collectively, "**Regulators**"); as such, Client's disclosure of information otherwise considered Confidential Information under this Agreement, as required by the California Public Records Act and/or as required by the Regulators pursuant to applicable law, shall not constitute a breach of this Section 4.

4.2 **Return or Destruction**. Upon the request of the disclosing party or upon the expiration or earlier termination of this Agreement, and to the extent feasible, the receiving party will return or destroy all Confidential Information of the disclosing party in the possession of the receiving party, provided that each party may maintain a copy if required to meet its legal or regulatory obligations and may maintain archival copies stored in accordance with regular computer back-up operations. To the extent that any portion of Confidential Information of a disclosing party remains in the possession of the receiving party following expiration or earlier termination of this Agreement, such Confidential Information shall remain subject to the generally applicable statutory requirements and the confidentiality protections contained in Section 4.1.

5 Intellectual Property

5.1 **Client IP Rights.** Except for the rights expressly granted to ADP in this Agreement, all rights, title and interests in and to Client Content, including all Intellectual Property Rights inherent therein and pertaining thereto, are owned exclusively by Client or its licensors. Client hereby grants to ADP for the Term a non-exclusive, worldwide, non-transferable, royalty-free license to use, edit, modify, adapt, translate, exhibit, publish, reproduce, copy and display the Client Content for the sole purpose of performing the Services; provided Client has the right to pre-approve the use by ADP of any Client trademarks or service marks.

5.2 **ADP IP Rights**. Except for the rights expressly granted to Client in this Agreement, all rights, title and interest in and to the Services, including all Intellectual Property Rights inherent therein and pertaining thereto, are owned exclusively by ADP or its licensors. ADP grants to Client for the Term a personal, non-exclusive, non-transferable, royalty-free license to use and access the ADP Application Programs solely for the Internal Business Purposes in the Approved Countries and solely up to the maximum number of Users (if any) indicated in the Sales Order. The ADP Application Programs do not include any Client-specific customizations unless otherwise agreed in writing by the parties. Client will not obscure, alter or remove any copyright, trademark, service mark or proprietary rights notices on any materials provided by ADP in connection with the Services, and will not copy, recompile, disassemble, reverse engineer, or make or distribute any other form of, or any derivative work from, such ADP materials.

5.3 **Ownership of Reports**. Client will retain ownership of the content of reports and other materials that include Client Content produced and delivered by ADP as a part of the Services, provided that ADP will be the owner of the format of such reports. To the extent any such reports or other materials incorporate any ADP proprietary information, ADP (i) retains sole ownership of such proprietary information and (ii) provides the Client a fully paid up, irrevocable, perpetual, royalty-free license to access and use samefor its Internal Business Purposes without the right to create derivative works (other than derivative works to be used solely for its Internal Business Purposes) or to further distribute any of the foregoing rights outside the Client Group.

5.4 **Improvements.** ADP will make available to Client, at no additional cost, software improvements, enhancements, or updates to any ADP Application Programs that are included in the Services (collectively "**Improvements**") if and as they are made generally available by ADP at no additional cost to ADP's other clients using the same ADP Application Programs as Client and receiving the same Services as Client. All Improvements provided under this Section 5.4 shall be considered part of the ADP Application Programs. If Client fails to implement Improvements provided or made available to Client by ADP, ADP shall be relieved of any responsibility for errors or degradation in the Services and shall have no obligation to provide support for the ADP Application Programs.

5.5 **Third Party Software.** Notwithstanding Sections 5.1 through 5.4, ADP Time & Attendance Services shall be subject to the additional licensing or access terms set forth at https://www.adp.com/wfmlicenseterms.

6 Indemnities

6.1 **ADP Indemnity.** Subject to the remainder of this Section 6.1, and Sections 6.3 and 7, ADP will defend Client against any third party claims and will indemnify and hold Client harmless from any resulting damage awards or settlement amounts in any cause of action to the extent such cause of action is based on a claim alleging that the Services or ADP Application Programs, as provided by ADP and used in accordance with the terms of this Agreement, infringe upon any Intellectual Property Rights of a third party in the United States. The foregoing infringement indemnity will not apply and ADP will not be liable for any damages assessed in any cause of action to the extent resulting from a Client Infringement Event or ADP's use of Client Content as contemplated by this Agreement. If any Service is held or believed to infringe on any third-party's Intellectual Property Rights, ADP may, in its sole discretion, (i) modify the Service to be non-infringing, (ii) obtain a license to continue using such Service, or (iii) if neither (i) nor (ii) are practical, terminatethis Agreement as to the infringing Service and return to Client any unearned fees prepaid by Client to ADP.

6.2 **Client Indemnity**. Subject to Sections 6.3 and 7, Client will defend ADP against any third party claims and will indemnify and hold ADP harmless from any resulting damage awards or settlement amounts in any cause of action to the extent such cause of action is based on the occurrence of a Client Infringement Event or ADP's use of Client Content as contemplated by this Agreement.

6.3 **Indemnity Conditions.** The indemnities set forth in this Agreement are conditioned on the following: (i) the party claiming indemnification (the **"Indemnitee"**) shall promptly notify the indemnifying party (the **"Indemnitor"**) of any matters in respect of which it seeks to be indemnified, and shall give the Indemnitor full cooperation and opportunity to control the response thereto and the defense thereof, including without limitation any settlement thereof, (ii) the Indemnitor shall have no obligation for any claim under this Agreement if the Indemnitee makes any admission, settlement or other communication regarding such claim without the prior written consent of the Indemnitor, which consent shall not be unreasonably withheld, and (iii) the Indemnitee's failure to promptly give notice to the Indemnitor shall affect the Indemnitor's obligation to indemnify the Indemnitee only to the extent the Indemnitor's rights are materially prejudiced by such failure. The Indemnitee may participate, at its own expense, in such defense and in any settlement discussions directly or through counsel of its choice.

7 Limit on Liability

7.1 **Ordinary Cap**. Notwithstanding anything to the contrary in this Agreement and subject to the remainder of this Section 7, neither party's aggregate liability in any calendar year shall exceed an amount equal to twelve (12) times the average ongoing monthly Services fees paid or payable to ADP by Client during such calendar year for all Services (the "**Ordinary Cap"**).

7.2 **Extraordinary Cap**. As an exception to Section 7.1, if damages arise from a breach of Section 4 (Confidentiality), Section 9.3 (Data Security) or Section 9.4 (Unauthorized Third Party Access), the Ordinary Cap will be increased by an additional twelve (12) times the average ongoing monthly Services fees paid or payable to ADP by Client during such calendar year for all Services (the "**Extraordinary Cap**"). For the avoidance of doubt, in no case shall either party's aggregate liability in any calendar year under this Agreement exceed an amount equal to twenty-four (24) times the average monthly ongoing Services fees paid or payable to ADP by Client during such calendar year for all Services.

7.3 **Matters not Subject to the Cap**. The foregoing limits on liability shall not apply to the following:

7.3.1 Client's funding obligations in connection with the Payment Services;

7.3.2 Loss or misdirection of Client funds in possession or control of ADP due to ADP's error or omission;

7.3.3 In connection with the ADP Employment Tax Services, (i) interest charges imposed by an applicable tax authority on Client for the failure by ADP to pay funds to the extent and for the period that such funds were held by ADP and (ii) all tax penalties resulting from ADP's error or omission in the performance of such Service. The provisions of this Section 7.3.3 shall only apply if (x) Client permits ADP to act on Client's behalf in any communications and negotiations with the applicable taxing authority that is seeking to impose any such penalties or interest and (y) Client assists ADP as reasonably required by ADP;

7.3.4 Either party's gross negligence, or willful, criminal or fraudulent misconduct;

7.3.5 The infringement indemnity set forth in Section 6.1 and 6.2;

7.3.6 Client's biometrics indemnity set forth in Section 14;

7.3.7 Client's obligations to pay the fees for Services; and

7.3.8 ADP's obligations to provide credit monitoring as set forth in Section 10.2.

7.4 **Mitigation of Damages.** ADP and Client will each use reasonable efforts to mitigate any potential damages or other adverse consequences arising from or related to the Services.

7.5 **No Consequential Damages.** NOTWITHSTANDING ANYTHING TO THE CONTRARY IN THIS AGREEMENT AND ONLY TO THE EXTENT PERMITTED BY APPLICABLE LAW, NONE OF ADP, CLIENT OR ANY BANK WILL BE RESPONSIBLE FOR SPECIAL, INDIRECT, INCIDENTAL, CONSEQUENTIAL OR OTHER SIMILAR DAMAGES (INCLUDING DAMAGES FOR LOSS OF BUSINESS OR PROFITS, BUSINESS INTERRUPTIONS OR HARM TO REPUTATION) THAT ANY OTHER PARTY OR ITS RESPECTIVE AFFILIATES MAY INCUR OR EXPERIENCE IN CONNECTION WITH THIS AGREEMENT OR THE SERVICES, HOWEVERCAUSED AND UNDER WHATEVER THEORY OF LIABILITY, EVEN IF SUCH PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. The foregoing exclusion shall not apply to claims for consequential damages arising from (i) ADP's or Client's gross negligence or willful, criminal or fraudulent misconduct, (ii) Client or Client's Users sharing or allowing access to a User's password, User ID, or other form of user authentication, or (iii) ADP's or Client's breach or breaches of Section 4.1 or Section 9.3 under this Agreement; provided however, that any consequential damages recovered by Client or ADP in a calendar year for claims pursuant to Sections 7.5(ii) and 7.5(iii) will be subject to the Extraordinary Cap set forth in Section 7.2 above.

8 Warranties and Disclaimer

8.1 **Warranties.** Each party warrants that (i) it has full corporate power and authority to execute and deliver this Agreement and to consummate the transactions contemplated hereby and (ii) this Agreement has been duly and validly executed and delivered and constitutes the valid and binding agreement of the parties, enforceable in accordance with its terms.

8.2 **DISCLAIMER**. EXCEPT AS EXPRESSLY SET FORTH IN THIS AGREEMENT, ALL SERVICES, ADP APPLICATION PROGRAMS AND EQUIPMENT PROVIDED BY ADP OR ITS SUPPLIERS ARE PROVIDED "AS IS" AND ADP AND ITS LICENSORS AND SUPPLIERS EXPRESSLY DISCLAIM ANY WARRANTY, EITHER EXPRESS OR IMPLIED, INCLUDING WITHOUT LIMITATION, ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, NON-INFRINGEMENT, NON-INTERRUPTION OF USE, AND FREEDOM FROM PROGRAM ERRORS, VIRUSES OR ANY OTHER MALICIOUS CODE, WITH RESPECT TO THE SERVICES, THE ADP APPLICATION PROGRAMS, ANY CUSTOM PROGRAMS CREATED BY ADP OR ANY THIRD-PARTY SOFTWARE DELIVERED BY ADP AND RESULTS OBTAINED THROUGH THE USE THEREOF.

9 Security and Controls

9.1 **Service Organization Control Reports.** Following completion of implementation of any applicable Services, ADP will, at Client's request and at no charge, provide Client with copies of any routine Service Organization Control 1 reports ("**SOC 1 Reports**") (or any successor reports thereto) that are both directly related to those Services provided hereunder for Client and already released to ADP by the public accounting firm producing the report. SOC 1 Reports are ADP Confidential Information and Client will not distribute or allow any third party (other than its independent auditors) to use any such report without the prior written consent of ADP. Client will instruct its independent auditors or other approved third parties to keep such report confidential and Client will remain liable for any unauthorized disclosure of such report by its independent auditors or other approved third parties.

9.2 **Business Continuity; Disaster Recovery**. ADP maintains a commercially reasonable business continuity and disaster recovery plan and will follow such plan.

9.3 **Data Security.** ADP has an established information security program containing appropriate administrative, technical and physical measures to protect Client data (including Personal Data) against accidental unlawful or unauthorized destruction, alteration, unauthorized disclosure or access consistent with applicable laws. In the event ADP suspects any unauthorized access to, or use of, the Services and ADP Application Programs, ADP may suspend access to the Services to the extent ADP deems necessary to preserve the security of ADP, Client or User data.

9.4 **Unauthorized Third Party Access.** Client and its Users are responsible for maintaining the security and confidentiality of any password, User ID, or other form of user authentication involved in obtaining access to ADP Application Programs, and Client and its Users shall not disclose any confidential account access credentials or related information to Unauthorized Third Parties.

10 Data Security Breach

10.1 **Notification.** If ADP becomes aware of a Data Security Breach of Client's Personal Data, ADP will take appropriate actions to contain, investigate and mitigate the Data Security Breach. ADP shall notify Client without undue delay after becoming aware that a Data Security Breach has occurred, unless otherwise required or instructed by law enforcement or regulatory authority. ADP will share information in its possession with Client for Client to determine any regulatory reporting obligations required by applicable law.

10.2 **Other ADP Obligations**. In the event that a Data Security Breach is the result of the failure of ADP to comply with the terms of this Agreement, ADP shall, to the extent legally required or otherwise necessary to notify the individuals of potential harm, bear the actual, reasonable costs of notifying affected individuals. ADP and Client shall mutually agree on the content and timing of any such notifications, in good faith and as needed to meet applicable legal requirements. In addition, where notifications are required, and where such monitoring is practicable and customary, ADP shall also bear the cost of one year of credit monitoring to affected individuals in the applicable jurisdictions.

11 Payment Terms

11.1 **Fees and Fee Adjustments.** Client will pay to ADP the fees and other charges for the Services at the rates set forth on the Sales Order for the first (1st) year of the Initial Term. During the remainder of the Initial Term, ADP will increase fees on an annual basis by three percent (3%) upon thirty days' prior written notice. After the Initial Term, ADP may modify the fees on an annual basis upon at least) one hundred and twenty days (120) days prior written notice to Client; provided, however, that if Client does not accept the fee increase, it may, subject to the Notice requirement of Section 12.1, terminate this Agreement prior to the rate increase going into effect. The fees presented on any Sales Order are calculated based upon particular assumptions relative to Client requirements (including funding requirements), specifications, volumes and quantities as reflected in the applicable Sales Order and related documentation, and if Client's actual requirements vary from what is stated, ADP may adjust the fees based on such changes. The fees do not include any customizations to any Service.

11.2 **Additional Services and Charges.** Any Services provided to Client but not included in a Sales Order will be provided subject to the terms of this Agreement and charged at the applicable rates as they occur; and those services will be considered to be "Services" for purposes of this Agreement. Any Services requested by Client that are not reflected in a Sales Order can be terminated by Client for convenience within 90 days of the commencement of the Services without payment of the early termination fee. Additional charges may be assessed Client in relation to the performance of the Services in certain circumstances, including without limitation, late funding, an insufficient funds notification and emergency payment requests from Client.

11.3 **Fees for Implementation Services.** Implementation fees are due and payable by Client upon the Go-Live Date for such Services. However, if this Agreement or any Service are terminated after implementation services have started but before the Go-Live Date, the greater of the following amounts shall be immediately due and payable by Client: (i) implementation fees for implementation services performed up to the date of termination; or (ii) thirty percent (30%) of the total Implementation Fees set out in the Sales Order.

Invoicing. ADP will notify Client of all applicable Services fees payable by Client by way of invoice or other method (i.e. ADP's on- line reporting tool). Client will pay the undisputed amount on each invoice or such other similar document in full pursuant to the agreed upon method of payment set forth in the Sales Order. All undisputed amounts not paid when due are subject to a late payment charge of one and one-half percent (1.5%) per month (not to exceed the maximum allowed by applicable law) of the past due amount from the due date until the date paid. If applicable, ADP shall invoice Client for any History Conversion Services fees upon the completion of the Services, unless the History Conversion Services will be provided over a time period which exceeds thirty (30) days, in which case ADP reserves the right to invoice the Client on a monthly basis for such Services rendered. If Client disputes any invoiced amount in good faith, Client will notify ADP in writing of the reason for such dispute within ten (10) Business Days following the invoice date. ADP then shall respond by providing documentation in reasonable detail for the disputed charges, and the parties shall cooperate in good faith to resolve the dispute within ten (10) Business Days of ADP's receipt of Client's notice. During such resolution period, Client's non-payment of such disputed amount shall not constitute default by Client nor entitle ADP to suspend or delay its performance under this Agreement. Should, however, the parties be unable to resolve such dispute during the resolution period notwithstanding ADP's having provided Client documentation in reasonable detail justifying the charges, either party may avail itself of all remedies available under this Agreement or at law.

11.4 **Currency.** Client shall pay the fees in US dollars.

11.5 **Taxes.** Unless Client provides ADP a valid tax exemption or direct pay certificate, Client will pay directly, or will pay to ADP, an amount equal to all applicable taxes or similar fees levied or based on the Agreement or the Services, exclusive of taxes based on ADP's net income.

11.6 **Postage, Shipping Travel and out-of-pocket expenses**. ADP will invoice Client for commercially reasonable postage charges, delivery charges, other third party charges incurred, and reasonable pre-approved travel and out-of-pocket expenses as necessary to provide the Services.

11.7 **Funding Requirements and Disbursement Disclosures.** With respect to Payment Services to be deducted by ACH or Pre-Authorized Debit, Client must have sufficient good funds for payment of the payroll obligations, tax filing obligations, wage garnishment deduction obligations, service fees (as applicable), expenses, and any other applicable charges, to be direct debited from Client's designated account no later than one (1) Business Day prior to the pay date for the applicable payroll (in the case of payroll processing services), or as otherwise agreed by the parties. For reverse wire clients, funds must be available (a) by 6:00 a.m. Pacific time on the Business Day immediately before the associated payroll check date (in the case of the ADP Employment Tax Services) and (b) by 6:00 a.m. Pacific time two (2) Business Days prior to the associated payroll check date for all other Payment Services. In consideration for the additional costs incurred by ADP in providing wire transfer service, Client agrees to pay a reasonable fee for each wire transfer. Notwithstanding the foregoing, ADP reserves the right to modify the aforementioned deadlines at any time and will communicate any such modifications to Client with reasonable Notice, as soon as practical under the circumstances.

11.8 **Change Control.** In the event either party requests a change in the scope of Services (including implementation services) or any rework is required by ADP as a result of a delay by Client in implementation of any Services (each a "**Change Control Item**"), the parties shall address such change request, if possible via ADP's change control process. Change Control Items and the cost associated with such changes (if any) to the Services shall be mutually agreed to by the parties and shall be defined in a statement of work agreed to by the parties, with the exceptions of Change Control Items that are required to be made by law or regulation applicable to the Services or to the duration of implementation services, which ADP will notify Client of prior to making the change. The standard rate for a Change Control Item is $200.00 per hour.

12 Term; Termination; Suspension

12.1 **Term.** This Agreement is effective for the Initial Term and will automatically continue unless terminated by either party upon at least ninety (90) days written notice to the other party (except as otherwise set forth in this Section 12). In the event Client does not provide ADP with the proper notice as set forth in the previous sentence, Client shall pay ADP for any fees for Services that would have been incurred by Client during such notice period (calculated based on an average of the prior six months of invoices for such terminated Services, or shorter period of time if there has been less than six months of invoices).

12.2 **Termination for Cause.** Either party may terminate this Agreement for the other's material breach of this Agreement if such breach is not cured within thirty (30) days following notice thereof or in the event either party is the subject of a Termination Event. In addition, ADP may terminate this Agreement in the event Client fails to timely pay undisputed fees for Services performed within thirty (30) days following notice that such fees are past due. ADP may also terminate this Agreement or the Services immediately on written notice to Client if the provision of Service to Client causes or will cause ADP or its Affiliates to be in violation of any laws, rules or regulations applicableto it including any sanction laws applicable to ADP or any Affiliate.

12.3 **Suspension**. Without limiting the foregoing, the parties agree that Payment Services involve credit risk to ADP. Payment Services may be suspended by ADP (A) immediately following notice to Client (i) that Client has failed to remit sufficient, good and available funds within the deadline and via the method of delivery agreed upon as it relates to the applicable Payment Services, or (ii) if Client breaches any rules promulgated by the NACHA (or other similar local regulator) as it relates to ADP conducting ACH (or similar electronic payment) transactions on behalf of Client, and (B) with 24 hour notice if: (i) a bank notifies ADP that it is no longer willing to originate debits from Client's account(s) or credits for Client's behalf for any reason or (ii) the authorization to debit Client's account is terminated or ADP reasonably believes that there is or has been fraudulent activity on the account. If the Payment Services are terminated or suspended pursuant to Sections 12.2 or 12.3, Client acknowledges that ADP shall be entitled to allocate any funds in ADP's possession that have been previously remitted or otherwise made available by Client to ADP relative to the Payment Services in such priorities as ADP may determine appropriate, including reimbursing ADP for payments made by ADP on Client's behalf to a third party. If the Payment Services are terminated by ADP, Client understands that it will (x) immediately become solely responsible for all of Client's third party payment obligations covered by the Payment Services then or thereafter due (including, without limitation, for ADP Employment Tax Services, any and all penalties and interest accruing after the date of such termination, other than penalties and interest for which ADP is responsible under Section 7.3.3), and (y) reimburse ADP for all payments properly made by ADP on behalf of Client to any Payee**,** which has not been paid or reimbursed by Client. If the Payment Services remains suspended for 30 days, the affected Payment Service shall be deemed terminated on the 31st day following suspension.

12.4 **Early Termination Fee.** In order for ADP to recoup certain costs associated with the Services provided under the Agreement in the event of an early termination prior to the expiration of the Initial Term, if Client terminates the Agreement for convenience or ADP terminates Agreement pursuant to Section 12.2 or 12.3 above, Client will reimburse ADP for its costs which shall be five (5) times the average monthly fee for the Services. If monthly fees for Services have not been payable at the time of termination, the average monthly fees shall be equal to the estimated monthly fees that would have been payable under the Agreement.

12.5 **Additional Termination Provisions**.

12.5.1 **Additional Termination Provisions for ADP Employment Tax Services**. If the ADP Employment Tax Services in the United States are terminated, Client's access to ADP websites containing Client's data will expire 90 days from the effective date of the termination, and Client will be responsible for downloading all relevant data, including Statements of Deposit (SODs) prior to the expiration of such access.

12.5.2 **Additional Termination Provisions for Employment Verification Services**. ADP may, in its sole discretion, terminate the Employment Verification Services at any time upon 90 days prior written notice to Client should a Verification Agent notify ADP that it is no longer willing to provide the Employment Verification Services and ADP, after taking commerciallyreasonable steps, cannot engage a successor Verification Agent.

12.5.3 **Additional Termination Provisions for ADP Time & Attendance Services.** If ADP determines that Client has failed to comply with any potentially applicable laws and regulations applicable to the Biometric Services, ADP may, in its sole discretion and upon notice to Client, immediately suspend or terminate the Biometric Services.

12.5.4 **Additional Termination Provisions for ADP Health Compliance.** If ADP reasonably determines that it can no longer provide all or any portion of ADP Health Compliance due to changes in applicable law or application of existing law, ADP may, in its sole discretion and upon notice to Client, immediately terminate the applicable portion of ADP Health Compliance. Client may upon written notice to ADP terminate the ADP Health Compliance if Client reasonably determines that it can no longer, or no longer has a need under current law, to receive all or any portion of the type of service provided by ADP Health Compliance.

12.5.5 **Additional Suspension for ADP Compliance on Demand.** ADP may, in its sole discretion, immediately suspend access to the "Community" feature of the ADP Compliance on Demand without prior notice to Client in the event Client posts or otherwise distributes any content online that is (i) inappropriate or otherwise objectionable, (ii) potentially violates the privacy or publicity right of a third party, or
(iii) advertises any other site or business. In the event Client continues to post or distribute such content after access to ADP Compliance on Demand is restored, ADP shall have the right to terminate ADP Compliance on Demand.

13 Transition Services

13.1 **Scope**. Upon expiration or termination of the Services, subject to Sections 13.2 and 13.3, ADP shall provide Client and its designee(s) with reasonable transition services (**"Transition Services"**) consisting of continuation of the terminated Services and, if requested by Client and mutually agreed by the parties in an Amendment, any additional services (including technical assistance) that will be delivered at ADP's then prevailing rates in effect at the time of expiration or termination of the Agreement. In connection with the Transition Services, ADP will not be required to provide any third party with access to ADP's systems, intellectual property or any Confidential Information of ADP.

13.2 **Performance of Obligations**. During the provision of Transition Services, ADP and Client shall continue to perform their respective obligations under this Agreement, including, with respect to ADP, the provision of ongoing Services to Client and with respect to Client, the payment of all fees for such Services specified in the Sales Order.

13.3 **Past Due Amounts**. If ADP has terminated this Agreement due to Client's failure to pay fees, ADP's obligations in Section 13.1 will be subject to Client's payment of all past due amounts and ADP may require Client to prepay for any services.

14 Additional Terms

14.1 **ADP Employment Tax Services.** The following additional terms and conditions apply to the ADP Employment Tax Services:

14.1.1 **Important Tax Information (IRS Disclosure) for U.S. Only.** Notwithstanding Client's engagement of ADP to provide the ADP Employment Tax Services in the United States, please be aware that Client remains responsible for the timely filing of payroll tax returns and the timely payment of payroll taxes for its employees. The Internal Revenue Service recommends that employers enroll in the U.S. Treasury Department's Electronic Federal Tax Payment System (EFTPS) to monitor their accounts and ensure that timely tax payments are being made for them, and that online enrollment in EFTPS is available at www.eftps.gov; an enrollment form may also be obtained by calling (800) 555-4477; that state tax authorities generally offer similar means to verify tax payments; and that Client may contact appropriate state offices directly for details.

14.2 **Benefit Services.** The following additional terms and conditions apply to the Benefit Services:

14.2.1 **Benefits Liaison.** Client shall designate in writing to ADP one or more contacts for the Benefit Services to serve as the Client Benefits Liaison, and such Client Benefits Liaison shall have the authority to (i) provide information,instructions and direction on behalf of the Client, each Plan Administrator and, if applicable, each "fiduciary" (as definedin Section 3(21) of ERISA) of each separate Plan, and (ii) grant or provide approvals (other than Amendments)required or permitted under the Agreement in connection with the Benefit Services.

14.2.2 **Compliance of Benefit Plans.** Client shall furnish to ADP all necessary information and data for each Plan. Client shall be responsible for the final preparation, approval and submission of Plans and related amendments to applicable governmental authorities. Client is responsible for, and shall take measures required under state and federal law to assure the qualification and compliance of the Plans with such laws.

14.2.3 **Disclaimer.** NOTWITHSTANDING ANYTHING TO THE CONTRARY CONTAINED HEREIN OR IN THE SCOPE OF SERVICES, CLIENT EXPRESSLY ACKNOWLEDGES THAT ADP IS NOT THE "ADMINISTRATOR" OR "PLAN ADMINISTRATOR" AS DEFINED IN SECTION 3(16)(A) OF ERISA AND SECTION 414(g) OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED, RESPECTIVELY, NOR IS ADP A "FIDUCIARY" WITHIN THE MEANING OF ERISA SECTION 3(21), NOR IS ADP A "HEALTH CARE CLEARINGHOUSE" WITHIN THE MEANING OFSECTION 1171 OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED("HIPAA") AND CLIENT SHALL NOT REQUEST OR OTHERWISE REQUIRE ADP TO ACT AS SUCH. FURTHER, ADP DOES NOT PROVIDE CLAIMS PROCESSING OR ANY OTHER COVERED FUNCTION WHICH WOULDCAUSE ADP TO BE CONSIDERED A BUSINESS ASSOCIATE AS DEFINED AT 45 CFR §160.103. ALL ENROLLMENT INFORMATION AND RELATED DATA COLLECTED BY ADP IS ON BEHALF OF CLIENT AND NOT ANY EMPLOYER-SPONSORED BENEFIT PLAN. ALL OTHER INFORMATION COLLECTED BY ADP FOR PROVIDING BENEFITS SERVICES IS CONSIDERED EMPLOYMENT RECORDS AND EXPLICITLY EXCLUDED FROM THE DEFINITION OF PROTECTED HEALTH INFORMATION AS STATED AT 45 CFR §164.501, AND IS NOTPROTECTED BY HIPAA'S PRIVACY RULE. SEE ALSO 65 FED. REG. 82461, 53181. ADP SHALL NOT EXERCISE ANY DISCRETIONARY AUTHORITY OR DISCRETIONARY CONTROL REGARDING MANAGEMENT OF ANY PLANOR MANAGEMENT OR DISPOSITION OF ANY PLAN ASSETS. ADP SHALL NOT RENDER INVESTMENT ADVICE FOR A FEE OR OTHER COMPENSATION, DIRECT OR INDIRECT, WITH RESPECT TO ANY MONIES OR OTHER PROPERTY OF ANY PLAN, NOR DOES ADP HAVE ANY AUTHORITY OR RESPONSIBILITY TO DO SO. ADP HASNO DISCRETIONARY AUTHORITY OR DISCRETIONARY RESPONSIBILITY IN THE ADMINISTRATION OF THE PLAN(S).

14.2.4 **Carrier Connections.** ADP will, at Client's request, and for an additional charge as set forth on the Sales Order, provide Client with the following Carrier Connections services:

14.2.4.1 ADP will electronically transmit employee data, including employee benefits enrollment data, to Client's carriers or other third parties authorized by Client, and Client authorizes ADP to provide such transmission on Client's behalf. Commencement of carrier connection service is subject to Client completing the configuration setup of Client Content and the format for such transmission to the designated carriers.

14.2.4.2 ADP's ability to transmit Client Content data is subject to the provision by Client's designated carriers of a current functional interface between ADP's systems and the designated carriers' systems. ADP will not be obligated to transmit Client's data to designated carriers if at any time Client's designated carriers fail to provide the proper interface as described above. Client is responsible for promptly reviewing all records of carrier transmissions and other reports prepared by ADP for validity and accuracy according to Client's records, and Client will notify ADP of any discrepancies promptly after receipt thereof. In the event of an error or omission in carrier connection services caused by ADP, ADP will correct such error oromission, provided that Client promptly advises ADP of such error or omission.

14.2.5 **Additional Third-Party Terms.** During the Term of this Agreement, the Client's use of, and access to, the Benefit Services may be subject to additional terms of service which shall be included within the Benefit Services. Prior to enabling such Services, Client shall ensure that its Users of Benefit Services click through and accept such additional terms of service.

14.2.6 **Technology Credit Program.** ADP has a Technology Credit Program to accept technology credits from Strategic Carrier Partners and apply those funds to Client invoices for ADP benefits administration services, subject to the following additional terms:

14.2.6.1 As between Client and ADP, Client is solely responsible for (i) Client's acceptance of the Technology Credit; and directing ADP to apply such Technology Credit to offset Client's benefits administration Services fees; (ii) the determination whether the Technology Credit is a Plan Asset and the consequences resulting from such determination; and (iii) any compliance obligations that may arise under ERISA or other applicable laws as a result of Client's acceptance of the Technology Credit.

14.2.6.2 If Client elects to accept a Technology Credit, Client will instruct ADP how to apply such Technology Credit. ADP will verify all information provided by Client regarding the Technology Credit with the applicable Strategic Carrier Partner. Per Client direction, ADP will apply the Technology Credit to Client's invoice for benefits administration services fees no earlier than sixty (60) days following ADP's receipt of the Technology Credit from the Strategic Carrier.

14.2.6.3 Client shall remain responsible for payment of the fees for the Services in accordance with the Agreement if the Strategic Carrier fails to remit sufficient, good and available funds to ADP.

14.2.6.4 To the extent Client adds a Strategic Carrier's benefits plan to Client's ADP Workforce Now benefits module, Client consents to ADP working with such carrier with respect to the Services, including sharing with such carrier that Client offers a benefits plan provided by such carrier.

14.3 **WFN EI-9 Services.** The following additional terms and conditions apply to the WFN EI-9 Services.

14.3.1 **Use of Services.** Client shall, and cause the members of the Client Group, receiving the WFN EI-9 Services to do the following:

14.3.1.1 Review the USCIS Form I-9, which is the employment eligibility verification form issued by the DHS, including instructions in the form and the guidelines in the current I-9 Handbook, each of which is available on the USCIS website, currently located at http://www.uscis.gov/i-9central. Client certifies that it has reviewed the current USCIS Form I-9 and the I-9 Handbook and that it agrees to comply with the applicable policy and procedures set forth therein, and any future new or amended policies or procedures, as required by law. Client will ensure availability of the most recent version of the USCIS Form I-9 and the I-9 Handbook to all employees authorized to complete the USCIS Form I-9 on behalf of Client and/or its Affiliates.

14.3.1.2 Client is responsible for reviewing reports available to Client on the WFN EI-9 Services and for resolving (or causing the applicable employee to take action to resolve) missing or incomplete Forms I-9. This includes communicating with the employee in question and the submission or resubmission of themissing or incomplete Form I-9.

14.3.1.3 ADP executed a Memorandum of Understanding with the DHS as the E-Verify employer agent. E-Verify is the DHS's employment eligibility verification program which allows participating employers to electronically verify the employment eligibility of each newly hired employee and/or employee assigned to a covered federal contract. The following is required as it relates to the use of E-Verify through ADP and will apply only to the extent Client is using E-Verify through ADP

14.3.1.3.1 Notify ADP of (i) the location(s) where Client elects to enroll; and (ii) whether the employer is a federal contractor or a federal, state or local government organization.

14.3.1.3.2 Execute a Memorandum of Understanding with the DHS and ADP (as its E-Verifyemployer agent), and comply with the terms and conditions set forth therein.

14.3.1.3.3 Review and comply with the policy and procedures contained in the E-Verify User Manual for Employers, and any superseding policy and procedures, available to Client on the WFN EI-9 Service.

14.3.1.3.4 To the extent the Client elects to have more than one company location participate in E-Verify, ensure all authorized users in each location have complied with all requirements of this Section.

14.3.1.3.5 Ensure all of Client's authorized users (i) complete the mandated E-Verify training course and any applicable update courses administered by ADP and (ii) pass a knowledge test with the required score.

14.3.1.3.6 Immediately notify ADP of any updates/changes to its E-Verify employer status (e.g., Client becomes a federal contractor or Client ceases being a federal contractor).

14.3.2 **Form I-9 Retention**. During the term of the Agreement, ADP will store electronic copies of Forms I-9 in the WFN EI-9 Services for a minimum of three years from the employee's hire date or until one year after the employee ceases to be employed by Client (or the applicable Affiliate), whichever is later (or as otherwise required by changes to federal regulations that come into effect hereafter). Upon termination or expiration of the Agreement, ADP shall use commercially reasonable methods to transfer all electronically stored Forms I-9 to Client in accordance with ADP's current security policies. Upon termination of the WFN EI-9 Services, Client shall be solely responsible for storage of copies of Forms I-9.

14.4 **ADP Wage Payment Services.** The following additional terms and conditions apply to ADP Wage Payment Services:

14.4.1 **ADPCheck; Direct Deposit**. Client agrees not to distribute any ADPChecks to Payees in a manner that would allow Payees to access the associated funds before pay date. Prior to the first credit to the account of any employee or other individual under ADP Direct Deposit Services, Client shall obtain and retain a signed authorization from such employee or individual authorizing the initiation of credits to such party's account and debits of such account to recover funds credited to such account in error.

14.5 **ADP Time & Attendance Services.** The following additional terms and conditions apply to the ADP Time & Attendance Services:

14.5.1 Time & Attendance Hardware.

14.5.1.1 If Client procures Time & Attendance Hardware, Client shall provide and maintain an installation environment (including all power, wiring and cabling required for installation) as specified in the manufacturer's product documentation and other written instructions provided to Client by ADP.

14.5.2 Biometric Services. Biometric Services are optional. In certain jurisdictions, there are laws and regulations that govern the collection, use, and retention of biometric information, which potentially may apply to Client's use of Biometric Services. To the extent Client elects to use Biometric Services, Client agrees to comply with all such potentially applicable laws and regulations in accordance with this section. In the event Client is unwilling to comply with laws and regulations potentially applicable to Biometric Services, Client will be able to continue to use ADP Time &Attendance Services without Biometric Services. The following terms and conditions apply to Biometric Services to the extent Biometric Services are part of the scope of Services:

14.5.2.1 **Requirements for Receipt of Biometric Services.** Before any Client or Biometric User is permitted to use any Biometric Services in a jurisdiction where laws and regulations potentially govern such use, Client will comply with the following requirements, in addition to any other requirements imposed by potentially applicable law (to the extent there is a conflict between the requirements below and the requirements of potentially applicable law, Client will comply with potentially applicable law):

14.5.2.1.1 **Client Biometric Information Policy**. Client will implement, distribute and make available to the public, a written policy establishing Client's policy with respect to the use of Biometric Data. Such policy will include:

14.5.2.1.1.1 a retention schedule and guidelines for permanently destroying Biometric Data;

14.5.2.1.1.2 a commitment to destroy Biometric Data when the initial purpose for collecting or obtaining such Biometric Data has been satisfied or within 3 years of the individual's last interaction with Client, whichever occurs first; and

14.5.2.1.1.3 any additional requirements as required by potentially applicable law.

14.5.2.1.2 **Biometric User Notice and Consent**. Client will provide notice to and procure and retain appropriate consents or releases from Biometric Users in the manner and to extentthe same are required by potentially applicable law, including:

14.5.2.1.2.1 notifying Biometric Users in writing that Client, its vendors, and/or the licensor of Client's time and attendance software are collecting, capturing, or otherwise obtaining Biometric Users' Biometric Data, and that Client is providing such Biometric Data to its vendors and the licensor of Client's time and attendance software; such notice will specify the purpose and length of time for which Biometric User's Biometric Data is being collected, stored, and used;

14.5.2.1.2.2 obtaining a written release or consent from Biometric Users (or their legally authorized representative) authorizing Client, its vendors, and licensor of Client's time and attendance software to collect, store, and use the individual's Biometric Data for the specific purpose disclosed by Client, and authorizing Client to provide such Biometric Data to its vendors and the licensor of Client's time and attendance software; and

14.5.2.1.2.3 if requested by ADP, providing to ADP copies of the required consents or releases collected and retained by Client, and/or certifying to ADP that such consents or releases have been obtained.

14.5.2.1.3 **Retention and Purging of Biometric Data.** Client will work with ADP to ensure that Biometric Data is retained and purged in accordance with potentially applicable law. To the extent necessary for the purging or deletion of such Biometric Data, Client agrees to provide timely notification to ADP of the termination of the employment, or the satisfaction of the purpose for which Biometric Data was collected with respect to any given Biometric User. ADP is not responsible for Client's failure to provide timely notification of the termination of the employment, or the satisfaction of the purpose for which Biometric Data was collected with respect to any given Biometric User.

14.5.2.1.4 **Storage of Biometric Data in Timeclocks.** Client agrees that it shall use a reasonable standard of care consistent with potentially applicable law to store, transmit and protect from disclosure any Biometric Data. Such storage, transmission, and protection from disclosure shall be performed in a manner that is the same as or more protective than the manner in which Client stores, transmits and protects from disclosure other confidential and sensitive information, including personal information that can be used to uniquely identify an individual or an individual's account or property, such as genetic markers, genetic testing information, account numbers, PINs, driver's license numbers and social security numbers.

14.5.2.2 **Biometrics Indemnity.** Subject to Sections 6.3 and 7, Client will defend ADP against any third party claims (including claims made by or on behalf of Biometric Users) and will indemnify and hold ADP harmless from resulting damage awards or settlement amounts in any cause of action to the extent such cause of action is based on any performance or breach of Client's obligations in connection with the Biometric Services, including any failure by Client to obtain consent from Biometric Users in connection with the use of the Biometric Services.

14.5.2.3 **Third Party Beneficiary.** Notwithstanding anything to the contrary in the Agreement, Client agrees that ADP and licensor of any applicable Biometric Services (and their respective successors and assigns) are third party beneficiaries of this Agreement solely as it relates to Biometric Services.

14.6 **State Unemployment Insurance (SUI) Management Services**. The following additional terms and conditions apply to the SUI Management Services:

14.6.1 **Provision and Transfer of Information**. Client will provide ADP with accurate, complete and timely information necessary for ADP to perform the SUI Management Services, including without limitations, the claimants' names, relevant dates, wage and separation information, state-specific required information, and other documentation to support responses to unemployment compensation agencies. Client will transfer this information via (i) on-line connection between ADP and Client's computer system or (ii) inbound data transmissions from Client to ADP, using mutually acceptable communications protocols and delivery methods. Client will promptly notify ADP in writing if Client wishes to modify the communication protocol or delivery method.

14.6.2 **Definition of Claim; Claim Cap**. For purposes of the SUI Management Services provided under this Agreement and billed to Client, a "claim" shall be defined as a claim notice generated by a state agency as a result of an individual filing for unemployment insurance benefits. In addition, Client acknowledges and agrees that (i) claim notices are typically generated for each state unemployment tax ID number under which an employee had worked and earned wages; (ii) state unemployment agencies generally issue multiple claim notices per individual as identified by a Social Security Number during the benefit eligibility period upon receiving a request for unemployment benefits; and (iii) all such claim notices require review ADP (e.g., including but not limited to, last employer claims, base period employer claims, periodic qualification claims, additional benefit claims, renewed claims and extended benefit claims). Client further acknowledges and agrees that an applicable claim cap applies to the fees for SUI Management Services and that the claim cap shall be stated on the Sales Order, and will be based on all claim notices processed by ADP as a result of an individual filing for unemployment benefits. The number of claims counted for billing purposes will be reported to Client by ADP as "Claims Processed" via on-line reports.

14.7 **ADP Wage Garnishment Payment Services.** The following additional terms and conditions apply to the ADP Wage Garnishment Payment Services:

14.7.1 **Description of Services.** ADP will act solely in the capacity of a third party service provider of payment processing.

14.7.2 **Client's Use of Services.** Client agrees not to distribute any ADPChecks to Payees in a manner that would allow Payees to access the associated funds before pay date.

14.8 **Employment Verification Services; Employee Authorized Disclosure.** The following additional terms and conditions apply to the Employment Verification Services and Employee Authorized Disclosure:

14.8.1 **Employment Verification Services.** Client authorizes ADP and Verification Agents through which Employment Verification Services are performed to disclose, on Client's behalf, Verification Data to Verifiers who wish to obtain or verify any of Client's employees' (or former employees') Verification Data. Verification Data will be disclosed to Verifiers who certify they are entitled to receive such data (as described below) pursuant to FCRA, and, in the case of income information requests, who additionally certify they have a record of the employee's consent to such disclosure or who utilize a salary key. In accordance with FCRA, Verification Data may be provided to Verifiers where (i) the employee has applied for a benefit (such as credit, other employment or social services assistance); (ii) the employee has obtained a benefit and the Verifier is seeking to (a) determine whether the employee is qualified to continue to receive the benefit; and/or (b) collect a debt or enforce other obligations undertaken by the employee in connection with the benefit; or (iii) the Verifier is otherwise entitled under FCRA to obtain the Verification Data. In certifying they have a record of the employee's consent, Verifiers generally rely on the employee's signature on the original application as authorization for the Verifier to access the employee's income data at the time of the application and throughout the life of the obligation. Client understands that Verifiers are charged for commercial verifications processed through ADP or its Verification Agents.

14.8.1.1 **Data Quality.** If requested by ADP, Client agrees to work with ADP during implementation to produce a test file and validate the Verification Data using validation reports made available by ADP or its Verification Agents. If Client uses ADP's hosted payroll processing services, ADP will utilize the latest Verification Data available on ADP's payroll processing system.

14.8.1.2 **Notice to Furnishers of Information: Obligations of Furnishers of Information**". Client certifies that it has read the Notice to Furnishers provided to Client at the following URL: https://www.consumer.ftc.gov/articles/ pdf-0092-notice-to-furnishers.pdf. Client understands its obligations as a data furnisher set forth in such notice and under FCRA which include duties regarding data accuracy and investigation of disputes, and certifies it will comply with all such obligations. Client further understands that if it does not comply with such obligations, ADP may correct incorrect Verification Data on behalf of Client or terminate the Employment Verification Services upon 90 days prior written notice to Client.

14.8.1.3 **Archival Copies**. Notwithstanding anything to the contrary in the Global Master Terms and Conditions, Client agrees that, after the termination of this Agreement, ADP and its Verification Agents may maintain archival copies of the Verification Data as needed to show the discharge and fulfillment of obligations to Client's employees and former employees and the provisions of Section 4 of the Global Master Terms and Conditions will continue to apply during the time that ADP and its Verification Agents maintain any such archival copies.

14.8.2 **Employee Authorized Disclosure.** ADP may disclose or use Personal Data of Client's employees to the extent the employee requested or consented to the disclosure or use such as but not limited to when an employee needs their identity verified when they submit an application for a bank account, cellular service, credit or a benefit.

14.9 **ADP Health Compliance.** ADP will provide the Health Compliance Services specified in the Sales Order (and any applicable service specification) to Client in accordance with the terms of this Agreement.

14.9.1 **ADP Health Compliance.** A technology, software, and service solution to assist in managing the compliance needs related to the employer shared responsibility provisions of the Affordable Care Act (ACA), including eligibility calculations, affordability determinations, and regulatory management (provision of notices of coverage; management of exchange notices; preparation, delivery, and filing of annual IRS Forms 1094-C and 1095-C; and penalty management).

14.9.2 **Client ACA Liaison.** Client shall designate in writing to ADP the name of one person who shall serve as the Client ACA Liaison for the Health Compliance Solution, and such Client ACA Liaison shall have the authority to (i) provide information, instructions and direction on behalf of Client, and (ii) grant or provide approvals (other than Amendments) required or permitted under the Agreement in connection with the Health Compliance Solution. Client shall designate an alternate Client ACA Liaison in the event the principal Client ACA Liaison is not available.

14.9.3 **Disclaimer.** NOTWITHSTANDING ANYTHING TO THE CONTRARY CONTAINED HEREIN OR IN THE SCOPE OF SERVICES, CLIENT EXPRESSLY ACKNOWLEDGES THAT ADP IS NOT THE "ADMINISTRATOR" OR "PLAN ADMINISTRATOR" AS DEFINED IN SECTION 3(16)(A) OF ERISA AND SECTION 414(g) OF THE CODE,RESPECTIVELY, NOR IS ADP A "FIDUCIARY" WITHIN THE MEANING OF ERISA SECTION 3(21). ADP SHALL NOT EXERCISE ANY DISCRETIONARY AUTHORITY OR DISCRETIONARY CONTROL RESPECTING MANAGEMENT OF ANY BENEFIT PLANS SPONSORED OR OFFERED BY CLIENT. ADP HAS NO DISCRETIONARY AUTHORITY OR DISCRETIONARY RESPONSIBILITY IN THE ADMINISTRATION OF THE CLIENT'S BENEFIT PLAN(S). ADPEXPRESSLY DISCLAIMS ANY WARRANTY, EITHER EXPRESS OR IMPLIED, INCLUDING ANY IMPLIED WARRANTIESOF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, NON-INFRINGEMENT, NON-INTERRUPTION OF USE, AND FREEDOM FROM PROGRAM ERRORS WITH RESPECT TO THE ADP HEALTH COMPLIANCE SOLUTION, THE APPLICATION PROGRAMS OR ANY THIRD-PARTY SOFTWARE DELIVERED BY ADP.

14.9.4 **Client Vendors.** Client will at its own cost make all necessary arrangements with its third party vendors to cause such vendors to send data to and receive data from ADP as required for ADP to provide ADP Health Compliance. Client shall reimburse ADP for any costs ADP is required to bear in connection with or arising out of any such transmissions of data from and/or to such third party vendors.

14.9.5 **Important Tax Information (IRS Disclosure)**: Notwithstanding Client's engagement of ADP to provide ADP Health Compliance, please be aware that Client remains responsible for the timely filing of all required reports and filings, and the timely payment of Client penalty obligations. The Internal Revenue Service recommends that employers enroll in the U.S. Treasury Department's Electronic Federal Tax Payment System (EFTPS) to monitor their accounts and ensure that timely tax payments are being made for them, and that online enrollment in EFTPS is available at www.eftps.gov; an enrollment form may also be obtained by calling (800) 555-4477.

14.10 **ADP Marketplace and Use of ADP APIs.**

14.10.1 **Disclaimer.** ADP may provide Client with access to the ADP Marketplace. Client acknowledges that any third party application or service purchased by Client through the ADP Marketplace is provided by a third party and not ADP and ADP makes no endorsements, representations or warranties (including any representations or warranties regarding compliance with laws) regarding such application or service. Client will enter into a relationship directly with the third party provider of such application or service. Any application or service purchased through the ADP Marketplace will be governed exclusivelyby the terms and conditions agreed to by Client and the third party provider and not by this Agreement. ADP will not provide any advice, service or support with respect to any third party application or service purchased on the ADP Marketplace.

14.10.2 **Transmitting Information to Third Parties.** In the event that Client elects to use an API to provide any Client Content or employee or plan participant information to any third party, Client represents that it has acquired any consents or provided any notices required to transfer such content or information and that such transfer does not violate any applicableinternational, federal, state, or local laws and/or regulations. ADP shall not be responsible for any services or data provided by any such third party.

14.10.3 **Use of the ADP APIs.** Client will use the ADP APIs to access Client's information only. Client may not use any robot, spider, or other automated process to scrape, crawl, or index the ADP Marketplace and will integrate Client's application with the ADP Marketplace only through documented APIs expressly made available by ADP. Client also agrees that Client will not (a) use the ADP Marketplace or any ADP API to transmit spam or other unsolicited email; (b) take any action that may impose an unreasonable or disproportionately large load on the ADP infrastructure, as determined by ADP; or (c) use the ADP APIs or the ADP Marketplace in any way that threatens the integrity, performance or reliability of the ADP Marketplace, Services or ADP infrastructure. ADP may limit the number of requests that Client can make to the ADP API gateway to protect ADP's system or to enforce reasonable limits on Client's use of the ADP APIs. Specific throttling limits may be imposed and modified from time to time by ADP.

14.11 **ESS & MSS Technology.** The following additional terms and conditions apply to the ESS & MSS Technology.

14.11.1 Client acknowledges that Client's employees or participants may input information into the self-service portions of the ADP Application Programs. ADP shall have no responsibility to verify, nor does ADP review the accuracy or completeness of the information provided by Client's employees or participants to ADP using any self-service features. ADP shall be entitled to rely upon such information in the performance of the Services under this Agreement as if such information was provided to ADP by Client directly.

14.12 ADP Compliance on Demand. The following additional terms and conditions apply to ADP Compliance on Demand:

14.12.1 Compliance Assistance. Client may have access to certain human resources or compliance professionals who may, in ADP's sole discretion, provide reasonable guidance or best practice recommendations to Client which Client may choose to follow. Client assumes all responsibility and risk arising from its use and reliance upon such recommendations. ADP may require Client to include its legal counsel in communications with such professionals. The ADP Compliance on Demand Services are not a substitute for advice of an attorney. Client agrees that ADP is not a law firm, does not provide legal advice or representation, and that no attorney-client relationship between ADP and Client exists or will be formed as part of the Services. ADP may discontinue access to human resources and compliance professionals in its discretion.

14.13 History Conversion Services. The following additional terms and conditions apply to the History Conversion Services:

14.13.1 Description of Services. The History Conversion Services are described in the History Conversion Services Appendix. History Conversion Services includes virtual training only (all training is done remotely via the internet and/or telephone). History Conversion Services do not include the conversion or import of any documents.

14.13.2 Client Obligations. As a prerequisite to receiving the History Conversion Services, Client agrees that (a) it has sufficient resources to allocate to the project; (b) it will provide access to prior vendor data in order to perform an extraction of data (access may include either extraction of data related to the history conversion or registers); (c) it will perform an audit of converted data and review internally; (d) it will consent to the direct import of the converted check history data files into ADP Workforce Now; (e) it will ensure that all employees with data to be converted be loaded into ADP Workforce Now (to include prior year terminated employees) in advance of the import of check history data; (f) it will provide ADP a single pointof contact for data extraction from a prior single vendor database (if multiple points of contact are required whichnecessitates additional data extraction work efforts and/or separate security access rights for the external viewer, such additional work efforts will be subject to additional fees). All other historical data items will be loaded to an external history viewer as described in the History Conversion Services Appendix**.** In addition, Client agrees that it will complete and validate the data mapping and will be responsible for final review of data during the mapping process. If ADP discovers errors in the data mapping following Client's final validation and submission, corrections to the check history data may be required. In connection therewith, additional fees may be charged by ADP in order to correct such errors.

14.13.3 Billing. Client will pay ADP for the History Conversion Services at the rates set forth in the Sales Order. Additional fees may apply for History Conversion Services that extend more than 30 days due to Client's delay.

15 Miscellaneous

15.1 Amendment. This Agreement may not be modified, supplemented or amended, except by a writing signed by the authorized representatives of ADP and Client. If at any time a modification becomes required by a Regulator or change in applicable law or regulation, the parties will negotiate the terms of such modification in good faith. If the parties are not able to agree upon the terms of such modification within thirty (30) days, either party may terminate the Agreement upon written notice to the other party without payment of the early termination fee.

15.2 Assignment. Neither this Agreement, nor any of the rights or obligations under this Agreement, may be assigned by any party without the prior written consent of the other party, such consent not to be unreasonably withheld. However, Client may assign any or all of its rights and obligations to any other Client Group member and ADP may assign any or all of its rights and obligations to any Affiliate of ADP, provided that any such assignment shall not release the assigning party from its obligations under this Agreement. This Agreement is binding upon and inures to the benefit of the parties hereto and their respective successors and permitted assigns.

15.3 Additional Documentation. In order for ADP to perform the Services, it may be necessary for Client to execute and deliver additional documents (including reporting agent authorization, client account agreement, limited powers of attorney, etc.) and Client agrees to execute and deliver such additional documents.

15.4 Subcontracting. Notwithstanding Section 15.2, ADP reserves the right to subcontract any or all of the Services, provided that ADP remains fully responsible under this Agreement for the performance of any such subcontractor. For the avoidance of doubt, third parties used by ADP to provide delivery or courier services, including the postal service in any country or any third party courier service, and banking institutions, are not considered subcontractors of ADP. ADP has provided to Client prior to the Effective Date a list of subcontractors that may provide Services under the Agreement, and Client's execution of this Agreement constitutes its assent to the use of those subcontractors.

15.5 Entire Agreement. This Agreement constitutes the entire agreement and understanding between ADP and Client with respect to its subject matter and merges and supersedes all prior discussions, agreements and understandings of every kind and nature between the parties. No party will be bound by any representation, warranty, covenant, term or condition other than as expressly stated in this Agreement. Except where the parties expressly state otherwise in a relevant exhibit, annex, appendix or schedule, in case of conflict or inconsistency between these Global Master Terms and Conditions and any such exhibit, annex, appendix or schedule, theGlobal Master Terms and Conditions will prevail and control. Purchase orders or statements of work submitted to ADP by Client will be for Client's internal administrative purposes only and the terms and conditions contained in any purchase order or statements of work will have no force and effect and will not amend or modify this Agreement.

15.6 No Third Party Beneficiaries. Except as expressly provided herein or in an applicable exhibit, annex, appendix or schedule, nothing in this Agreement creates, or will be deemed to create, third party beneficiaries of or under this Agreement. Client agrees that ADP's obligations in this Agreement are to Client only, and ADP has no obligation to any third party (including, without limitation,Client's personnel, directors, officers, employees, Users and any administrative authorities).

15.7 **Force Majeure**. Any party to this Agreement will be excused from performance of its obligations under this Agreement, except for Client's obligation to pay the fees to ADP pursuant to Section 11, for any period of time that the party is prevented from performing its obligations under this Agreement due to an act of God, war, earthquake, civil disobedience, court order, labor disputes or disturbances, governmental regulations, communication or utility failures or other cause beyond the party's reasonable control; provided, however, if such an event continues for a period of thirty (30) days, the other party may terminate this Agreement upon written notice to the party that cannot perform its obligations. Such non-performance will not constitute grounds for breach.

15.8 **Waiver**. The failure by any party to this Agreement to insist upon strict performance of any provision of this Agreement will not constitute a waiver of that provision. The waiver of any provision of this Agreement shall only be effective if made in writing signed by the authorized representatives of ADP and Client and shall not operate or be construed to waive any future omission or breach of,or compliance with, any other provision of this Agreement.

15.9 **Headings**. The headings used in this Agreement are for reference only and do not define, limit, or otherwise affect the meaning of any provisions hereof.

15.10 **Severability.** If any provision of this Agreement is finally determined to be invalid, illegal or unenforceable by a court of competent jurisdiction, the validity, legality or enforceability of the remainder of this Agreement will not in any way be affected or impaired and such court shall have the authority to modify such invalid, illegal or unenforceable provision to the extent necessary to render such provision valid, legal or enforceable, preserving the intent of the parties to the furthest extent permissible.

15.11 **Relationship of the Parties**. The performance by ADP of its duties and obligations under this Agreement will be that of an independent contractor and nothing contained in this Agreement will create, construe or imply an agency, joint venture, partnership or fiduciary relationship of any kind between ADP and Client. None of ADP's employees, agents or subcontractors will be considered employees, agents or subcontractors of Client. Unless expressly stated in this Agreement, none of ADP, its employees, agents or its subcontractors may enter into contracts on behalf of, bind, or otherwise obligate Client in any manner whatsoever.

15.12 **Governing Law.** This Agreement is governed by the laws of the State of California without giving effect to its conflict of law provisions.

15.13 Reserved

15.14 **Jurisdiction.** Any disputes that may arise between ADP and Client regarding the performance or interpretation of this Agreement shall be subject to the exclusive jurisdiction of the state and federal courts of Orange County, California. The parties hereby irrevocably consent to the exclusive jurisdiction of the state and federal courts of Orange County, California, and waive any claim that any proceedingsbrought in such courts have been brought in an inconvenient forum. THE PARTIES HEREBY IRREVOCABLY WAIVE THEIR RIGHT TO TRIAL BY JURY.

15.15 **Counterparts.** This Agreement may be signed in two or more counterparts by original, .pdf (or similar format for scanned copies of documents) or facsimile signature, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

15.16 **Notices.** All notices required to be sent or given under this Agreement will be sent in writing and will be deemed duly given and effective (i) immediately if delivered in person, or (ii) upon confirmation of signature recording delivery, if sent via an internationally recognized overnight courier service with signature notification requested to Client at the address indicated on the signature page hereof or to ADP at 5800 Windward Parkway, Alpharetta, Georgia 30005, Attn: Legal Department or to any other address a party may identify in writing from time to time. A copy (which shall not constitute notice) of all such notices shall be sent to ADP at One ADP Boulevard, MS 425, Roseland, New Jersey 07068, Attention: General Counsel and to Client at the address indicated on the signature page hereof.

15.17 **Survival.** Those provisions which by their content are intended to, or by their nature would, survive the performance, termination, or expiration of this Agreement, shall survive termination or expiration of this Agreement.

15.18. ADP Insurance

15.18.1. During the term of this Agreement, ADP shall (directly or through Automatic Data Processing, Inc. its ultimate corporate parent entity) maintain the following insurance coverage in at least the following amounts:

15.18.1.1. Workers' Compensation with statutory limits required by each state exercising jurisdiction over the ADP associates engaged in performing services under this agreement.

15.18.1.2. Employer's Liability coverage with a minimum limit of $500,000 for bodily injury by accident or disease.

15.18.1.3. Commercial General Liability coverage (including products and completed operations, blanket or broad form contractual, personal injury liability and broad form property damage) with minimum limits of one million dollars ($1,000,000) per occurrence for bodily injury/property damage and one million dollars ($1,000,000) for personal injury and products/completed operations.

15.18.1.4. Business Automobile Liability coverage (covering the use of all owned, non-owned and hired vehicles) with minimum limits (combined single limit) of one million dollars ($1,000,000) for bodily injury and property damage.

15.18.1.5. Excess or Umbrella Liability coverage with a minimum limit of two million dollars ($2,000,000) coverage in excess of the coverage as set forth in items 15.18.1.2, 15.18.1. 3, and 15.18.1.4 above.

15.18.1.6. Employee Dishonesty (Fidelity) and Computer Crime coverage (for losses arising out of or in connection with any fraudulent or dishonest acts committed by employees of ADP, acting alone or in collusion with others) with a minimum limit of ten million dollars ($10,000,000).

15.18.1.7. Errors & Omissions coverage (including Cyber Liability) in the amount of ten million dollars ($10,000,000).

15.18.2. Subject to ADP's right to self-insure coverage as set forth below, the foregoing coverages shall be maintained with insurers which have an A.M. Best rating of A- or better and /or an equivalent rating from a recognized insurance company rating agency.

15.18.3. ADP's policies shall be primary and any insurance maintained by Client is excess and noncontributory. Promptly upon Client's written request for same, ADP shall cause its insurers or insurance brokers to issue certificates of insurance evidencing that the coverages required under this Agreement are maintained and in force. In addition, ADP will use reasonable efforts to give thirty days' notice to Client prior to cancellation or non-renewal of any of the policies providing such coverage; provided, however that ADP shall not be obligated to provide such notice if, concurrently with such cancellation or non-renewal, ADP provides self-insurance coverage as described below or obtains coverage from another insurer meeting the requirements described above.

15.18.4. Notwithstanding the foregoing, ADP reserves the right to self-insure coverage (directly or through the corporate risk management programs of its ultimate corporate parent, Automatic Data Processing, Inc.), in whole or in part, in the amounts and categories designated above, in lieu of ADP's obligations to maintain insurance as set forth above, at any time.

15.18.5. This section does not replace or otherwise amend, in any respect, the limitations on ADP's liability as set forth elsewhere in this Agreement.

15.19 **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 Client under this Agreement are solely the obligations of Client, and the County of Orange, State of California, shall have no obligation or liability related to this Agreement.

15.20 **Debarment and Suspension Certification**.

15.20.1 By signing this Agreement, ADP agrees to comply with any and all applicable federal suspension and debarment regulations that affect its business generally, including, as applicable, 7 C.F.R. 3017, 45 C.F.R. 76, 40 C.F.R. 32, or 34 C.F.R. 85.

15.20.2 By signing this Agreement, ADP certifies to the best of its knowledge and belief, that it and its principals:

15.20.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any state or federal department or agency;

15.20.2.2 Have not within a three (3)-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 anti-trust statutes; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

15.20.2.3 Have not within a three (3)-year period preceding the Effective Date of this Agreement had one or more public transactions (federal, state or local) terminated for cause or default; and

15.20.2.4 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

15.20.3 If ADP is unable to certify to any of the statements in this certification, ADP shall submit an explanation to Client.

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

15.20.5 If ADP knowingly violates this certification, in addition to other remedies available to the federal government, Client may terminate this Agreement for breach.

15.21 **Prohibited Interest**.

15.21.1 ADP shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws that affect its business generally, including the California Political Reform Act (California Government Code § 81000 *et seq*.) and California Government Code § 1090 *et seq*. (collectively, the "Conflict of Interest Laws").

15.21.2 ADP understands that if this Agreement is made in violation of California Government Code § 1090 *et seq*., the entire Agreement can be terminated for breach.

15.21.3 If ADP 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 15.21, ADP shall immediately make full written disclosure of such acts to Client. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

15.22 **State Auditor Audit Disclosure**. Pursuant to California Government Code § 8546.7, if this Agreement is more than ten thousand dollars ($10,000), it is subject to examination and audit of the California State Auditor, at the request of Client or as part of any audit of Client for a period of three (3) years after final payment under this Agreement. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Agreement, ADP agrees that during the Term and for a period of three (3) years after its termination, Client shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of ADP relating to services provided under this Agreement. Where another right of access or inspection in this Agreement provides for a

period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

Appendix

History Conversion Services

CONVERSION SERVICE	DESCRIPTION
Check History	***Includes****:* Net/Gross Salary, Taxes, Deductions, Hours, Hours & Earnings Codes. Check History data files will be created and imported into ADP Workforce Now for Client practitioner level access only (not individual employee access).
Pay Rate History	***Includes:*** Position ID, Change Effective On, Compensation change Reason, Rate Type, Rate 1 Amount, Standard Hours, Pay Frequency Code, Rate 2 Amount, Rate Currency, Annual Salary. History data will be loaded to an external viewer (see below).
Position History	***Includes:*** Job Title, Department, Business Unit, Location, Assigned Shift, Full time Employee, Pay Grade, Job Class, Salary Structure, Allocation, Union, FLSA, Workers Compensation, Scheduled Hours, Hours period, EEO Job Class, Cost Number, Management Position, Reports to Position ID. History data will be loaded to an external viewer (see below). Automated Export Services may be available (see below).
Employee Status History	***Includes:*** Changes to Employee Status, including Termination, Rehire, LOA, and LOA Return records along with status change reasons.

Loading History Data. *History data will be loaded to an external history viewer, a standalone system, provided by a designated ADP subcontractor which allows Client to retain history from its legacy systems. History Viewer URL access will be provided to Client practitioner for login with password. Access to History Viewer will be at the Client practitioner level only (not individual employee access).*
Automated Export Services. *The Automated Export Services associated with History Viewer, applies to the custom report that loads data from the ADP Application Platform to the History Viewer on a one time daily basis. The data loaded from the ADP Application Platform to the History Viewer is specific to pay rate, status and position data only. This enables joint reporting from History Viewer for both current and historical employee data. ADP (through its designated subcontractor) shall setup the custom report under a specific practitioner during the history conversion process and the ADP integration team shall initiate the automation of the report.*

Data Privacy Appendix

This Data Privacy Appendix is a data processing agreement under Applicable Law and supplements the Agreement, including Sections 4 (Confidentiality), 9.3 (Data Security) and 10.1 (Data Security Breach/Notification), between ADP, Inc. and Client. Capitalized terms throughout this Data Privacy Appendix not defined in the Agreement are defined in the ADP Privacy Glossary at www.adp.com/-/media/adp/privacy/pdf/glossary_en.pdf.

PART I - GENERAL

1. Client Obligations. Client shall only provide ADP with Client Personal Data that: (a) is required to perform the Services; (b) has been collected in accordance with Applicable Laws; and (c) the Client has authority to provide under Applicable Law.

2. ADP Obligations. ADP, as a Data Processor (or equivalent term under Applicable Law), will comply with Applicable Law for Processing Client Personal Data pursuant to the Agreement. ADP will not: (a) "sell" or "share" Client Personal Data; (b) retain, use, disclose or otherwise Process Client Personal Data outside of its direct business relationship with Client or for any commercial or other purpose other than the business purposes specified in the agreement(s) between Client and ADP, except as permitted by Applicable Laws; or (c) combine Client Personal Data with personal data that ADP receives from, or on behalf of, other persons, or collects from its own interaction with a consumer, except as permitted under Applicable Law. ADP shall have the right to Process Client Personal Data in order to comply with its legal obligations (e.g., compliance with sanction laws) or in order to prevent, detect or investigate fraud. ADP employees and contingent workers are authorized to Process Client Personal Data to the extent necessary to provide Services and as permitted under the Agreement and by Applicable Law.

3. De-identification and Aggregation. In addition to any rights granted to ADP in Section 4 of the Agreement to use aggregated and anonymized data, ADP will not attempt to, and will not, re-identify any Client Personal Data.

4. Transfers to Subprocessors. ADP may transfer Client Personal Data to ADP Subprocessors and Third Party Subprocessors located outside of the country in which Client Personal Data was collected. Third Party Subprocessors are bound by written contracts with ADP that impose data protection terms that are not less protective than those imposed by this Data Privacy Appendix. An up-to-date list of ADP Subprocessors and Third Party Subprocessors, including locations, is accessible at https://adp4me.adp.com/. Such list may be updated from time to time.

5. Compliance Obligations. ADP will notify Client if ADP makes a determination that it can no longer meet its Processing obligations under Applicable Laws. Client may, upon providing written notice to ADP, take reasonable steps to stop and remediate unauthorized Processing of Client Personal Data.

6. Client Instructions. When receiving a Client instruction regarding the Processing of Personal Data, ADP will notify Client if ADP considers such instruction violates Applicable Law; however, ADP is not obliged to and will not perform a legal examination with respect to a Client instruction.

7. Assistance. ADP will assist Client with its data privacy obligations where required under Applicable Law, including assisting Client in responding to andaddressing Client Employee individual rights requests and complaints and providing Client with relevant information for conducting data protection impact or risk assessments. ADP reserves the right to charge for such assistance rendered. If ADP receives an individual rightsrequest or complaint directly from a Client Employee, ADP shall promptly forward the Client Employee request to Client.

8. Client Audit. ADP will answer questions asked by Client regarding the Processing of Client Personal Data by ADP. In the event Client reasonably considers that the answers provided by ADP justify further analysis, ADP will, in agreement with Client, either:

(a) provide security materials known as ADP's trust package (which includes security policy and standards overview, password summary, resiliency program summary, disaster recovery program overview, data center and hosting service summary and a third party risk management executive summary), that details ADP's business processes and procedures for the Processing of Client Personal Data; or,

(b) make the facilities it uses to Process Client Personal Data available for an audit by a qualified independent third-party assessor reasonably acceptable to ADP, bound by confidentiality obligations satisfactory to ADP and engaged by Client. The Client will provide a copy of the audit report to ADP's Global Chief Privacy Officer which will be ADP Confidential

Information. Except as required by Applicable Laws or otherwise provided in the Agreement, audits shall be conducted no more than once per year during the term of the Agreement during regular business hours and will be subject to (i) a writtenrequest submitted to ADP at least 45 days in advance ofthe proposed audit date; (ii) a detailed written audit plan reviewed and approved in advance by ADP's security organization; and (iii) ADP's on-site security policies. Such audits will take place only in the presence of a representative of ADP's global security office, ADP'sglobal data privacy & governance team, or such person designated by the appropriate ADP representative. The audits shall not be permitted to disrupt ADP's Processing activities or compromise the security and confidentiality of Personal Data pertaining to other ADP Clients. ADP will charge Client a reasonable fee forsuch audit.

PART II – GDPR

9. Scope. This Part II applies solely with respect to Client Personal Data subject to Regulation (EU) 2016/679 on the protection of natural persons with regard to the processing of Personal Data and on the free movement of such data ("General Data Protection Regulations" or "GDPR"). With respect to ADP's processing of Client Personal Data subject to GDPR, the ADP Privacy Code, located at https://www.adp.com/-/media/adp/privacy/pdf/bcrpc_en.pdf, governs. ADP has obtained EU authorization of its ADP Privacy Code.

10. International Transfers. For transfers outside of the EEA, Switzerland and United Kingdom, the ADP Privacy Code serves as the legal basis for the data transfer to an ADP Group Company or between ADP and an ADP Subprocessor, which the Client acknowledges and accepts. ADP shall enter into appropriate contractual agreements, such as standard contractual clauses, or rely upon any other lawful transfer mechanism prior to transferring Client Personal Data to a Third Party Subprocessor or to an ADP company when the ADP Privacy Code does not apply.

11. Additional Subprocessor Obligations. Within 30 days of a written update (including electronic notice) by ADP to Client adding a new Subprocessor, Client may object to such new Subprocessor by providing written notice to ADP alleging objective justifiable grounds that such Subprocessor is unable to protect Client Personal Data. If the parties cannot reach a mutually acceptable solution, ADP shall, at its option, either: (a) not allow the Subprocessor to access Client Personal Data; or (b) allow Client to terminate the relevant Services in accordance with the terms of the Agreement.

12. ADP Privacy Code EU Authorization. ADP will make commercially reasonable efforts to maintain the EU authorization of its ADP Privacy Code for the duration of the Agreement and will promptly notify Client of any subsequent material changes in the EU authorization of its ADP Privacy Code.

PART III - Miscellaneous

13. Order of Precedence. In the event of a conflict between the Agreement, this Data Privacy Appendix, the ADP Privacy Code and Applicable Law, then the conflict will be resolved by giving effect to such in the following order of precedence: (a) Applicable Law; (b) the ADP Privacy Code; (c) this Data Privacy Appendix; and (d) the Agreement.

14. Scope. This Data Privacy Appendix provides no additional rights to a Client Employee that are not already provided under the Applicable Law to which the Client Employee is subject.

Sales Order

Quote Number 05-2023-307740 2

Company Information

CalOptima
505 City Pkwy W Orange,
CA 92868-2924
United States

Executive Contact

Maria Medina
Buyer
mmedina@caloptima.org (714) 246-8400

Recurring Fees and Considerations

Number of Employees: 1500 on CalOptima

Per Processing	Count	Min	Base	Rate	Bi-Weekly	Annual
Workforce Now Payroll Solutions • Enhanced Payroll	1500	-	-	$0.95	$1,425.00	$37,050.00
Employment and Income Verification • Employment Verification	1500	-	-	-	$0.00	$0.00

Monthly Processing	Count	Min	Base	Rate	Monthly	Annual
Workforce Now HCM Solutions • Enhanced HR • HCM Analytics • Enhanced Benefits • Performance and Goal Management • Compensation Management	1500	-	-	$4.18	$6,270.00	$75,240.00
Health Compliance	1500	-	-	$0.70	$1,050.00	$12,600.00
Workforce Manager Time and Attendance						
Hourly Employees	1249	-	-	$3.10	$3,871.90	$46,462.80
Salaried Employees • Compliance on Demand	160	-	-	$2.01	$321.60	$3,859.20
Accruals and Leave	1409	-	-	$0.40	$563.60	$6,763.20
Analytics	1409	-	-	$0.44	$619.96	$7,439.52
InTouch DX Bar Code Clock Subscription	13	-	-	$210.00	$2,730.00	$32,760.00
InTouch DX QuickPunch Plus OptionSubscription	13	-	-	$20.00	$260.00	$3,120.00

Additional Jurisdiction (if applicable) 2+ $10.00/monthInternational

Employees Rate (if applicable) $3.10/month Unless fully paperless, shipping fees for 3rd party courier delivery will be billed at prevailing rate.

Annual Processing	Count	Min	Base	Rate	Annual

Year End Forms, W2s or 1099s	1500 $6,750.00	-	-	$4.50

Other	Count	Rate	Setup
Total Annual Investment			**Total Annual**
Workforce Now Services			$232,044.72

Considerations

Hardware and Other Fees

• Professional Services: Pay Check History Conversion	1	$11,700.00	$11,700.00

Implementation

• Implementation for Workforce Now Payroll Solutions	$7,000.00
• Implementation for Workforce Now HCM Solutions	$11,000.00
• Implementation for Health Compliance	$1,500.00
• Implementation for ADP Workforce Manager	$14,627.00
• Implementation for Accruals and Leave	$8,500.00
• Implementation for Analytics	$2,000.00

Implementation

- Affordable Care Act (ACA) - Historical Hours Import up to 36 months $3,500.00

Total Other Considerations

	Total Setup
Implementation and Setup	$238,335.00
Implementation Discount Value	($178,508.00)
Estimated Total Net Implementation	$59,827.00

Important Project and Billing Information

Billing for Payroll Processing Services, HCM and any module bundled into the single per employee per processing fee for payroll, is billed immediately following the client's first payroll processing. The billing count is based on the number of pays submitted during each processing period, therefore total billing may fluctuate.

Billing for all modules bundled under HCM Solutions will begin on the date the ADP Product or Service is available for use by the CLIENT in a production environment. The billing count is based on all unique lives in the database paid in the previous calendar month. Any non-terminated employees based outside the United States will be billed separately as International Employees.

Billing for Workforce Manager will begin on the date Workforce Manager is available for use by the CLIENT in a production environment. The billing count is based on all non-terminated lives in the Time Module, including managers/supervisors that need to approve time cards. Billing for add-on modules will include counts based on those lives specifically added and maintained by the practitioner.

Workforce Manager can only be used for tracking time for US associates only. Clients are prohibited for leveraging this solution to track time for anyone located outside the US.

History Conversion: The services noted on this sales order are performed by ADP Professional Services and are for companies with more than 1000 active employees with data coming from a single data base source. Conversion of history from multiple databases must be quoted via a customized statement of work.

The costs detailed on this sales order include the first five practitioners at no cost. Each additional practitioner after the first five will be billed at $260 per practitioner per month.

Billing for Health Compliance will begin on the date Health Compliance is available for use by CLIENT. The billing count is based on all lives in the database that are marked as either Active or Leave.

Other

ADP's Fee for Service will be paid to ADP within thirty (30) days of Invoice Date unless fees are disputed as detailed in Section 11.3 of the General Master Services Agreement. Fees may be paid via ACH or Direct Debit (not check).

Expiration Date: 6/20/2023

Summary

Estimated Annual Net Investment:	$232,044.72	Total Net Implementation:	$59,827.00

Sales Order

Quote Number 05-2023-307740 2

Workforce Now Included Services

Enhanced Payroll

- Tax Filing Service
- Payment Services
- Reports Library and Custom Report Writer
- Wage Garnishment Processing
- New Hire Reporting
- General Ledger Solution
- Intelligent Employee Case Resolution
- Online Reports and Pay Statements
- Employee and Manager Self Service
- Paid Time Off Accruals
- ADP Portal with Customized Content
- Access to Mobile Apps
- Employee Discount Program
- Group Term Life Auto Calculation
- Conversational Virtual Assistant

Enhanced HR

- Employee Development Tracking
- Paid Time Off Accruals Engine
- Multiple Languages & Currencies
- Country Specific Workflows & Processes
- Country Specific Formatting & Custom Fields
- Secure Online Document Storage with Role Based Security, Search & Audit Functionality
- Communication Broadcasts
- New Hire Onboarding / I-9 Workflow
- Compliance Reporting
- Organization Charting
- Policy Acknowledgement
- Total Rewards Statements
- Employee Feedback and Sentiment Surveys

HCM Analytics

- Pre-Configured Key Performance
- Executive Dashboard
- Ability to Customize Additional KPIs
- Pay Equity Storyboard

Enhanced Benefits

- Multiple Benefit Plan Types
- Dependent & Beneficiary Tracking
- Employee Open Enrollment with Personalized Decision Support
- Invoice Auditing
- Flexible Rate Structures
- COBRA Event Triggers
- Notifications & Approvals
- Benefit Plan Creation

Performance and Goal Management

- Custom Performance Review Templates
- 360 Degree Peer Review
- Employee Goal Management
- Manager Dashboard

Compensation Management

- Performance & Award Alignment
- Configurable Merit Matrix
- Budget and Award Guidelines
- Configurable Workflow

Health Compliance

- Business Intelligence and Calculations
- State Reporting for Health Coverage
- Health Coverage Reporting
- Penalty Management

Workforce Manager Time and Attendance

- Multiple Time Collection Methods
- PTO Management & Reporting
- Request & Approval Workflows
- 100% mobile for supervisors and employees
- Rule Based Calculations
- Web Native
- Attestation Toolkit
- 3rd Party Integration Interface

Compliance on Demand

- Federal, state and local regulatory content
- Proactive legislative alerts from ADP
- An ADP client community discussion forum
- Access to ADP compliance experts

Employment Verification

- Commercial Employment and Income Verifications
- Social Services Verifications
- Workers Compensation Verifications

- Client access to Electronic Reports and Tools
- Immigration Verifications

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

14. Approve Reappointment to the CalOptima Health Board of Directors' Investment Advisory Committee

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6395

Recommended Actions

Approve reappointment of Annie Tran to the Investment Advisory Committee (IAC) for a two (2)-year term, beginning March 5, 2024.

Background

At a Special Meeting of the CalOptima Health Board of Directors held on September 10, 1996, the Board authorized the creation of the CalOptima Health IAC, established qualifications for committee members, and directed staff to proceed with the recruitment of the volunteer members of the IAC.

When creating the IAC, the Board specified that the IAC would consist of five (5) members; one (1) member would automatically serve by virtue of his or her position as CalOptima Health's Chief Financial Officer. The remaining four (4) members would be Orange County residents who possess experience in one (1) or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting.

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima Health on its investment activities.

Discussion

The candidate recommended for reappointment has proven leadership and expertise in finance and accounting.

Annie Tran is a Chartered Financial Analyst, holds an MBA in finance and a bachelor's degree in economics. Ms. Tran currently works for Charles Fish Investments as a Portfolio Manager. She has over 15 years of experience, and previously worked as an Analyst for US Bank, and an Investment Analyst intern for the City of Orange.

Ms. Tran was first appointed to the IAC on March 4, 2022, and her current term will end on March 4, 2024.

Fiscal Impact

There is no fiscal impact. An individual reappointed to the IAC assists CalOptima Health in suggesting updates to and ensuring compliance with CalOptima Health's Board-approved Annual Investment Policy, and monitors the performance of CalOptima Health's investments, investment advisor, and investment managers.

Back to Agenda

Rationale for Recommendation
The individual recommended for CalOptima Health's IAC has extensive experience that meets or exceeds the specified qualifications for membership on the IAC.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Investment Advisory Committee
Board of Directors' Finance and Audit Committee

Attachment
None

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

15. Authorize Actions Related to the mPulse Vendor Contract

Contacts

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

Recommended Actions

Authorize unbudgeted expenditures and appropriate funds in an amount not to exceed $610,000 from existing reserves to fund the mPulse vendor contract in Fiscal Year 2023-24.

Background

On May 7, 2020, the CalOptima Health Board authorized CalOptima Health to contract with vendor mPulse Mobile, a mobile health interactive text messaging services vendor, as part of CalOptima Health's Virtual Care Strategy to address timely access to care during the COVID-19 pandemic.

Although originally utilized for COVID-19-related member outreach, CalOptima Health staff has expanded the use of mobile texting to support quality measures, health promotion, health education, and preventive care messaging. Additionally, text campaigns were part of the CalFresh Outreach Strategy authorized by the Board on March 3, 2022, which successfully reached over 135,000 members via text message. As of September 2023, CalOptima Health has used mPulse to send over 7 million texts to its members.

Discussion

CalOptima Health departments, such as Quality Analytics, Population Health Management (PHM), and Community Relations, use mPulse for member outreach via text campaigns. mPulse is contracted at $0.11 per member per month. The Fiscal Year (FY) 2023-24 Operating Budget included $578,000 for the mPulse vendor contract.

Staff projects the mPulse vendor contract will have a budget shortfall of $610,000 through June 30, 2024. To address this shortfall, staff requests that the Board authorize an allocation of up to $610,000 from existing reserves in order to continue using mPulse services for member engagement and outreach campaigns through FY 2023-24.

Fiscal Impact

The recommended action is unbudgeted. An allocation of up to $610,000 from existing reserves will fund the mPulse vendor contract through June 30, 2024.

Back to Agenda

Rationale for Recommendation

An adequate amount of funding will ensure members are engaged through multiple modalities that include texting in addition to mailing and outbound calling.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Finance and Audit Committee

Attachments

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
mPulse	21255 Burbank Blvd.	Los Angeles	CA	91367

Back to Item

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

16. Ratify and Authorize Actions Related to the Contract of a Managed Security Service Provider (MSSP) to Manage the LogRhythm Security Incident and Event Monitoring (SIEM) System

Contacts

Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
James Steele, Senior Director, Information Security, (714) 497-6046

Recommended Actions

1. Ratify the scope of work (SOW) and the release of the request for proposal (RFP) for a Managed Security Service Provider (MSSP) to manage the LogRhythm Security Incident and Event Monitoring (SIEM) system.
2. Authorize the Chief Executive Officer to select a vendor and negotiate and execute a contract with the selected vendor.

Background

As part of CalOptima Health's Workplace Modernization and Digital Transformation Strategy, Information Technology Services (ITS) will be evaluating and deploying multiple solutions. These solutions coincide with CalOptima Health's Cloud First strategy and take regulatory compliance and security measures into consideration. These initiatives will assist CalOptima Health in achieving its vision statement of removing barriers to achieve real-time claims payments and 24-hour treatment authorizations and doing annual assessments around social determinants of health by 2027. The projects and products that CalOptima Health implements will result in value-based care and improvements for member, provider, and employee experiences. These enhancements will provide CalOptima Health with the ability to be robust and agile and to scale as a future-focused healthcare organization.

Discussion

By approving the SOW and the action to move forward with identifying and contracting with an MSSP, CalOptima Health will be able to monitor and manage its Security Information and Event Management (SIEM) system 24 hours a day, 7 days a week. The MSSP will conduct both manual and automated reviews and responses to ensure that CalOptima Health's cybersecurity tools are functioning optimally. They will provide real-time reviews of all alerts, investigate suspicious activities, onboard the collection of logs from IT systems, and automate security responses. This effort will increase CalOptima Health's ability to respond quickly to potential cybersecurity risks to its users, systems, and data. The MSSP will define rules for monitoring malicious activity based on the current threat landscape that is constantly changing.

Back to Agenda

Fiscal Impact

The recommended action is a budgeted item and is included in the Fiscal Year 2023-24 Digital Transformation Year Two operating budget approved by the Board on June 1, 2023. Management will include the remaining administrative expenses in future Digital Transformation operating budgets.

Rationale for Recommendation

The cybersecurity team is not able to review the logs and alerts 24 hours a day, 7 days a week. Using an MSSP provides continuous monitoring and mitigation of security events. Utilizing a vendor that specializes in log review, alert creation, and automated responses will improve the cybersecurity posture of CalOptima Health and aligns with the zero trust framework.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Finance and Audit Committee

Attachments

1. Scope of Work

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

SIEM MSSP SCOPE OF WORK

I. OBJECTIVE

The purpose of this request is to solicit proposals from qualified managed service providers specializing in SIEM (Security Information and Event Management) as a service, with a focus on the Log Rhythm solution. We seek a partner capable of providing a comprehensive SIEM service utilizing Log Rhythm's advanced capabilities for security data collection, analysis, and incident response. Our objective is to enhance our organization's cybersecurity posture, threat detection, and compliance with industry regulations through the effective implementation and management of Log Rhythm's SIEM solution.

II. SCOPE OF WORK BASICS

1. Products/Services
2. Performance Guaranties/Measures
3. Professional Requirements

1. PRODUCTS/SERVICES

Real-time Event Monitoring

a. The Supplier will deliver real-time event monitoring services, generating alerts based on the activities of various devices, utilizing the LogRhythm SIEM solution. These devices include:
    i. Firewalls
    ii. Routers
    iii. Switches
    iv. Wireless Controllers
    v. Web Proxies
    vi. Load Balancers
    vii. IPS/IDS Systems
    viii. Windows Servers
    ix. Windows Domain Controllers
    x. Windows/Mac Workstations
    xi. Other security-related devices listed in the LogRhythm Architecture Discovery Document (LADD).

Custom Parser Support

a. The Supplier must support the creation of custom parsers or additional parsing rules to ingest logs from any device not officially supported by LogRhythm.

Rules & Alarms Support

a. The Supplier will be responsible for the creation of new rules, to include alarms, notifications and Smart Response implementation.
b. Rules will look for known cybersecurity risk and proactively monitor for new risks as they are identified.

Application Management

a. The Supplier will manage security applications, including application patching and agent deployment, on a continuous basis. This includes LogRhythm Hardware, SAAS/Cloud, or Software License.

Knowledge Base Modules

a. The Supplier will select the most suitable set of Knowledge Base (KB) modules and rulesets within each module as baseline policies for CalOptima Health. The default KB sets will be from the Core Threat Detection Module and one (1) compliance package chosen by CalOptima Health.
b. The Supplier will select default rulesets within the KB modules, ensuring they have undergone a diligence process to maintain system stability.

Investigation

a. The Supplier's certified Information Security Analysts will continuously perform forensic investigations, including log, flow, and event data analysis, network analytics, and more to determine the true threat of an event and provide real-time intelligence and mitigation strategies based on CalOptima Health network.
b. The Supplier will execute ad-hoc investigations via LogRhythm, as requested by CalOptima Health, included in this agreement, and performed on a best-effort basis.

Continuous Mitigation (MDR)

a. The Supplier can act on behalf of CalOptima Health 24x7x365 for specified alarms, working with CalOptima Health to determine best practice-based actions for CalOptima Health devices.

On-Demand Custom Reporting

a. The Supplier will assist CalOptima Health in creating and maintaining custom reports and metrics for baseline tracking, compliance assistance, and a detailed understanding of security posture.

Notification of Events

a. The Supplier will notify CalOptima Health directly through phone calls, text messages, and high-priority emails.

Security Events

a. All events will be categorized by the Provider based on criticality, event type, and location. Examples of security events include but are not limited to:
    i. Denial of Service (DoS)/Distributed Denial of Service (DDoS)

    ii. Actual data breaches in progress

    iii. Potential data breaches in progress

iv. Potential system exploits

v. Virus/Malware activity

vi. Device health alerts

vii. Location-based categorization of devices (e.g., External, DMZ, Untrusted Internal Network, Trusted Internal Network, Secured Internal Network) to determine event criticality.

Reporting

a. In addition to alerting and response, the Provider will provide a monthly executive summary of events detected by criticality and ongoing trend lines for continuing analysis and event tuning.

Monitoring Incident Response Workflow

a. The Provider will be the first point of contact for all alerts from the SIEM device.

b. Upon receiving an alert, the Provider will review its criticality and forward it to the CalOptima Health as appropriate:

   i. High or Critical risk events will result in phone calls, text messages, and emails to primary, secondary, and tertiary contacts until a CalOptima Health contact is reached.

   ii. Medium events will result in emails to CalOptima Health contacts.

   iii. Low events will be reported monthly.

2. PERFORMANCE GUARANTIES/MEASURES

SLA and Response Times

a. All security-related incidents and alerts will be reviewed and acted upon according to the following SLA:

   i. Critical events (LogRhythm Risk Based Prioritization (RBP) rating of 80 or above) will be acknowledged within 15 minutes, and CalOptima Health contacts will be notified via phone, text, and email.

   ii. Medium criticality events (LogRhythm RBP rating of 50-79) will be acknowledged within two business hours (9am EST to 5pm PST, Mon-Fri) and the next business day for events outside these hours.

   iii. Low criticality events (LogRhythm RBP rating of 49 or below) will be noted and reported through regular reporting.

3. PROFESSIONAL REQUIREMENTS

I. The Supplier must be a certified Log Rhythm partner.
II. The Supplier will be required to demonstrate a proven track record of deploying SIEM solutions following a distributed architecture.

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

17. Ratify and Authorize Actions Related to the Purchase and Upgrade of the Existing LogRhythm Appliance and Additional Capacity License

Contacts

Wael Younan, Chief Information Officer / Chief Information Security Officer, (657) 900-1154
James Steele, Senior Director, Information Security, (714) 497-6046

Recommended Actions

1. Ratify the scope of work (SOW) and the release of the request for proposal (RFP) for the purchase and upgrade of hardware and an additional capacity license for the Security Incident and Event Monitoring (SIEM) system.
2. Authorize the Chief Executive Officer to select a vendor and negotiate and execute a contract with the selected vendor.

Background

The SIEM system is a critical tool for safeguarding a company's digital assets and networks and is part of CalOptima Health's cybersecurity toolset. The SIEM system gathers and analyzes data from all of the workstations, servers, and tools in CalOptima Health's network, looking for any signs of trouble. If the SIEM system detects something unusual or potentially harmful, it sends an alert so that action can be taken to protect CalOptima Health's data and systems.

The SIEM system also aids in ensuring that CalOptima Health complies with regulatory requirements and data protection standards. This is especially crucial in today's landscape, where data privacy and security regulations have become increasingly stringent. In essence, the SIEM system functions as a digital compliance officer, monitoring and maintaining the security and integrity of CalOptima Health's information assets.

Discussion

Approving the recommended action will allow CalOptima Health to upgrade the current SIEM hardware that is at the end of support and increase CalOptima Health's monitoring capabilities from processing 5,000 messages per second to 10,000 messages per second. This upgrade will support the existing IT infrastructure and facilitate the migration from the current device to the new one. The new device will enable CalOptima Health to collect logs more efficiently and support future growth to align with its IT roadmap.

The vendor will be responsible for configuring and deploying the new LogRhythm device, upgrading it to support new licenses, migrating all data, rules, alerts, and responses, as well as onboarding additional systems and appliances.

Back to Agenda

Fiscal Impact
The recommended action is a budgeted item and is included in the Fiscal Year 2023-24 Routine Capital and Operating Budget, approved by the Board on June 1, 2023.

Rationale for Recommendation
The existing hardware is at the end of support, and CalOptima Health has a need to increase the license amount to support current and future roadmap requirements.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Finance and Audit Committee

Attachments
1. Scope of Work

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

SIEM Hardware, Software, Support and Professional SCOPE OF WORK

I. OBJECTIVE

The purpose of this request is to solicit proposals from qualified vendors specializing in SIEM (Security Information and Event Management) hardware, software (license increase from 5,000MPS to 10,000MPS), support and professional services, with a focus on the Log Rhythm solution. Our objective is to enhance our organization's cybersecurity posture, threat detection, and compliance with industry regulations through a hardware and software upgrade and migration of CalOptima Health's Log Rhythm SIEM solution.

II. SCOPE OF WORK BASICS

1. Products/Services

1. PRODUCTS/SERVICES

Hardware, Software, Support and Professional Services

a. LogRhythm All-in-one XM8600 Appliance (Quantity 1)
b. LogRhythm SIEM Perpetual License (Quantity 5000):
    I. LogRhythm Perpetual License at 10K MPS (from existing 5K MPS)
    II. Unlimited Collection Agents
    III. Includes services licenses for PM, DP, DX, AIE
    IV. Includes Geo Location and Premium Suites
c. 1 Year Prepaid Standard Maintenance and Support Services
d. Professional Services Includes:
    I. Migration and Deployment Services from the previous LogRhythm resource to the new platform to include:
        a. Migrate Existing Defined Smart Response Alerts
        b. Migrate Existing Defined Rules
        c. Tuning of Rules and Smart Response Alerts
        d. Onboarding of additional systems and appliances

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

18. Adopt Resolution No 23-1207-01 to Add Two Additional Seats and Rename One Seat on the CalOptima Health Board of Directors' Member Advisory Committee.

Contacts

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

Recommended Actions

1. Adopt Resolution No. 23-1207-01 that:
    a. Adds two additional OneCare Member or Authorized Family Member Representative seats to the Member Advisory Committee (MAC); and
    b. Renames the existing Consumer Representative seat to Medi-Cal Beneficiaries or Authorized Family Member Representative

2. Authorize modifications to CalOptima Health policy AA.1219a: Member Advisory Committee Policy and Procedures to reflect the seat additions and the seat name change.

Background

The CalOptima Health Board of Directors (Board) established the MAC by resolution on February 14, 1995, to provide input to the Board. The MAC is currently comprised of 15 voting members, with each seat representing a constituency or population that CalOptima Health serves. The Board is responsible for appointing all MAC members.

Regulations issued by the Centers for Medicare & Medicaid Services (CMS) in 2023 and incorporated into the Department of Health Care Services (DHCS) contract, required CalOptima Health to establish a MAC for the OneCare (HMO D-SNP) program. The regulation also allowed plans to either establish a new committee or use an existing committee to meet the regulatory requirement.

Discussion

Beginning January 1, 2024, CMS is requiring that D-SNP plans designate four (4) Member or Authorized Family Members Representative seats on the MAC. Currently there are two OneCare Member or Authorized Family Member Representatives. To meet the new requirement, staff recommends that two additional OneCare Member or Authorized Family Member MAC seats be added to fulfill the CMS and DHCS new contract requirements for 2024.

Consistent with the Board's policy of encouraging member and provider involvement in the ongoing refinement of CalOptima Health's programs, staff recommends that the MAC expand its membership by two additional seats to fulfill the CMS and DHCS contract request of including four OneCare Member or Authorized Family Member seats. This would expand the MAC membership from 15 to 17 representatives.

Back to Agenda

Renaming the Consumer Representative seat to Medi-Cal Beneficiaries or Authorized Family Member allows for two Medi-Cal seats on the committee.

The draft updated CalOptima Health policy AA.1219a: Member Advisory Committee is attached for reference and approval.

Fiscal Impact

The recommended action has no additional fiscal impact. Unspent budgeted funds from the Fiscal Year 2023-24 CalOptima Health Administrative Budget: Other Operating Expenses will fund the additional stipend expenses related to this action through June 30, 2024.

Rationale for Recommendation

CalOptima Health recommends adding two MAC seats to be filled by OneCare Member or Family Member Representative. The addition of two seats will increase the MAC from 15 members to 17 members and fulfill the requirements of the CalOptima Health contract with CMS and DHCS for 2024. Renaming the currently vacant Consumer Representative seat to Medi-Cal Beneficiaries or Authorized Family Member Representative allows for consistency among the member seats on the MAC.

Concurrence

James Novello, Outside General Counsel Kennaday Leavitt

Attachments

1. Resolution Number 23-1207-01
2. AA.1219a: Member Advisory Committee Policy

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

RESOLUTION NO. 23-1207-01

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

APPROVE ADDITION OF TWO ONECARE MEMBER OR AUTHORIZED FAMILY MEMBER SEATS AND NAME CHANGE TO CONSUMER REPRESENTATIVE

WHEREAS, the CalOptima Health Board of Directors established the Member Advisory Committee (MAC) pursuant to Resolution No. 2-14-95 to represent the constituencies served by CalOptima Health and to advise the Board of Directors and later amended to rename seats pursuant to Resolution No. 22-0901-02; and

WHEREAS, CalOptima Health recommends adding two OneCare Member or Authorized Family Member Representative seats and changing the name of the current Consumer Representative seat to Medi-Cal Beneficiaries or Authorized Family Member Representative.

NOW, THEREFORE, BE IT RESOLVED:

I. That the Board of Directors hereby approves the recommended addition of two seats for OneCare Member or Authorized Family Members to the MAC.

II. That the Consumer Representative seat on the MAC is renamed to Medi-Cal Beneficiaries or Authorized Family Members Representative.

III. That effective December 7, 2023, the seats comprising the MAC are:

a. Adult Beneficiaries
b. Behavioral/Mental Health
c. Children
d. Family Support
e. Foster Children
f. Medi-Cal Beneficiaries or Authorized Family Member
g. Medi-Cal Beneficiaries or Authorized Family Member
h. Member Advocate
i. OneCare Member or Authorized Family Member
j. OneCare Member or Authorized Family Member
k. OneCare Member or Authorized Family Member
l. OneCare Member or Authorized Family Member
m. Orange County Social Services Agency (Standing Seat)
n. Persons with Disabilities
o. Persons with Special Needs
p. Recipients of CalWORKs
q. Seniors

Back to Item

Back to Agenda

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 7th day of December, 2023.

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

Back to Item

Back to Agenda

Policy:	AA.1219a
Title:	**Member Advisory Committee**
Department:	~~Customer Service~~Executive Office
Section:	~~Not Applicable~~Clerk of the Board
CEO Approval:	*/s/*
Effective Date:	02/14/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ~~☐ OneCare Connect~~ ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the composition and role of CalOptima Health's Member Advisory Committee (MAC) and to establish a process for recruiting, evaluating, and selecting prospective candidates to CalOptima Health's MAC.

II. POLICY

A. As directed by CalOptima Health's Board of Directors (CalOptima Health Board), the MAC shall report to the CalOptima Health Board and shall provide advice and recommendations to the CalOptima Health Board relative to CalOptima Health's programs, and relevant policies and procedures affecting quality and Health Equity updates. CalOptima Health shall inform MAC members how their input was incorporated.

B. CalOptima Health's Board encourages Member involvement in CalOptima Health's programs.

C. CalOptima Health shall designate a staff member and maintain a written job description detailing the staff member's responsibilities, which includes having responsibility for managing the operations of the MAC in compliance with all statutory, regulatory, and contractual requirements.

~~C.~~D. MAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima Health Policies GA.8012: Conflicts of Interest~~'s conflict of interest code~~ and~~, CalOptima Health Policy~~ AA.1204: Gifts, Honoraria, and Travel Payments.

~~D.~~E. The composition of the MAC shall reflect the diversity of the health care consumer. All MAC members shall have direct or indirect contact with CalOptima Health Members.

~~E.~~F. An organization may have no more than one (1) employee or representative on the MAC at any one time.

~~F.~~G. An individual may participate in no more than one (1) CalOptima Health advisory committee at any one time.

Back to Item

Back to Agenda

~~G.~~H. In accordance with CalOptima Health Board Resolution Numbers 2-14-95 (effective February 14, 1995) and ~~11-1103~~23 1207-01 (effective ~~November 3, 2011~~December 7, 2023), MAC shall be comprised of ~~fifteen (15~~seventeen (17) voting members, each seat representing a constituency served by CalOptima Health.

1. One (1) of the ~~fifteen (15~~seventeen (17) positions is a standing seat and is held by the Social Services Agency (SSA).

2. The remaining ~~fourteen (14~~sixteen (16) members shall serve staggered terms of three (3) years.

   a. ~~One (1~~Two (2) of the remaining ~~fourteen (14~~sixteen (16) positions shall be a dedicated ~~Consumer seat~~Medi-Cal Beneficiaries or Authorized Family Member seats.

   b. ~~Two (2~~Four (4) of the ~~fourteen (14~~sixteen (16) positions shall be dedicated to OneCare Member or Authorized Family Member seats.

   a. The three (3) year term shall coincide with CalOptima Health's fiscal year (i.e., July 1 through June 30).

   b. Effective July 1, 2023, staggered nominations shall occur at a rate of approximately one-third (1/3) of the membership each year.

   c. MAC m~~M~~embers may serve no more than two (2) consecutive terms or the equivalent of six (6) consecutive years.

   d. MAC members shall be allowed to reapply after a hiatus of six (6) years.

3. MAC may include, but is not limited to, individuals representing, or that represent the interests of:

   a. Adult beneficiaries;

   b. Behavioral/Mental Health;

   c. Children;

   ~~d. Consumer;~~

   ~~e.~~d. Family Support Representative;

   ~~f.~~e. Foster children;

   f. Medi-Cal or Authorized Family Member beneficiaries;

   ~~g. Medi-Cal or Authorized Family Member beneficiaries;~~

   ~~h.~~g. Member Advocate;

   ~~i.~~h. OneCare Member~~/~~ or Authorized Family Member;

   ~~j. OneCare Member/ or Authorized Family Member;~~

~~OneCare Member or Authorized Family Member;~~

~~OneCare Member or Authorized Family Member;~~

~~k.~~i. Orange County SSA;

~~l.~~j. Persons with disabilities;

~~m.~~k. Persons with Special Needs;

~~n.~~l. Recipients of CalWORKs; or

~~o.~~m. Seniors.

4. The ~~Member Advisory Committee (~~MAC~~)~~ shall carry out ~~the~~ duties in ~~accordance~~ with DHCS contract requirements. Duties include, but are not limited to:

a. Identifying and advocating for preventive care practices to be utilized by CalOptima Health;

b. Involvement in developing and updating cultural and linguistic policy and procedure decisions including those related to Quality Improvement (QI), education, and operational and cultural competency issues affecting Members who speak a primary language other than English. The MAC may also advise on necessary Member or provider targeted services, programs, and trainings;

c. Providing and making recommendations to CalOptima Health regarding the cultural appropriateness of communications, partnerships, and services;

d. Reviewing Population Needs Assessment (PNA) findings and having a process to discuss improvement opportunities with an emphasis on Health Equity and Social Determinants of Health (SDOH); and

e. Providing input and advice, including, but not limited to, the following:

i. Culturally appropriate service or program design;

ii. Priorities for health education and outreach program;

iii. Member satisfaction survey results;

iv. Findings of the PNA;

v. Plan marketing materials and campaigns;

vi. Communication of needs for network development and assessment;

vii. Community resources and information;

viii. Population Health Management (PHM);

ix. Quality;

x. Health delivery systems reforms to improve health outcomes;

xi. Carved out services;

xii. Coordination of care;

xiii. Health Equity; and

xiv. Accessibility of services.

5. CalOptima Health shall allow ~~its~~the MAC to provide input on selecting targeted health education, cultural and linguistic, and QI strategies, provide sufficient resources for the MAC to support the required MAC activities outlined above, including supporting the MAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys.

6. CalOptima Health shall provide a location for MAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants, and providing accommodations to allow all individuals to attend and participate in the meetings.

7. CalOptima Health shall draft written minutes of each ~~of its~~MAC meetings and ~~the~~ associated discussions. All minutes shall be posted on CalOptima Health's website and submitted to DHCS no later than forty-five (45) calendar days after each meeting.

8. CalOptima Health shall retain ~~the~~ minutes for no less than ten (10) years and provide copies~~d~~ to DHCS, upon request.

9. CalOptima Health shall support ~~the~~ MAC members in their MAC roles ~~on the MAC~~, including but not limited to providing resources to educate MAC members to ensure they are able to effectively participate in MAC meetings, providing transportation to MAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest MAC member participation possible.

10. CalOptima Health shall appoint one (1) member of the MAC to serve as CalOptima Health's representative to DHCS' Statewide Consumer Advisory Committee.

a. The appointed MAC representative shall be reimbursed for eligible expenses associated with attending the DHCS Statewide Consumer Advisory Committee in accordance with CalOptima Health Policy GA.5004: Travel and Business Meal Policy.

~~H.~~I. Stipends

1. CalOptima Health may provide a reasonable per diem payment of up to fifty dollars ($50) per meeting to ~~a~~the Medi-Cal Member or ~~family~~Authorized Family Member beneficiaries representative and the OneCare Member or Authorized Family Member beneficiaries serving on the MAC. CalOptima Health shall maintain a log of each payment provided to the Member or family representative, including type and value, and shall provide such log to DHCS upon request.

2. Representatives of provider organizations, community-based organizations and consumer advocates are not eligible for stipends.

~~I.~~J. The MAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. The MAC shall conduct an annual recruitment and nomination process.

    a. At the end of each fiscal year, approximately one-third (1/3) of the MAC seats' terms expire, alternating between six (6) vacancies, one (1) year and four (4) vacancies each of the following two (2) years. The standing seat on the MAC is not impacted by term expiration.

2. The MAC shall conduct a recruitment and nomination process if a seat is vacated mid-term.

    a. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full three (3) year term.

~~J.~~K. Special Elections

1. Special elections for the MAC shall occur under the following circumstances:

    a. ~~When a~~A MAC seat is vacant due to the resignation of a sitting MAC member; or

    b. The current MAC member is deemed unqualified to serve in his or her current capacity as a MAC member.

        i. Every effort will be made to replace the vacant seat within sixty (60) calendar days from the date the seat is vacated.

2. Any new MAC member appointed to fill an open seat created mid-term shall serve the remainder of the resigning member's term.

~~K.~~L. MAC Vacancies

1. If a vacancy occurs prior to the start of the nomination process, there shall be no need for a special election and the vacant seat shall be filled during that nomination process.

2. If a vacancy occurs after the annual nomination process is complete, a special election may be conducted to fill the open seat, subject to approval by the MAC.

~~L.~~M. On a bi-annual basis, the MAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-E of this policy.

1. The MAC chair and vice chair may serve one (1) two (2) year term.

2. The MAC chairperson or vice chair may be removed by a majority vote from CalOptima Health's Board.

~~M.~~N. To establish a nomination ad hoc subcommittee, the MAC chair or vice chair shall ask for three (3) to four (4) members to serve on the ad hoc subcommittee. MAC members, who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.

1. The MAC nomination ad hoc subcommittee shall:

a. Review, evaluate, and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-E of this policy; and

b. Forward the prospective chair, vice chair and slate of candidate(s) to the full MAC for consideration.

2. Following approval from the MAC, the recommended chair, vice chair and slate of candidate(s) shall be forwarded to CalOptima Health's Board for review and approval.

~~N.~~O. CalOptima Health's Board shall review and have final approval for all appointments, reappointments, and chair and vice chair appointments to the MAC.

~~O.~~P. MAC members shall attend all regularly scheduled meetings unless they have an excused absence. An absence shall be considered excused if a MAC member provides notification of an absence to CalOptima Health staff prior to the MAC meeting. CalOptima Health staff shall maintain an attendance log of the MAC members' attendance at MAC meetings. Upon request from the MAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima Health staff shall provide a copy of the attendance log to the requester. In addition, the MAC chair or vice chair shall contact any committee member who has three consecutive unexcused absences.

1. MAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. MAC composition

1. The composition of MAC shall reflect the cultural diversity and special needs of the CalOptima Health population.

2. Specific agency representatives shall serve on the MAC as standing members.

a. The SSA representative shall serve as a standing member and shall not be subject to reapplying.

B. MAC meeting frequency

1. The MAC shall ~~meet~~hold its first regular meeting promptly after all initial members have been selected by the MAC selection committee and at least quarterly thereafter.

2. The MAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. MAC meetings shall be open to the public, in person or virtually, meeting information shall be posted publicly on CalOptima Health's MAC webpage thirty (30) calendar days prior to the meeting, and in no event later than seventy-two (72) hours prior to the meeting.

~~3.~~4. Attendance by a simple majority of appointed members shall constitute a quorum.

a. A quorum must be present for any votes to be valid.

C. MAC recruitment process

1. CalOptima Health shall begin recruitment of potential candidates in February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima Health population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima Health shall recruit potential candidates utilizing a variety of notification methods, which may include, but are not limited to, the following:

   a. Outreach to the respective Member community;

   b. Placement of vacancy notices on the CalOptima Health Website

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.

4. During the MAC meeting held before June 30 of a recruitment year for the chair and vice chair, the current chair or vice-chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. The candidates are requested to submit a letter of interest for these positions.

D. CalOptima Health shall conduct a special election with a truncated recruitment process to fill a MAC seat that has been vacated mid-term.

E. MAC nomination process

1. The MAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination ad hoc subcommittee.

   a. At the discretion of the MAC nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the MAC nomination ad hoc subcommittee meeting:

   a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the Applicant Evaluation Tool.

   b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair.

   c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the expiring seats by using the findings from the Applicant Evaluation Tool, the attendance record if relevant, and the prospective candidate's references.

F. MAC selection and approval process for prospective chair, vice chair and MAC candidates

1. Upon selection of a recommendation for a slate of candidates, the ad hoc subcommittee shall forward its recommendation to the MAC for consideration.

2. Following consideration, the MAC's recommendation for a slate of candidates shall be submitted to CalOptima Health's Board for review and final approval.

3. Chair and vice chair candidates who submitted a letter of interest will be reviewed at the first MAC meeting of the fiscal year and the members will vote on their candidate of choice for both positions. Candidates must have a quorum of members approving their recommendation in order to be submitted to CalOptima Health's Board for appointment.

4. Following CalOptima Health's Board approval of MAC's recommendation, the new MAC members' terms shall be effective July 1.

   a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following MAC meeting.

~~4.~~5. CalOptima Health shall provide new MAC members with a new member orientation.

G. CalOptima Health shall complete and submit to DHCS an annual MAC m~~M~~ember demographic report by April 1 of each year.

IV. ATTACHMENT(S)

A. Member Advisory Committee - Consumer Application
B. Member Advisory Committee - Community Application
C. Member Advisory Committee - Applicant Evaluation Tool
D. Member Advisory Committee - Seat Descriptions

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
C. CalOptima Health Policy GA.5004: Travel and Business Meal Policy
D. CalOptima Health Policy GA.8012: Conflicts of Interest
~~C.~~E. CalOptima Board Resolution 2-14-95
~~D.~~F. CalOptima Board Resolution 06-0707
~~E.~~G. CalOptima Board Resolution 11-1103
~~F.~~H. CalOptima Board Resolution 13-0307
~~G.~~I. CalOptima Board Resolution 15-08-06-02
~~H.~~J. CalOptima Board Resolution 16-08-04-02

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/15/2014	Department of Health Care Services (DHCS)	Approved as Submitted
08/11/2017	Department of Health Care Services (DHCS)	Approved as Submitted
06/27/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
02/14/1995	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
07/07/2006	Regular Meeting of the CalOptima Board of Directors
11/03/2011	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
05/07/2020	Regular Meeting of the CalOptima Board of Directors
08/06/2020	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/04/2016	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	07/01/2017	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	03/01/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/06/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	02/01/2022	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	12/01/2022	AA.1219a	Member Advisory Committee	Medi-Cal OneCare
Revised	TBD	AA.1219a	Member Advisory Committee	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Member	A beneficiary enrolled in a CalOptima Health program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
~~Social Determinants of Health (SDOH)~~	~~The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include: safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.~~
Social Drivers of Health (SDOH):	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.
Threshold Language	Medi-Cal: Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA). OneCare: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.

Policy:	AA.1219a
Title:	**Member Advisory Committee**
Department:	Executive Office
Section:	Clerk of the Board
CEO Approval:	*/s/*
Effective Date:	02/14/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the composition and role of CalOptima Health's Member Advisory Committee (MAC) and to establish a process for recruiting, evaluating, and selecting prospective candidates to CalOptima Health's MAC.

II. POLICY

A. As directed by CalOptima Health's Board of Directors (CalOptima Health Board), the MAC shall report to the CalOptima Health Board and shall provide advice and recommendations to the CalOptima Health Board relative to CalOptima Health's programs, and relevant policies and procedures affecting quality and Health Equity updates. CalOptima Health shall inform MAC members how their input was incorporated.

B. CalOptima Health's Board encourages Member involvement in CalOptima Health's programs.

C. CalOptima Health shall designate a staff member and maintain a written job description detailing the staff member's responsibilities, which includes having responsibility for managing the operations of the MAC in compliance with all statutory, regulatory, and contractual requirements.

D. MAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima Health Policies GA.8012: Conflicts of Interest and AA.1204: Gifts, Honoraria, and Travel Payments.

E. The composition of the MAC shall reflect the diversity of the health care consumer. All MAC members shall have direct or indirect contact with CalOptima Health Members.

F. An organization may have no more than one (1) employee or representative on the MAC at any one time.

G. An individual may participate in no more than one (1) CalOptima Health advisory committee at any one time.

H. In accordance with CalOptima Health Board Resolution Numbers 2-14-95 (effective February 14, 1995) and 23 1207-01 (effective December 7, 2023), MAC shall be comprised of seventeen (17) voting members, each seat representing a constituency served by CalOptima Health.

Back to Item

Back to Agenda

1. One (1) of the seventeen (17) positions is a standing seat and is held by the Social Services Agency (SSA).

2. The remaining sixteen (16) members shall serve staggered terms of three (3) years.

    a. Two (2) of the remaining sixteen (16) positions shall be a dedicated Medi-Cal Beneficiaries or Authorized Family Member seats.

    b. Four (4) of the sixteen (16) positions shall be dedicated to OneCare Member or Authorized Family Member seats.

    a. The three (3) year term shall coincide with CalOptima Health's fiscal year (i.e., July 1 through June 30).

    b. Effective July 1, 2023, staggered nominations shall occur at a rate of approximately one-third (1/3) of the membership each year.

    c. MAC members may serve no more than two (2) consecutive terms or the equivalent of six (6) consecutive years.

    d. MAC members shall be allowed to reapply after a hiatus of six (6) years.

3. MAC may include, but is not limited to, individuals representing, or that represent the interests of:

    a. Adult beneficiaries;

    b. Behavioral/Mental Health;

    c. Children;

    d. Family Support Representative;

    e. Foster children;

    f. Medi-Cal or Authorized Family Member beneficiaries;

    g. Member Advocate;

    h. OneCare Member or Authorized Family Member;

    i. Orange County SSA;

    j. Persons with disabilities;

    k. Persons with Special Needs;

    l. Recipients of CalWORKs; or

    m. Seniors.

4. The MAC shall carry out duties in accordance with DHCS contract requirements. Duties include, but are not limited to:

    a. Identifying and advocating for preventive care practices to be utilized by CalOptima Health;

    b. Involvement in developing and updating cultural and linguistic policy and procedure decisions including those related to Quality Improvement (QI), education, and operational and cultural competency issues affecting Members who speak a primary language other than English. The MAC may also advise on necessary Member or provider targeted services, programs, and trainings;

    c. Providing and making recommendations to CalOptima Health regarding the cultural appropriateness of communications, partnerships, and services;

    d. Reviewing Population Needs Assessment (PNA) findings and having a process to discuss improvement opportunities with an emphasis on Health Equity and Social Determinants of Health (SDOH); and

    e. Providing input and advice, including, but not limited to, the following:

        i. Culturally appropriate service or program design;

        ii. Priorities for health education and outreach program;

        iii. Member satisfaction survey results;

        iv. Findings of the PNA;

        v. Plan marketing materials and campaigns;

        vi. Communication of needs for network development and assessment;

        vii. Community resources and information;

        viii. Population Health Management (PHM);

        ix. Quality;

        x. Health delivery systems reforms to improve health outcomes;

        xi. Carved out services;

        xii. Coordination of care;

        xiii. Health Equity; and

        xiv. Accessibility of services.

5. CalOptima Health shall allow the MAC to provide input on selecting targeted health education, cultural and linguistic, and QI strategies, provide sufficient resources for the MAC to support the required MAC activities outlined above, including supporting the MAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys.

6. CalOptima Health shall provide a location for MAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants, and providing accommodations to allow all individuals to attend and participate in the meetings.

7. CalOptima Health shall draft written minutes of each MAC meeting and associated discussions. All minutes shall be posted on CalOptima Health's website and submitted to DHCS no later than forty-five (45) calendar days after each meeting.

8. CalOptima Health shall retain minutes for no less than ten (10) years and provide copies to DHCS, upon request.

9. CalOptima Health shall support MAC members in their MAC roles, including but not limited to providing resources to educate MAC members to ensure they are able to effectively participate in MAC meetings, providing transportation to MAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest MAC member participation possible.

10. CalOptima Health shall appoint one (1) member of the MAC to serve as CalOptima Health's representative to DHCS' Statewide Consumer Advisory Committee.

    a. The appointed MAC representative shall be reimbursed for eligible expenses associated with attending the DHCS Statewide Consumer Advisory Committee in accordance with CalOptima Health Policy GA.5004: Travel and Business Meal Policy.

I. Stipends

1. CalOptima Health may provide a reasonable per diem payment of up to fifty dollars ($50) per meeting to the Medi-Cal Member or Authorized Family Member beneficiaries representative and the OneCare Member or Authorized Family Member beneficiaries serving on the MAC. CalOptima Health shall maintain a log of each payment provided to the Member or family representative, including type and value, and shall provide such log to DHCS upon request.

2. Representatives of provider organizations, community-based organizations and consumer advocates are not eligible for stipends.

J. The MAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. The MAC shall conduct an annual recruitment and nomination process.

    a. At the end of each fiscal year, approximately one-third (1/3) of the MAC seats' terms expire, alternating between six (6) vacancies, one (1) year and four (4) vacancies each of the following two (2) years. The standing seat on the MAC is not impacted by term expiration.

2. The MAC shall conduct a recruitment and nomination process if a seat is vacated mid-term.

    a. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full three (3) year term.

K. Special Elections

1. Special elections for the MAC shall occur under the following circumstances:

    a. A MAC seat is vacant due to the resignation of a sitting MAC member; or

    b. The current MAC member is deemed unqualified to serve in his or her current capacity as a MAC member.

        i. Every effort will be made to replace the vacant seat within sixty (60) calendar days from the date the seat is vacated.

2. Any new MAC member appointed to fill an open seat created mid-term shall serve the remainder of the resigning member's term.

L. MAC Vacancies

1. If a vacancy occurs prior to the start of the nomination process, there shall be no need for a special election and the vacant seat shall be filled during that nomination process.

2. If a vacancy occurs after the annual nomination process is complete, a special election may be conducted to fill the open seat, subject to approval by the MAC.

M. On a bi-annual basis, the MAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-E of this policy.

1. The MAC chair and vice chair may serve one (1) two (2) year term.

2. The MAC chairperson or vice chair may be removed by a majority vote from CalOptima Health's Board.

N. To establish a nomination ad hoc subcommittee, the MAC chair or vice chair shall ask for three (3) to four (4) members to serve on the ad hoc subcommittee. MAC members, who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.

1. The MAC nomination ad hoc subcommittee shall:

    a. Review, evaluate, and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-E of this policy; and

    b. Forward the prospective chair, vice chair and slate of candidate(s) to the full MAC for consideration.

2. Following approval from the MAC, the recommended chair, vice chair and slate of candidate(s) shall be forwarded to CalOptima Health's Board for review and approval.

O. CalOptima Health's Board shall review and have final approval for all appointments, reappointments, and chair and vice chair appointments to the MAC.

P. MAC members shall attend all regularly scheduled meetings unless they have an excused absence. An absence shall be considered excused if a MAC member provides notification of an absence to CalOptima Health staff prior to the MAC meeting. CalOptima Health staff shall maintain an

attendance log of the MAC members' attendance at MAC meetings. Upon request from the MAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima Health staff shall provide a copy of the attendance log to the requester. In addition, the MAC chair or vice chair shall contact any committee member who has three consecutive unexcused absences.

1. MAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. MAC composition

1. The composition of MAC shall reflect the cultural diversity and special needs of the CalOptima Health population.

2. Specific agency representatives shall serve on the MAC as standing members.

   a. The SSA representative shall serve as a standing member and shall not be subject to reapplying.

B. MAC meeting frequency

1. The MAC shall hold its first regular meeting promptly after all initial members have been selected by the MAC selection committee and at least quarterly thereafter.

2. The MAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. MAC meetings shall be open to the public, in person or virtually, meeting information shall be posted publicly on CalOptima Health's MAC webpage thirty (30) calendar days prior to the meeting, and in no event later than seventy-two (72) hours prior to the meeting.

4. Attendance by a simple majority of appointed members shall constitute a quorum.

   a. A quorum must be present for any votes to be valid.

C. MAC recruitment process

1. CalOptima Health shall begin recruitment of potential candidates in February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima Health population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima Health shall recruit potential candidates utilizing a variety of notification methods, which may include, but are not limited to, the following:

   a. Outreach to the respective Member community;

   b. Placement of vacancy notices on the CalOptima Health Website

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.

4. During the MAC meeting held before June 30 of a recruitment year for the chair and vice chair, the current chair or vice-chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. The candidates are requested to submit a letter of interest for these positions.

D. CalOptima Health shall conduct a special election with a truncated recruitment process to fill a MAC seat that has been vacated mid-term.

E. MAC nomination process

1. The MAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination ad hoc subcommittee.

   a. At the discretion of the MAC nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the MAC nomination ad hoc subcommittee meeting:

   a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the Applicant Evaluation Tool.

   b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair.

   c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the expiring seats by using the findings from the Applicant Evaluation Tool, the attendance record if relevant, and the prospective candidate's references.

F. MAC selection and approval process for prospective chair, vice chair and MAC candidates

1. Upon selection of a recommendation for a slate of candidates, the ad hoc subcommittee shall forward its recommendation to the MAC for consideration.

2. Following consideration, the MAC's recommendation for a slate of candidates shall be submitted to CalOptima Health's Board for review and final approval.

3. Chair and vice chair candidates who submitted a letter of interest will be reviewed at the first MAC meeting of the fiscal year and the members will vote on their candidate of choice for both positions. Candidates must have a quorum of members approving their recommendation in order to be submitted to CalOptima Health's Board for appointment.

4. Following CalOptima Health's Board approval of MAC's recommendation, the new MAC members' terms shall be effective July 1.

   a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following MAC meeting.

5. CalOptima Health shall provide new MAC members with a new member orientation.

G. CalOptima Health shall complete and submit to DHCS an annual MAC member demographic report by April 1 of each year.

IV. ATTACHMENT(S)

A. Member Advisory Committee - Consumer Application
B. Member Advisory Committee - Community Application
C. Member Advisory Committee - Applicant Evaluation Tool
D. Member Advisory Committee - Seat Descriptions

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
C. CalOptima Health Policy GA.5004: Travel and Business Meal Policy
D. CalOptima Health Policy GA.8012: Conflicts of Interest
E. CalOptima Board Resolution 2-14-95
F. CalOptima Board Resolution 06-0707
G. CalOptima Board Resolution 11-1103
H. CalOptima Board Resolution 13-0307
I. CalOptima Board Resolution 15-08-06-02
J. CalOptima Board Resolution 16-08-04-02

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/15/2014	Department of Health Care Services (DHCS)	Approved as Submitted
08/11/2017	Department of Health Care Services (DHCS)	Approved as Submitted
06/27/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
02/14/1995	Regular Meeting of the CalOptima Board of Directors
07/07/2006	Regular Meeting of the CalOptima Board of Directors
11/03/2011	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
05/07/2020	Regular Meeting of the CalOptima Board of Directors
08/06/2020	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/04/2016	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	07/01/2017	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	03/01/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/06/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	02/01/2022	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	12/01/2022	AA.1219a	Member Advisory Committee	Medi-Cal OneCare
Revised	TBD	AA.1219a	Member Advisory Committee	Medi-Cal OneCare

1

IX. GLOSSARY

Term	Definition
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Member	A beneficiary enrolled in a CalOptima Health program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Social Drivers of Health (SDOH):	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.
Threshold Language	Medi-Cal: Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA). OneCare: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.

MEMBER ADVISORY COMMITTEE
CalOptima Health Member Application

Instructions: Please answer all questions. You may write or type your answers. If you have any questions regarding the application, call 1-714-347-5785.

Name: _____ Phone: _____

Address: _____ Cell: _____

City, State, ZIP: _____ Fax: _____

Email: _____

I hereby submit my application for the following Member Advisory Committee (MAC) seat, and I understand that service on the MAC is on a voluntary basis and if selected I will receive a $50 stipend for meetings attended:

☐ **Medi-Cal beneficiaries or family member representative**
☐ **OneCare member or family member representative**

Current position (e.g., title, student, volunteer, retired): _____

_____

1a. What is your direct or indirect experience working with the CalOptima Health population you wish to represent on the MAC?

_____

_____

_____

1b. Include any relevant community experience.

_____

_____

_____

2a. What is your understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County?

Back to Item

Back to Agenda

2b. Include relevant experience related to working with diverse populations.

3. What is your current understanding of managed care systems and/or CalOptima Health?

4a. Please explain why you wish to serve on CalOptima Health's MAC.

4b. Please explain why you would be a qualified representative to serve on the MAC.

5. Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic

6. If selected, are you able to commit to a monthly MAC meeting as well as serve on at least one subcommittee? ☐ Yes ☐ No

Back to Item

Back to Agenda

7. References (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the MAC? ☐ Yes ☐ No

If selected as a representative on MAC, do you agree that you will complete the required annual compliance courses within the appointed time frame? ☐ Yes ☐ No

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the board materials that are available on CalOptima Health's website and, even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

Back to Item

Back to Agenda

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal is a private matter that may only be disclosed by CalOptima Health as necessary to administer the Medi-Cal program, unless other disclosures are authorized by the eligible member. Because the position of Consumer Representative on the Member Advisory Committee requires that the person appointed must be a member, the member's Medi-Cal eligibility will be disclosed to the general public. The member should check the box below and sign this waiver to allow his or her name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT**

I understand that by signing below and applying to serve on the MAC, I am disclosing my eligibility for the Medi-Cal program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

_____

Member (Printed Name)

_____ _____

Member (Signature) Date

Back to Item

Back to Agenda

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Federal HIPAA Privacy Regulations require that you complete this form to authorize CalOptima Health to use or disclose your protected health information (PHI) to another person or organization. Please complete, sign and return the form to CalOptima Health.

Date of Request: _____ Phone: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima Health, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific):

Medi-Cal beneficiary status and any information member chooses to disclose in connection with his or her application for appointment to the CalOptima Health Member Advisory Committee (MAC).

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow service as beneficiary representative on the CalOptima Health Member Advisory Committee (MAC).**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the applied-for position.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

Attn: Cheryl Simmons
CalOptima Health
505 City Parkway West
Orange CA 92868

I understand that a revocation will not affect the ability of CalOptima Health or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

*** Revocation of this authorization will immediately terminate involvement in the MAC.*

RESTRICTIONS:

I understand that certain information (e.g., Medi-Cal beneficiary status and name) used or disclosed as a result of my signing this authorization may be further used or disclosed in accordance with the California Public Records Act. Information precluded from the Public Records Act maintained by CalOptima Health will not be

Back to Item
Back to Agenda

used or disclosed unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Submit the completed application, your biography or resume, and signed authorization forms to:

Attn: Cheryl Simmons
CalOptima Health
505 City Parkway West
Orange CA 92868

For questions, call **1-714-347-5785**

Back to Item

Back to Agenda

MEMBER ADVISORY COMMITTEE APPLICATION

Instructions: Please answer all questions. You may write or type your answers. Please use a separate sheet if necessary. If you have any questions regarding the application, please call Cheryl Simmons at 714-347-5785.

Name: _____ Work Phone: _____

Address: _____ Cell Phone: _____

City, State, ZIP: _____ Fax: _____

Email: _____ Date: _____

I hereby submit my application for the following Member Advisory Committee (MAC) seat(s), and I understand that service on the MAC is on a voluntary basis:

- ☐ **Behavioral/Mental Health Representative**
- ☐ **Children Representative**
- ☐ **Member Advocate Representative**
- ☐ **Persons with Special Needs Representative**

Current position and tenure (i.e., employee, student, volunteer, retired, agency, etc.).

_____

_____

_____

Education and/or licenses (if applicable):

_____

_____

_____

_____

_____

Back to Item

Back to Agenda

What is your direct or indirect experience working with the CalOptima Health population you wish to represent on MAC? Please include any relevant community experience.

Explain your ability and specific plan to reach out for input and communicate with the CalOptima Health population you would represent on the MAC (i.e., primary professional/trade association(s), stakeholder involvement, etc.)

Please list similar committees on which you have served or describe your ability to collaborate in a multidisciplinary way.

What is your understanding, experience, and familiarity with the diverse cultural community in Orange County?

What is your current understanding and experience with CalOptima Health programs?

Back to Item

Back to Agenda

_____

_____

_____

Please explain why you wish to serve on the MAC and how you might uniquely contribute to this advisory committee on behalf of all CalOptima Health members.

_____

_____

_____

_____

Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic

Include a biography or résumé and two references (below) with this application. **Submitting letters of recommendation from your references is preferred but not required.**

1) Professional
2) Community or Personal

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email: _____

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email: _____

If selected, are you able to commit to attend all regularly scheduled bi-monthly MAC meetings and volunteer to serve on at least one subcommittee? ☐ Yes ☐ No

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the MAC? ☐ Yes ☐ No

If selected as a representative on the MAC, do you agree that you will complete the required annual compliance courses within the appointed time frame? ☐ Yes ☐ No

All Member Advisory Committee Representatives are appointed by the CalOptima Health Board of Directors and are subject to the CalOptima Health Code of Conduct.

Back to Item

Back to Agenda

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published with the contact information removed, as part of the Board materials that are available on CalOptima Health's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Submit this application, along with a biography or résumé and the preferred but optional letters of recommendation to:

Attn: Cheryl Simmons
CalOptima Health
505 City Parkway West
Orange CA 92868

Phone: **1-714-347-5785** Fax: **1-714-571-2479** Email: csimmons@caloptima.org

Back to Item

Back to Agenda

Attachment C

Applicant Name:

Member Advisory Committee

Position Applying for:

Applicant Evaluation Tool (use one per applicant)

Please rate questions 1 through 5 based on how well the applicant satisfies the following statements where:
5 is Excellent **4** is Very good **3** is Average **2** is Fair **1** is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1a. Direct or indirect experience working with members the applicant wishes to represent	1–5	
1b. Include relevant community involvement	1–5	
2a. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	
2b. Include relevant experience with diverse populations	1–5	
3. Knowledge of managed care systems and/or CalOptima Health programs	1–5	
4a. Expressed desire to serve on the MAC	1–5	
4b. Explanation why applicant is a qualified representative	1–5	
5. Ability to speak one of the threshold languages (other than English)	Yes / No	
6. Availability and willingness to attend meetings	Yes / No	
7. Supportive references	Yes / No	

Total Possible Points 35

_____

Name of MAC Evaluator

Total Points Awarded _____

Back to Item

Back to Agenda

~~2022~~ 2023 MAC Position Description

Adult Beneficiaries Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima adult members in pursuit of their health and wellness
- At least three years of employment in the field and/or three years of experience in field or "is a member with lived-experience"
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Behavioral/Mental Health Representative (Formerly Persons with Mental Illness Representative)

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members with behavioral/mental health needs such as:
  - Licensed Clinical Social Worker (LCSW)
  - Marriage and Family Therapist (MFT)
  - Mental Health Facility or Hospital Psychiatric Facility
  - Psychologists
  - Psychiatrist
  - Registered Psychiatric Nurse (Psych RN)
  - Multi-Specialty Clinics/Group Practice
  - Community Mental Health Center
  - Board Certified Behavior Analyst-D (BCBA-D)
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Medi-Cal children in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

~~***Consumer Representative***~~

~~**Position Description**~~

- ~~Must be a current CalOptima Medi-Cal member~~
- ~~Understanding and familiarity with the diverse cultural and/or social environments of Orange County~~
- ~~Availability and willingness to attend regular, special and ad hoc MAC meetings~~
- ~~All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks~~

Family Support Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima families in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Foster Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima foster children in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience representing CalOptima members directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Member Advocate Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members in pursuit of their health and wellness
- When license or credential is required, applicant must have an active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima's Members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Medi-Cal Beneficiaries Representative (two seats)

Position Description

- Current CalOptima Medi-Cal member or current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Medi-Cal beneficiaries
- When license or credential is required, applicant must have an active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima Medi-Cal members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings

- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

OneCare Member or Authorized Family Member Representative (~~two~~ four seats)

Position Description

- Must be a current CalOptima OneCare member or authorized family member
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Persons with Disabilities Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima persons with disabilities in pursuit of their health and wellness
- Candidate should represent an organization that does advocacy work on behalf of persons with disabilities with either direct medical or non-medical services for Medi-Cal members of all ages
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s) and local chapters.
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Persons with Special Needs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima persons with special needs in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings

- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Recipients of CalWORKs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima CalWORKs members in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience as a CalWORKs recipient or representative
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Seniors Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input, and advocate for CalOptima seniors including, but not limited to:
  - Community Based Adult Services (CBAS) Centers
  - Community-Based Organization (CBO)
  - Senior centers
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Social Services Representative (Standing Seat)

Position Description

- Represents CalOptima members and is appointed by the Orange County Social Services Agency
- No term limits
- Must have understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings

- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

MAC Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate all MAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison between MAC and the Board of Directors
- Provides MAC Report to CalOptima Board of Directors' monthly meetings
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

MAC Vice-Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate in absence of the MAC Chair all MAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison in absence of the MAC Chair between MAC and the Board of Directors
- Provide MAC Report to CalOptima Board of Directors' at monthly meetings when MAC Chair is unavailable
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

2023 MAC Position Description

Adult Beneficiaries Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima adult members in pursuit of their health and wellness
- At least three years of employment in the field and/or three years of experience in field or "is a member with lived-experience"
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Behavioral/Mental Health Representative (Formerly Persons with Mental Illness Representative)

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members with behavioral/mental health needs such as:
  - Licensed Clinical Social Worker (LCSW)
  - Marriage and Family Therapist (MFT)
  - Mental Health Facility or Hospital Psychiatric Facility
  - Psychologists
  - Psychiatrist
  - Registered Psychiatric Nurse (Psych RN)
  - Multi-Specialty Clinics/Group Practice
  - Community Mental Health Center
  - Board Certified Behavior Analyst-D (BCBA-D)
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Medi-Cal children in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Family Support Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima families in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Foster Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima foster children in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience representing CalOptima members directly
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Member Advocate Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members in pursuit of their health and wellness
- When license or credential is required, applicant must have an active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima's Members
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Medi-Cal Beneficiaries Representative (two seats)

Position Description

- Current CalOptima Medi-Cal member or current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Medi-Cal beneficiaries
- When license or credential is required, applicant must have an active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima Medi-Cal members
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OneCare Member or Authorized Family Member Representative (four seats)

Position Description

- Must be a current CalOptima OneCare member or authorized family member
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
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Persons with Disabilities Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima persons with disabilities in pursuit of their health and wellness
- Candidate should represent an organization that does advocacy work on behalf of persons with disabilities with either direct medical or non-medical services for Medi-Cal members of all ages
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Persons with Special Needs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima persons with special needs in pursuit of their health and wellness
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Seniors Representative

Position Description

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  - Senior centers
- When license or credential is required, applicant must have active CA license/credential as appropriate
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MAC Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
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MAC Vice-Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate in absence of the MAC Chair all MAC meetings using standard meeting rules of order
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- Liaison in absence of the MAC Chair between MAC and the Board of Directors
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- Two-year term
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CalOptima Health Community Outreach Summary — November and December 2023

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

CalOptima Health took a proactive approach to address the growing concerns about opioid use and accidental overdoses in Orange County by presenting an InfoSeries webinar on October 19. Bringing together an array of community stakeholders, healthcare partners and advocates, the InfoSeries featured a diverse panel of experts to shed light on the multifaceted aspects of the crisis and provide a better understanding of the risks of accidental overdoses.

In addition, reflecting our ongoing commitment to boost overdose awareness and preparedness for our members and the larger community, CalOptima Health hosted a Naloxone Member Distribution Event at our 505 building on December 2. The event provided crucial education on the opioid crisis in Orange County and equipped community members to respond quickly in an overdose situation. During the event, attendees accessed essential resources, gained insights from experts and had the opportunity to obtain life-saving naloxone.

Summary of Public Activities

As of November 15, CalOptima Health plans to participate in, organize or convene 59 public activities in November and December. In November, there were 33 public activities, including 19 virtual community/collaborative meetings, seven community-based presentations, six community events and one Health Network Forum. In December, there will be 26 public activities, including 19 virtual community/collaborative meetings, three community-based presentations, three community events, one Health Network Forum and one Cafecito meeting. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided no endorsements since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

CalOptima Health

Attachment to the December 7, 2023, CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in November and December 2023:

November 2023

November 1, 10–11 a.m., CalOptima Health Medi-Cal Overview in Spanish

Mitchell Development Center, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

November 3, 11:30 a.m.–1:30 p.m., Day of the Dead, hosted by the Anaheim Community Services Department

Pearson Park, 401 Lemon St., Anaheim

- Sponsorship fee: $5,000; included resource table at event, logo on all marketing materials and social media posts, display of banners throughout event, and recognition on main stage.
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

November 4, 8:30 a.m.–2 p.m., 15th Annual Alzheimer's Latino Conference, hosted by Alzheimer's Orange County

Templo Calvario Church, 2501 W. 5 St., Santa Ana

- Sponsorship fee: $2,000; included resource table at the event; recognition at the event during opening ceremonies; acknowledgment in press releases; advertisements one month prior to conference (radio, magazine, website and newspaper); organization's logo prominently placed around conference, on event agenda and in looping acknowledgment video; organization's information placed in event goody bag; lunch for two attendees; and certificate of recognition.
- At least two staff members attended (in person).
- Health/resource fair, open to the public.

November 4, 11:30 a.m.–1:30 p.m., Senior Resource Fair, hosted by the Office of U.S. Representative Michelle Steel

Dieu Ngu Temple, 14472 Chestnut St., Westminster

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

November 4, 10 a.m.–2 p.m., Community Health and Resource Fair, hosted by Senator Tom Umberg

Independence Park, 801 W. Valencia Dr., Fullerton

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

November 5, 9 a.m.–2 p.m., Free Annual Health Fair, hosted by the Vietnamese Physician Association of Southern California

Mile Square Park-Freedom Hall, 16801 Euclid St., Fountain Valley

- Sponsorship fee: $6,000; included resource table at the event, name on event flier, recognition at the event during opening ceremonies, acknowledgment in radio and newspaper, banner display, materials in attendee gift bag, email blast, and website and social media mentions.
- At least two staff members attended (in person).
- Health/resource fair, open to the public.

November 7, 9–10 a.m., CalOptima Health Medi-Cal Overview in Spanish

Willard Intermediate School, 1342 N. Ross St., Santa Ana

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

November 8, 5:30–6:30 p.m., CalOptima Health Medi-Cal Overview in Spanish

Sunburst Youth Academy, 4022 Saratoga Ave., Los Alamitos

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

November 13, 6–7 p.m., CalOptima Health Medi-Cal Overview in English

Willard Intermediate School, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

November 14, 7:45–8:45 a.m., CalOptima Health Medi-Cal Overview in English

Anaheim Elementary School District, 1001 S. East St., Anaheim

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

November 18, 10 a.m.–2 p.m., Medi-Cal and CalFresh Event, hosted by the Office of Supervisor Andrew Do

Thuan Phat, 15440 Beach Blvd., Westminster

- At least one staff member attended (in person).
- Health/resource fair, open to the public.

November 29, 11 a.m.–Noon, CalOptima Health Medi-Cal Overview in Spanish

Hermosa Village Apartments, 1515 S. Calle Del Mar, Anaheim

- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

November 29, 10–11 a.m., CalOptima Health Medi-Cal Overview in English

Laura's House, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community.

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

December 2023

December 1, 10–11 a.m., CalOptima Health Medi-Cal Overview in Spanish
Santa Ana Senior Center, 424 W. 3rd St., Santa Ana
- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

December 2, 9 a.m.–Noon, Kid Builder Community Resource Fair, hosted by First 5 OC and the Office of Supervisor Andrew Do
Oak View Family Resource Center, 17261 Oak Ln., Huntington Beach
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

December 2, 9 a.m.–1 p.m., Naloxone Distribution Event, hosted by CalOptima Health
CalOptima Health, 505 City Pkwy W., Orange
- At least seven staff members attended (in person).
- Health/resource fair, open to the public.

December 5, 9–10:30 a.m., Cafecito Meeting
CalOptima Health, 505 City Pkwy W., Orange
- At least nine staff members attended.
- Steering committee meeting, open to collaborative members.

December 6, 4–7 p.m., Flu and COVID Health Clinic, hosted by Latino Health Access
Latino Health Access, 450 W. 4th St., Santa Ana
- At least one staff member attended (in person).
- Health/resource fair, open to the public.

December 7, 8:30–9:30 a.m., CalOptima Health Medi-Cal Overview in Spanish
Lathrop Intermediate School, 1111 S. Broadway, Santa Ana
- At least one staff member presented (in person).
- Community-based organization presentation, open to members/community.

December 20, 3–4:30 p.m., CalOptima Health Medi-Cal Overview in English
Rob Richardson Welcoming Center, 1801 S. Poplar St., Santa Ana
- At least one staff member to present (in person).
- Community-based organization presentation, open to members/community.

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

Financial Summary

October 31, 2023

Board of Directors Meeting
December 7, 2023

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.

Back to Agenda

Financial Highlights: October 2023

October 2023					July - October 2023			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
969,731	943,283	26,448	2.8%	Member Months	3,918,738	3,871,201	47,537	1.2%
388,532,137	345,327,000	43,205,137	12.5%	Revenues	1,616,176,101	1,414,821,271	201,354,830	14.2%
346,213,367	325,884,671	(20,328,696)	(6.2%)	Medical Expenses	1,468,149,251	1,319,139,901	(149,009,350)	(11.3%)
18,171,859	20,782,838	2,610,979	12.6%	Administrative Expenses	71,778,684	82,359,797	10,581,113	12.8%
24,146,911	(1,340,509)	25,487,420	1901.3%	Operating Margin	76,248,166	13,321,573	62,926,593	472.4%
13,896,639	2,083,330	11,813,309	567.0%	Net Investment Income/Expense	51,328,576	8,333,320	42,995,256	515.9%
(38,549)	(89,380)	50,831	56.9%	Net Rental Income/Expense	29,080	(187,519)	216,599	115.5%
-	(1,003,219)	1,003,219	(100.0%)	Grant Expense	(28,965,738)	(24,012,877)	(4,952,860)	(20.6%)
15	-	15	100.0%	Other Income/Expense	(830,003)	-	(830,003)	(100.0%)
13,858,105	990,731	12,867,374	1298.8%	Total Non-Operating Income (Loss)	21,561,915	(15,867,076)	37,428,991	235.9%
38,005,016	**(349,778)**	**38,354,795**	**10965.5%**	**Change in Net Assets**	**97,810,081**	**(2,545,503)**	**100,355,584**	**3942.5%**
89.1%	*94.4%*	*(5.3%)*		*Medical Loss Ratio*	*90.8%*	*93.2%*	*(2.4%)*	
4.7%	*6.0%*	*1.3%*		*Administrative Loss Ratio*	*4.4%*	*5.8%*	*1.4%*	
89.1%	*94.4%*	*(5.3%)*		**MLR (excluding Directed Payments)*	*90.0%*	*93.2%*	*(3.2%)*	
4.7%	*6.0%*	*1.3%*		**ALR (excluding Directed Payments)*	*4.9%*	*5.8%*	*1.0%*	

Back to Agenda

CalOptima Health

Financial Highlights Notes: October 2023

- Notable events/items in October 2023
  - $148.4 million of Calendar Year (CY) 2022 Hospital Quality Assurance Fee (HQAF) Program disbursed*
  - $138.2 million of Phase II of CY 2021 Hospital Directed Payments (DP) disbursed

*Note: Includes approximately $1.0 million in prior year adjustments

Back to Agenda

CalOptima Health

FY 2023-24: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) October 2023: $38.0 million, favorable to budget $38.4 million or 10,965.5% driven primarily by slower disenrollment in Medi-Cal, favorable performance and net investment income
  - Year To Date (YTD) July - October 2023: $97.8 million, favorable to budget $100.4 million or 3,942.5% due to favorable performance and net investment income
- Enrollment
  - MTD: 969,731 member months, favorable to budget 26,448 or 2.8%
  - YTD: 3,918,738 member months, favorable to budget 47,537 or 1.2%

Back to Agenda

CalOptima Health

FY 2023-24: Management Summary (cont.)

- Revenue
  - MTD: $388.5 million, favorable to budget $43.2 million or 12.5% driven by the Medi-Cal (MC) Line of Business (LOB)
    - Due primarily to favorable enrollment, Proposition 56 risk corridor and net impact of rate change to Unsatisfactory Immigration Status/Satisfactory Immigration Status (UIS/SIS)
  - YTD: $1,616.2 million, favorable to budget $201.4 million or 14.2% driven primarily by CY 2022 Hospital DP and favorable enrollment

Back to Agenda

CalOptima Health

FY 2023-24: Management Summary (cont.)

- Medical Expenses
  - MTD: $346.2 million, unfavorable to budget $20.3 million or 6.2%
    - Due to increased Proposition 56, crossover, and Community Support claims and Shared Risk Pool updates
  - YTD: $1,468.1million, unfavorable to budget $149.0 million or 11.3% driven primarily by CY 2022 Hospital DP

Back to Agenda

FY 2023-24: Management Summary (cont.)

- Administrative Expenses
  - MTD: $18.2 million, favorable to budget $2.6 million or 12.6%
  - YTD: $71.8 million, favorable to budget $10.6 million or 12.8%

- Non-Operating Income (Loss)
  - MTD: $13.9 million, favorable to budget $12.9 million or 1,298.8%
  - YTD: $21.6 million, favorable to budget $37.4 million or 235.9% due primarily to net investment income

Back to Agenda

CalOptima Health

FY 2023-24: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 89.1% (89.1% excluding DP), Budget 94.4%
  - YTD: Actual 90.8% (90.0% excluding DP), Budget 93.2%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 4.7% (4.7% excluding DP), Budget 6.0%
  - YTD: Actual 4.4% (4.9% excluding DP), Budget 5.8%

- Balance Sheet Ratios
  - Current ratio*: 1.6
  - Board Designated Reserve level: 1.83
  - Net-position: $1.8 billion, including required Tangible Net Equity (TNE) of $111.1 million

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

Back to Agenda

CalOptima Health

Enrollment Summary: October 2023

October					July - October 2023			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
143,314	139,465	3,849	2.8%	SPD	573,386	564,126	9,260	1.6%
297,811	311,329	(13,518)	(4.3%)	TANF Child	1,204,264	1,261,235	(56,971)	(4.5%)
140,960	127,841	13,119	10.3%	TANF Adult	571,126	525,069	46,057	8.8%
2,819	3,118	(299)	(9.6%)	LTC	11,779	12,472	(693)	(5.6%)
355,451	331,913	23,538	7.1%	MCE	1,439,865	1,390,240	49,625	3.6%
11,177	11,401	(224)	(2.0%)	WCM	45,475	45,520	(45)	(0.1%)
951,532	**925,067**	**26,465**	**2.9%**	**Medi-Cal Total**	**3,845,895**	**3,798,662**	**47,233**	**1.2%**
17,757	**17,750**	**7**	**0.0%**	**OneCare**	**71,103**	**70,701**	**402**	**0.6%**
442	**466**	**(24)**	**(5.2%)**	**PACE**	**1,740**	**1,838**	**(98)**	**(5.3%)**
494	**568**	**(74)**	**(13.0%)**	**MSSP**	**2,000**	**2,272**	**(272)**	**(12.0%)**
969,731	**943,283**	**26,448**	**2.8%**	**CalOptima Health Total**	**3,918,738**	**3,871,201**	**47,537**	**1.2%**

*CalOptima Health Total does not include MSSP

Back to Agenda

CalOptima Health

Consolidated Revenue & Expenses: October 2023 MTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	596,081	355,451	951,532	17,757		442	494	969,731
REVENUES								
Capitation Revenue	217,461,976	$ 134,428,208	$ 351,890,184	$ 32,671,385	$ (13,722)	$ 3,777,538	$ 206,752	$ 388,532,137
Total Operating Reven	**217,461,976**	**134,428,208**	**351,890,184**	**32,671,385**	**(13,722)**	**3,777,538**	**206,752**	**388,532,137**
MEDICAL EXPENSES								
Provider Capitation	65,837,768	50,457,353	116,295,122	13,069,456				129,364,577
Claims	74,397,742	47,422,990	121,820,733	5,482,813	30,830	1,683,715		129,018,091
MLTSS	42,386,708	5,708,706	48,095,414	(245,824)		110,815	26,717	47,987,122
Prescription Drugs	(2,242)		(2,242)	9,680,066	(3,605)	514,834		10,189,053
Case Mgmt & Other Medic	14,820,555	11,961,989	26,782,544	1,555,753	56,607	1,107,172	152,447	29,654,523
Total Medical Expense	**197,440,532**	**115,551,039**	**312,991,572**	**29,542,263**	**83,832**	**3,416,536**	**179,164**	**346,213,367**
Medical Loss Ratio	*90.8%*	*86.0%*	*88.9%*	*90.4%*	*-610.9%*	*90.4%*	*86.7%*	*89.1%*
GROSS MARGIN	**20,021,444**	**18,877,168**	**38,898,613**	**3,129,122**	**(97,554)**	**361,002**	**27,588**	**42,318,770**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			10,939,477	1,001,893		167,139	92,792	12,201,302
Non-Salary Operating Expenses			2,236,878	411,891		3,923	1,337	2,654,029
Depreciation & Amortization			1,016,088			1,118		1,017,206
Other Operating Expenses			1,790,436	123,103		9,316	5,965	1,928,820
Indirect Cost Allocation, Occupancy			(522,962)	873,504		14,059	5,900	370,502
Total Administrative Expenses			**15,459,918**	**2,410,391**	**-**	**195,556**	**105,993**	**18,171,859**
Administrative Loss Ratio			*4.4%*	*7.4%*	*0.0%*	*5.2%*	*51.3%*	*4.7%*
Operating Income/(Loss)			**23,438,695**	**718,731**	**(97,554)**	**165,445**	**(78,405)**	**24,146,911**
Investments and Other Non-Operating			15					13,858,105
CHANGE IN NET ASSETS			**$ 23,438,710**	**$ 718,731**	**$ (97,554)**	**$ 165,445**	**$ (78,405)**	**$ 38,005,016**
BUDGETED CHANGE IN NET ASSETS			1,372,808	(2,660,563)	-	20,106	(72,860)	(349,778)
Variance to Budget - Fav/(Unfav)			$ 22,065,902	$ 3,379,294	$ (97,554)	$ 145,339	$ (5,545)	$ 38,354,795

Back to Agenda

CalOptima Health

Consolidated Revenue & Expenses: October 2023 YTD

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	2,406,030	1,439,865	3,845,895	71,103		1,740	2,000	3,918,738
REVENUES								
Capitation Revenue	850,207,465	$ 623,494,858	$1,473,702,323	$ 128,137,448	$ (1,367,126)	$ 14,851,557	$ 851,899	$ 1,616,176,101
Total Operating Reven	**850,207,465**	**623,494,858**	**1,473,702,323**	**128,137,448**	**(1,367,126)**	**14,851,557**	**851,899**	**1,616,176,101**
MEDICAL EXPENSES								
Provider Capitation	248,211,262	197,505,377	445,716,638	51,768,825				497,485,464
Claims	294,773,792	191,232,548	486,006,339	26,505,839	(26,366)	6,123,040		518,608,851
MLTSS	164,452,085	21,848,297	186,300,382	-	(17,616)	111,412	91,101	186,485,279
Prescription Drugs	(11,660)		(11,660)	34,635,423	(1,822,950)	1,891,936		34,692,749
Case Mgmt & Other Medic	130,149,274	90,429,745	220,579,019	5,112,777	90,779	4,478,206	616,127	230,876,908
Total Medical Expense	**837,574,752**	**501,015,967**	**1,338,590,719**	**118,022,864**	**(1,776,154)**	**12,604,595**	**707,227**	**1,468,149,251**
Medical Loss Ratio	*98.5%*	*80.4%*	*90.8%*	*92.1%*	*129.9%*	*84.9%*	*83.0%*	*90.8%*
GROSS MARGIN	**12,632,713**	**122,478,891**	**135,111,604**	**10,114,584**	**409,028**	**2,246,962**	**144,672**	**148,026,850**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			42,761,262	3,948,408	(0)	627,263	380,424	47,717,357
Non-Salary Operating Expenses			7,887,128	1,197,784	(4,364)	52,338	5,356	9,138,243
Depreciation & Amortization			3,528,579			4,494		3,533,073
Other Operating Expenses			9,515,752	262,117		41,453	18,949	9,838,271
Indirect Cost Allocation, Occupancy			(2,022,055)	3,494,017		56,178	23,601	1,551,741
Total Administrative Expenses			**61,670,666**	**8,902,326**	**(4,364)**	**781,726**	**428,330**	**71,778,684**
Administrative Loss Ratio			*4.2%*	*6.9%*	*0.3%*	*5.3%*	*50.3%*	*4.4%*
Operating Income/(Loss)			**73,440,938**	**1,212,258**	**413,392**	**1,465,237**	**(283,658)**	**76,248,166**
Investments and Other Non-Operating			(830,003)					21,561,915
CHANGE IN NET ASSETS			**$ 72,610,935**	**$ 1,212,258**	**$ 413,392**	**$ 1,465,237**	**$ (283,658)**	**$ 97,810,081**
BUDGETED CHANGE IN NET ASSETS			22,640,355	(9,252,540)	-	220,698	(286,940)	(2,545,503)
Variance to Budget - Fav/(Unfav)			$ 49,970,580	$ 10,464,798	$ 413,392	$ 1,244,539	$ 3,282	$ 100,355,584

Back to Agenda

CalOptima Health

Balance Sheet: As of October 2023

ASSETS	
Current Assets	
Operating Cash	$791,125,217
Short-term Investments	1,682,326,188
Receivables & Other Current Assets	480,637,243
Total Current Assets	**2,954,088,648**
Capital Assets	
Capital Assets	163,354,891
Less Accumulated Depreciation	(71,391,238)
Capital Assets, Net of Depreciation	91,963,653
Other Assets	
Restricted Deposits	300,000
Board Designated Reserve	613,915,703
Total Other Assets	**614,215,703**
TOTAL ASSETS	**3,660,268,003**
Deferred Outflows	**75,969,067**
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,736,237,070**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$13,031,171
Medical Claims Liability and Capitation Payable	1,671,424,685
Capitation and Withholds	143,261,615
Other Current Liabilities	54,410,021
Total Current Liabilities	**1,882,127,491**
Other Liabilities	
GASB 96 Subscription Liabilities	15,494,769
Postemployment Health Care Plan	19,157,815
Net Pension Liabilities	40,465,145
Total Other Liabilities	**75,117,729**
TOTAL LIABILITIES	**1,957,245,220**
Deferred Inflows	**11,175,516**
Net Position	
TNE	111,117,658
Funds in Excess of TNE	1,656,698,676
TOTAL NET POSITION	**1,767,816,334**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**3,736,237,070**

Back to Agenda

CalOptima Health

Board Designated Reserve and TNE Analysis: As of October 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	250,928,813				
	Tier 1 - MetLife	249,237,040				
Board Designated Reserve		500,165,853	359,099,361	560,620,941	141,066,492	(60,455,088)
	Tier 2 - Payden & Rygel	56,993,520				
	Tier 2 - MetLife	56,756,330				
TNE Requirement		113,749,850	111,117,658	111,117,658	2,632,192	2,632,192
	Consolidated:	**613,915,703**	**470,217,019**	**671,738,599**	**143,698,684**	**(57,822,896)**
	Current reserve level	*1.83*	*1.40*	*2.00*		

Back to Agenda

CalOptima Health

Net Assets Analysis: As of October 2023

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 10/31/2023	**$1,767.8**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**613.9**			**34.7%**
	Capital Assets, net of Depreciation[2]	**92.0**			**5.2%**
Resources Allocated[3]	Homeless Health Initiative[4]	$19.9	$59.9	$40.0	1.1%
	Housing and Homelessness Initiative Program[4]	69.3	97.2	27.9	3.9%
	Intergovernmental Transfers (IGT)	58.6	111.7	53.2	3.3%
	Digital Transformation and Workplace Modernization	66.2	100.0	33.8	3.7%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	6.4	8.0	1.6	0.4%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.7%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.9	1.0	0.1	0.1%
	General Awareness Campaign	0.9	2.7	1.8	0.1%
	Member Health Needs Assessment	0.8	1.0	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	147.8	153.5	5.7	8.4%
	Medi-Cal Annual Wellness Initiative	2.0	3.8	1.8	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.6%
	In-Home Care Pilot Program with the UCI Family Health Center	1.7	2.0	0.3	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.5	5.0	0.5	0.3%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	1.0%
	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	2.8%
	Distribution Event- Naloxone	2.5	15.0	12.5	0.1%
	Garden Grove Bldg Improvement	10.5	10.5	0.0	0.6%
	Post-Pandemic Supplemental	83.2	107.5	24.3	4.7%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	2.1%
	Subtotal:	**$622.9**	**$868.5**	**$245.6**	**35.2%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$439.0**			**24.8%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 92 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 summary and Allocated Funds for list of Board approved initiatives

Back to Agenda

CalOptima Health

Homeless Health Initiative and Allocated Funds: As of October 2023

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 & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Days, HCAP and FQHC Administrative Support	963,261	662,709	300,552
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine	8,276,652	2,489,000	5,787,652
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 39,981,061**	**$ 60,018,939**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 39,981,061**	**$ 19,918,939**

Notes:

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

Back to Agenda

CalOptima Health

Housing and Homelessness Incentive Program As of October 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	2,200,000	-
Pulse For Good	800,000	382,200	417,800
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	1,461,149	2,560,162
Infrastructure Projects	5,832,314	2,785,365	3,046,949
Capital Projects	73,247,369	21,000,000	52,247,369
System Change Projects	10,180,000	-	10,180,000
Non-Profit Healthcare Academy	354,530	56,013	298,517
Total of Approved Initiatives	**$ 97,235,524** [1]	**$ 27,884,727**	**$ 69,350,797**

Notes:

[1]Total funding $97.2M: $40.1M Board-approved reallocation from HHI, $22.3M from CalOptima Health existing reserves and $34.8M from DHCS HHIP incentive payments

Back to Agenda

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Back to Agenda

UNAUDITED FINANCIAL STATEMENTS

October 31, 2023

Back to Agenda

Table of Contents

Back to Agenda

CalOptima Health - Consolidated
Financial Highlights
For the Four Months Ending October 31, 2023

October 2023					July - October 2023			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
969,731	943,283	26,448	2.8%	Member Months	3,918,738	3,871,201	47,537	1.2%
388,532,137	345,327,000	43,205,137	12.5%	Revenues	1,616,176,101	1,414,821,271	201,354,830	14.2%
346,213,367	325,884,671	(20,328,696)	(6.2%)	Medical Expenses	1,468,149,251	1,319,139,901	(149,009,350)	(11.3%)
18,171,859	20,782,838	2,610,979	12.6%	Administrative Expenses	71,778,684	82,359,797	10,581,113	12.8%
24,146,911	**(1,340,509)**	**25,487,420**	**1901.3%**	**Operating Margin**	**76,248,166**	**13,321,573**	**62,926,593**	**472.4%**
				Non-Operating Income (Loss)				
13,896,639	2,083,330	11,813,309	567.0%	Net Investment Income/Expense	51,328,576	8,333,320	42,995,256	515.9%
(38,549)	(89,380)	50,831	56.9%	Net Rental Income/Expense	29,080	(187,519)	216,599	115.5%
-	(1,003,219)	1,003,219	(100.0%)	Grant Expense	(28,965,738)	(24,012,877)	(4,952,860)	(20.6%)
15	-	15	100.0%	Other Income/Expense	(830,003)	-	(830,003)	(100.0%)
13,858,105	**990,731**	**12,867,374**	**1298.8%**	**Total Non-Operating Income (Loss)**	**21,561,915**	**(15,867,076)**	**37,428,991**	**235.9%**
38,005,016	**(349,778)**	**38,354,795**	**10965.5%**	**Change in Net Assets**	**97,810,081**	**(2,545,503)**	**100,355,584**	**3942.5%**
89.1%	94.4%	(5.3%)		Medical Loss Ratio	90.8%	93.2%	(2.4%)	
4.7%	6.0%	1.3%		Administrative Loss Ratio	4.4%	5.8%	1.4%	
6.2%	(0.4%)	6.6%		Operating Margin Ratio	4.7%	0.9%	3.8%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
89.1%	94.4%	(5.3%)		*MLR (excluding Directed Payments)	90.0%	93.2%	(3.2%)	
4.7%	6.0%	1.3%		*ALR (excluding Directed Payments)	4.9%	5.8%	1.0%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

Back to Agenda

CalOptima Health - Consolidated
Full Time Employee Data
For the Four Months Ending October 31, 2023

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1252	1352	100
OneCare	185	197	12
PACE	104	101	(3)
MSSP	19	24	5
Total	1560	1673	113

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	5015	5409	394
OneCare	731	788	57
PACE	413	402	(11)
MSSP	82	94	12
Total	6241	6693	452

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	760	684	(76)
OneCare	96	90	(6)
PACE	4	5	1
MSSP	26	24	(2)
Total	622	564	(58)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	767	702	(65)
OneCare	97	90	(7)
PACE	4	5	1
MSSP	24	24	(0)
Total	628	578	(50)

Open Positions			
	Total	Medical	Admin
Medi-Cal	89.00	32.75	56.25
OneCare	5.00	2.00	3.00
PACE	4.00	4.00	0.00
MSSP	4.00	3.00	1.00
Total	102.00	41.75	60.25

CalOptima Health - Consolidated
Statement of Revenues and Expenses
For the One Month Ending October 31, 2023

	Actual		Budget		Variance	
	$	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
MEMBER MONTHS	969,731		943,283		26,448	
REVENUE						
Medi-Cal	$ 351,890,184	$ 369.81	$ 309,647,523	$ 334.73	$ 42,242,661	$ 35.08
OneCare	32,671,385	1,839.92	31,455,019	1,772.11	1,216,366	67.81
OneCare Connect	(13,722)		-		(13,722)	-
PACE	3,777,538	8,546.47	3,970,940	8,521.33	(193,402)	25.14
MSSP	206,752	418.53	253,518	446.33	(46,766)	(27.80)
Total Operating Revenue	388,532,137	400.66	345,327,000	366.09	43,205,137	34.57
MEDICAL EXPENSES						
Medi-Cal	312,991,572	328.93	290,465,157	313.99	(22,526,415)	(14.94)
OneCare	29,542,263	1,663.70	31,451,429	1,771.91	1,909,166	108.21
OneCare Connect	83,832				(83,832)	-
PACE	3,416,536	7,729.72	3,750,416	8,048.10	333,880	318.38
MSSP	179,164	362.68	217,669	383.22	38,505	20.54
Total Medical Expenses	346,213,367	357.02	325,884,671	345.48	(20,328,696)	(11.54)
GROSS MARGIN	**42,318,770**	**43.64**	**19,442,329**	**20.61**	**22,876,441**	**23.03**
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	12,201,302	12.58	12,575,778	13.33	374,476	0.75
Professional Fees	645,026	0.67	1,048,795	1.11	403,769	0.44
Purchased Services	1,515,742	1.56	2,206,248	2.34	690,506	0.78
Printing & Postage	493,262	0.51	542,126	0.57	48,864	0.06
Depreciation & Amortization	1,017,206	1.05	400,900	0.43	(616,306)	(0.62)
Other Expenses	1,928,820	1.99	3,564,112	3.78	1,635,292	1.79
Indirect Cost Allocation, Occupancy	370,502	0.38	444,879	0.47	74,377	0.09
Total Administrative Expenses	18,171,859	18.74	20,782,838	22.03	2,610,979	3.29
INCOME (LOSS) FROM OPERATIONS	24,146,911	24.90	(1,340,509)	(1.42)	25,487,420	26.32
INVESTMENT INCOME						
Interest Income	14,040,714	14.48	2,083,330	2.21	11,957,384	12.27
Realized Gain/(Loss) on Investments	(359,037)	(0.37)	-	-	(359,037)	(0.37)
Unrealized Gain/(Loss) on Investments	214,962	0.22	-	-	214,962	0.22
Total Investment Income	13,896,639	14.33	2,083,330	2.21	11,813,309	12.12
NET RENTAL INCOME	(38,549)	(0.04)	(89,380)	(0.09)	50,831	0.05
TOTAL GRANT EXPENSE	-	-	(1,003,219)	(1.06)	1,003,219	1.06
OTHER INCOME/EXPENSE	15	-	-	-	15	-
CHANGE IN NET ASSETS	**38,005,016**	**39.19**	**(349,778)**	**(0.37)**	**38,354,795**	**39.56**
MEDICAL LOSS RATIO	**89.1%**		**94.4%**		**(5.3%)**	
ADMINISTRATIVE LOSS RATIO	**4.7%**		**6.0%**		**1.3%**	

Back to Agenda

CalOptima Health- Consolidated
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2023

	Actual		Budget		Variance	
	$	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
MEMBER MONTHS	3,918,738		3,871,201		47,537	
REVENUE						
Medi-Cal	$ 1,473,702,323	$ 383.19	1,272,292,012	$ 334.93	$ 201,410,311	$ 48.26
OneCare	128,137,448	1,802.14	125,815,835	1,779.55	2,321,613	22.59
OneCare Connect	(1,367,126)		-		(1,367,126)	0.00
PACE	14,851,557	8,535.38	15,699,352	8,541.54	(847,795)	(6.16)
MSSP	851,899	425.95	1,014,072	446.33	(162,173)	(20.38)
Total Operating Revenue	1,616,176,101	412.42	1,414,821,271	365.47	201,354,830	46.95
MEDICAL EXPENSES						
Medi-Cal	1,338,590,719	348.06	1,179,120,972	310.40	(159,469,747)	(37.66)
OneCare	118,022,864	1,659.89	124,463,419	1,760.42	6,440,555	100.53
OneCare Connect	(1,776,154)				1,776,154	0.00
PACE	12,604,595	7,244.02	14,684,834	7,989.57	2,080,239	745.55
MSSP	707,227	353.61	870,676	383.22	163,449	29.61
Total Medical Expenses	1,468,149,251	374.65	1,319,139,901	340.76	(149,009,350)	(33.89)
GROSS MARGIN	**148,026,850**	**37.77**	**95,681,370**	**24.71**	**52,345,480**	**13.06**
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	47,717,357	12.18	49,635,836	12.82	1,918,479	0.64
Professional Fees	2,238,797	0.57	4,185,325	1.08	1,946,528	0.51
Purchased Services	4,880,267	1.25	8,582,622	2.22	3,702,355	0.97
Printing & Postage	2,019,179	0.52	2,310,504	0.60	291,325	0.08
Depreciation & Amortization	3,533,073	0.90	1,603,600	0.41	(1,929,473)	(0.49)
Other Expenses	9,838,271	2.51	14,262,394	3.68	4,424,123	1.17
Indirect Cost Allocation, Occupancy	1,551,741	0.40	1,779,516	0.46	227,775	0.06
Total Administrative Expenses	71,778,684	18.32	82,359,797	21.27	10,581,113	2.95
INCOME (LOSS) FROM OPERATIONS	76,248,166	19.46	13,321,573	3.44	62,926,593	16.02
INVESTMENT INCOME						
Interest Income	50,657,627	12.93	8,333,320	2.15	42,324,307	10.78
Realized Gain/(Loss) on Investments	(2,280,330)	(0.58)	-	0.00	(2,280,330)	(0.58)
Unrealized Gain/(Loss) on Investments	2,951,280	0.75	-	0.00	2,951,280	0.75
Total Investment Income	51,328,576	13.10	8,333,320	2.15	42,995,256	10.95
NET RENTAL INCOME	29,080	0.01	(187,519)	(0.05)	216,599	0.06
TOTAL GRANT EXPENSE	(28,965,738)	(7.39)	(24,012,877)	(6.20)	(4,952,860)	(1.19)
OTHER INCOME/EXPENSE	(830,003)	(0.21)	-	0.00	(830,003)	(0.21)
CHANGE IN NET ASSETS	**97,810,081**	**24.96**	**(2,545,503)**	**(0.66)**	**100,355,584**	**25.62**
MEDICAL LOSS RATIO	**90.8%**		**93.2%**		**(2.4%)**	
ADMINISTRATIVE LOSS RATIO	**4.4%**		**5.8%**		**1.4%**	

Back to Agenda

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending October 31, 2023

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	596,081	355,451	951,532	17,757		442	494	969,731
REVENUES								
Capitation Revenue	$ 217,461,976	$ 134,428,208	$ 351,890,184	$ 32,671,385	$ (13,722)	$ 3,777,538	$ 206,752	$ 388,532,137
Total Operating Revenue	**217,461,976**	**134,428,208**	**351,890,184**	**32,671,385**	**(13,722)**	**3,777,538**	**206,752**	**388,532,137**
MEDICAL EXPENSES								
Provider Capitation	65,837,768	50,457,353	116,295,122	13,069,456				129,364,577
Claims	74,397,742	47,422,990	121,820,733	5,482,813	30,830	1,683,715		129,018,091
MLTSS	42,386,708	5,708,706	48,095,414	(245,824)		110,815	26,717	47,987,122
Prescription Drugs	(2,242)		(2,242)	9,680,066	(3,605)	514,834		10,189,053
Case Mgmt & Other Medical	14,820,555	11,961,989	26,782,544	1,555,753	56,607	1,107,172	152,447	29,654,523
Total Medical Expenses	**197,440,532**	**115,551,039**	**312,991,572**	**29,542,263**	**83,832**	**3,416,536**	**179,164**	**346,213,367**
Medical Loss Ratio	*90.8%*	*86.0%*	*88.9%*	*90.4%*	*(610.9%)*	*90.4%*	*86.7%*	*89.1%*
GROSS MARGIN	**20,021,444**	**18,877,168**	**38,898,613**	**3,129,122**	**(97,554)**	**361,002**	**27,588**	**42,318,770**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			10,939,477	1,001,893		167,139	92,792	12,201,302
Non-Salary Operating Expenses			2,236,878	411,891		3,923	1,337	2,654,029
Depreciation & Amortization			1,016,088			1,118		1,017,206
Other Operating Expenses			1,790,436	123,103		9,316	5,965	1,928,820
Indirect Cost Allocation, Occupancy			(522,962)	873,504		14,059	5,900	370,502
Total Administrative Expenses			**15,459,918**	**2,410,391**	**-**	**195,556**	**105,993**	**18,171,859**
Administrative Loss Ratio			*4.4%*	*7.4%*	*0.0%*	*5.2%*	*51.3%*	*4.7%*
Operating Income/(Loss)			**23,438,695**	**718,731**	**(97,554)**	**165,445**	**(78,405)**	**24,146,911**
Investments and Other Non-Operating			15					13,858,105
CHANGE IN NET ASSETS			**$ 23,438,710**	**$ 718,731**	**$ (97,554)**	**$ 165,445**	**$ (78,405)**	**$ 38,005,016**
BUDGETED CHANGE IN NET ASSETS			1,372,808	(2,660,563)	-	20,106	(72,860)	(349,778)
Variance to Budget - Fav/(Unfav)			$ 22,065,902	$ 3,379,294	$ (97,554)	$ 145,339	$ (5,545)	$ 38,354,795

Back to Agenda

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Four Months Ending October 31, 2023

	Medi-Cal Classic/WCM	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Consolidated
MEMBER MONTHS	2,406,030	1,439,865	3,845,895	71,103		1,740	2,000	3,918,738
REVENUES								
Capitation Revenue	$ 850,207,465	$ 623,494,858	$ 1,473,702,323	$ 128,137,448	$ (1,367,126)	$ 14,851,557	$ 851,899	$ 1,616,176,101
Total Operating Revenue	**850,207,465**	**623,494,858**	**1,473,702,323**	**128,137,448**	**(1,367,126)**	**14,851,557**	**851,899**	**1,616,176,101**
MEDICAL EXPENSES								
Provider Capitation	248,211,262	197,505,377	445,716,638	51,768,825				497,485,464
Claims	294,773,792	191,232,548	486,006,339	26,505,839	(26,366)	6,123,040		518,608,851
MLTSS	164,452,085	21,848,297	186,300,382	-	(17,616)	111,412	91,101	186,485,279
Prescription Drugs	(11,660)		(11,660)	34,635,423	(1,822,950)	1,891,936		34,692,749
Case Mgmt & Other Medical	130,149,274	90,429,745	220,579,019	5,112,777	90,779	4,478,206	616,127	230,876,908
Total Medical Expenses	**837,574,752**	**501,015,967**	**1,338,590,719**	**118,022,864**	**(1,776,154)**	**12,604,595**	**707,227**	**1,468,149,251**
Medical Loss Ratio	*98.5%*	*80.4%*	*90.8%*	*92.1%*	*129.9%*	*84.9%*	*83.0%*	*90.8%*
GROSS MARGIN	**12,632,713**	**122,478,891**	**135,111,604**	**10,114,584**	**409,028**	**2,246,962**	**144,672**	**148,026,850**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits			42,761,262	3,948,408	(0)	627,263	380,424	47,717,357
Non-Salary Operating Expenses			7,887,128	1,197,784	(4,364)	52,338	5,356	9,138,243
Depreciation & Amortization			3,528,579			4,494		3,533,073
Other Operating Expenses			9,515,752	262,117		41,453	18,949	9,838,271
Indirect Cost Allocation, Occupancy			(2,022,055)	3,494,017		56,178	23,601	1,551,741
Total Administrative Expenses			**61,670,666**	**8,902,326**	**(4,364)**	**781,726**	**428,330**	**71,778,684**
Administrative Loss Ratio			*4.2%*	*6.9%*	*0.3%*	*5.3%*	*50.3%*	*4.4%*
Operating Income/(Loss)			**73,440,938**	**1,212,258**	**413,392**	**1,465,237**	**(283,658)**	**76,248,166**
Investments and Other Non-Operating			(830,003)					21,561,915
CHANGE IN NET ASSETS			**$ 72,610,935**	**$ 1,212,258**	**$ 413,392**	**$ 1,465,237**	**$ (283,658)**	**$ 97,810,081**
BUDGETED CHANGE IN NET ASSETS			22,640,355	(9,252,540)	-	220,698	(286,940)	(2,545,503)
Variance to Budget - Fav/(Unfav)			$ 49,970,580	$ 10,464,798	$ 413,392	$ 1,244,539	$ 3,282	$ 100,355,584

Back to Agenda

CalOptima Health

Unaudited Financial Statements as of October 31, 2023

MONTHLY RESULTS:

- Change in Net Assets is $38.0 million, $38.4 million favorable to budget
- Operating surplus is $24.1 million, with a surplus in non-operating income of $13.9 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $97.8 million, $100.4 million favorable to budget
- Operating surplus is $76.2 million, with a surplus in non-operating income of $21.6 million

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

October 2023				July - October 2023		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
23.4	1.4	22.1	Medi-Cal	73.4	22.6	50.8
0.7	(2.7)	3.4	OneCare	1.2	(9.3)	10.5
(0.1)	0.0	(0.1)	OCC	0.4	0.0	0.4
0.2	0.0	0.1	PACE	1.5	0.2	1.2
(0.1)	(0.1)	(0.0)	MSSP	(0.3)	(0.3)	0.0
24.1	**(1.3)**	**25.5**	**Total Operating Income (Loss)**	**76.2**	**13.3**	**62.9**
			Non-Operating Income (Loss)			
13.9	2.1	11.8	Net Investment Income/Expense	51.3	8.3	43.0
(0.0)	(0.1)	0.1	Net Rental Income/Expense	0.0	(0.2)	0.2
0.0	0.0	0.0	Net Operating Tax	0.0	0.0	0.0
0.0	(1.0)	1.0	Grant Expense	(29.0)	(24.0)	(5.0)
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)
13.9	**1.0**	**12.9**	**Total Non-Operating Income/(Loss)**	**21.6**	**(15.9)**	**37.4**
38.0	**(0.3)**	**38.4**	**TOTAL**	**97.8**	**(2.5)**	**100.4**

CalOptima Health - Consolidated
Enrollment Summary
For the Four Months Ending October 31, 2023

October 2023					July - October 2023			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
143,314	139,465	3,849	2.8%	SPD	573,386	564,126	9,260	1.6%
297,811	311,329	(13,518)	(4.3%)	TANF Child	1,204,264	1,261,235	(56,971)	(4.5%)
140,960	127,841	13,119	10.3%	TANF Adult	571,126	525,069	46,057	8.8%
2,819	3,118	(299)	(9.6%)	LTC	11,779	12,472	(693)	(5.6%)
355,451	331,913	23,538	7.1%	MCE	1,439,865	1,390,240	49,625	3.6%
11,177	11,401	(224)	(2.0%)	WCM	45,475	45,520	(45)	(0.1%)
951,532	**925,067**	**26,465**	**2.9%**	**Medi-Cal Total**	**3,845,895**	**3,798,662**	**47,233**	**1.2%**
17,757	**17,750**	**7**	**0.0%**	**OneCare**	**71,103**	**70,701**	**402**	**0.6%**
442	**466**	**(24)**	**(5.2%)**	**PACE**	**1,740**	**1,838**	**(98)**	**(5.3%)**
494	**568**	**(74)**	**(13.0%)**	**MSSP**	**2,000**	**2,272**	**(272)**	**(12.0%)**
969,731	**943,283**	**26,448**	**2.8%**	**CalOptima Health Total**	**3,918,738**	**3,871,201**	**47,537**	**1.2%**
				Enrollment (by Network)				
266,687	267,193	(506)	(0.2%)	HMO	1,075,197	1,095,460	(20,263)	(1.8%)
188,028	178,247	9,781	5.5%	PHC	761,976	731,784	30,192	4.1%
229,837	219,917	9,920	4.5%	Shared Risk Group	934,002	913,124	20,878	2.3%
266,980	259,710	7,270	2.8%	Fee for Service	1,074,720	1,058,294	16,426	1.6%
951,532	**925,067**	**26,465**	**2.9%**	**Medi-Cal Total**	**3,845,895**	**3,798,662**	**47,233**	**1.2%**
17,757	**17,750**	**7**	**0**	**OneCare**	**71,103**	**70,701**	**402**	**0**
442	**466**	**(24)**	**(5.2%)**	**PACE**	**1,740**	**1,838**	**(98)**	**(5.3%)**
494	**568**	**(74)**	**(13.0%)**	**MSSP**	**2,000**	**2,272**	**(272)**	**(12.0%)**
969,731	**943,283**	**26,448**	**2.8%**	**CalOptima Health Total**	**3,918,738**	**3,871,201**	**47,537**	**1.2%**

Note:* Total membership does not include MSSP

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									56,926	55,957	969
TANF Child	69,607	69,928	69,010	69,620									278,165	318,472	(40,307)
TANF Adult	50,979	51,388	50,896	50,392									203,655	200,213	3,442
LTC		1											1		1
MCE	132,523	133,978	131,301	130,441									528,243	511,892	16,351
WCM	2,050	2,095	2,021	2,041									8,207	8,926	(719)
Total	**269,426**	**271,677**	**267,407**	**266,687**									**1,075,197**	**1,095,460**	**(20,263)**
PHCs															
SPD	4,581	4,599	4,623	4,588									18,391	17,532	859
TANF Child	147,946	148,557	145,969	145,186									587,658	584,527	3,131
TANF Adult	8,999	9,050	9,404	8,885									36,338	13,280	23,058
LTC													-		-
MCE	23,230	23,489	22,708	22,540									91,967	89,173	2,794
WCM	6,919	6,974	6,900	6,829									27,622	27,272	350
Total	**191,675**	**192,669**	**189,604**	**188,028**									**761,976**	**731,784**	**30,192**
Shared Risk Groups															
SPD	11,210	11,137	11,111	10,982									44,440	44,594	(154)
TANF Child	55,211	55,471	54,427	53,505									218,614	233,443	(14,829)
TANF Adult	43,118	43,425	42,894	42,250									171,687	156,391	15,296
LTC	1	1											2		2
MCE	124,149	125,749	122,600	121,935									494,433	473,690	20,743
WCM	1,234	1,247	1,180	1,165									4,826	5,006	(180)
Total	**234,923**	**237,030**	**232,212**	**229,837**									**934,002**	**913,124**	**20,878**
Fee for Service (Dual)															
SPD	99,242	99,832	99,750	99,630									398,454	393,628	4,826
TANF Child													-	8	(8)
TANF Adult	2,442	2,397	2,370	2,307									9,516	9,568	(52)
LTC	2,661	2,630	2,612	2,492									10,395	10,992	(597)
MCE	8,968	9,230	9,418	9,312									36,928	37,186	(258)
WCM	15	14	14	13									56	72	(16)
Total	**113,328**	**114,103**	**114,164**	**113,754**									**455,349**	**451,454**	**3,895**
Fee for Service (Non-Dual - Total)															
SPD	13,519	13,778	13,957	13,921									55,175	52,415	2,760
TANF Child	29,143	30,159	31,025	29,500									119,827	124,785	(4,958)
TANF Adult	37,044	37,794	37,966	37,126									149,930	145,617	4,313
LTC	349	360	345	327									1,381	1,480	(99)
MCE	70,923	73,165	72,983	71,223									288,294	278,299	9,995
WCM	1,164	1,259	1,212	1,129									4,764	4,244	520
Total	**152,142**	**156,515**	**157,488**	**153,226**									**619,371**	**606,840**	**12,531**
Grand Totals															
SPD	142,819	143,633	143,620	143,314									573,386	564,126	9,260
TANF Child	301,907	304,115	300,431	297,811									1,204,264	1,261,235	(56,971)
TANF Adult	142,582	144,054	143,530	140,960									571,126	525,069	46,057
LTC	3,011	2,992	2,957	2,819									11,779	12,472	(693)
MCE	359,793	365,611	359,010	355,451									1,439,865	1,390,240	49,625
WCM	11,382	11,589	11,327	11,177									45,475	45,520	(45)
Total MediCal MM	**961,494**	**971,994**	**960,875**	**951,532**									**3,845,895**	**3,798,662**	**47,233**
OneCare	**17,695**	**17,815**	**17,836**	**17,757**									**71,103**	**70,701**	**402**
PACE	**429**	**432**	**437**	**442**									**1,740**	**1,838**	**(98)**
MSSP	**503**	**500**	**503**	**494**									**2,000**	**2,272**	**(272)**
Grand Total	**979,618**	**990,241**	**979,148**	**969,731**									**3,918,738**	**3,871,201**	**47,537**

Note:* Total membership does not include MSSP

Back to Agenda

ENROLLMENT:

Overall, October enrollment was 969,731

- Favorable to budget 26,448 or 2.8%
- Decreased 9,417 or 1.0% from Prior Month (PM) (September 2023)
- Increased 32,147 or 3.4% from Prior Year (PY) (October 2022)

Medi-Cal enrollment was 951,532

- Favorable to budget 26,465 or 2.9%
  - Medi-Cal Expansion (MCE) favorable 23,538 due to disenrollment being slower than originally anticipated based on the current economic conditions and expanded renewal outreach efforts
  - Seniors and Persons with Disabilities (SPD) favorable 3,849
  - Temporary Assistance for Needy Families (TANF) unfavorable 399
  - Long-Term Care (LTC) unfavorable 299
  - Whole Child Model (WCM) unfavorable 224
- Decreased 9,343 from PM

OneCare enrollment was 17,757

- Favorable to budget 7 or 0.0%
- Decreased 79 from PM

PACE enrollment was 442

- Unfavorable to budget 24 or 5.2%
- Increased 5 from PM

MSSP enrollment was 494

- Unfavorable to budget 74 or 13.0% due to MSSP currently being understaffed. There is a staff to member ratio that must be met
- Decreased 9 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
951,532	**925,067**	**26,465**	**2.9%**	**Member Months**	**3,845,895**	**3,798,662**	**47,233**	**1.2%**
				Revenues				
351,890,184	309,647,523	42,242,661	13.6%	Medi-Cal Capitation Revenue	1,473,702,323	1,272,292,012	201,410,311	15.8%
351,890,184	**309,647,523**	**42,242,661**	**13.6%**	**Total Operating Revenue**	**1,473,702,323**	**1,272,292,012**	**201,410,311**	**15.8%**
				Medical Expenses				
116,295,122	103,298,326	(12,996,796)	(12.6%)	Provider Capitation	445,716,638	425,909,293	(19,807,345)	(4.7%)
65,367,428	74,101,979	8,734,551	11.8%	Facilities Claims	273,703,846	299,055,743	25,351,897	8.5%
56,453,305	45,984,343	(10,468,962)	(22.8%)	Professional Claims	212,302,493	185,895,608	(26,406,885)	(14.2%)
48,095,414	51,509,488	3,414,074	6.6%	MLTSS	186,300,382	205,444,044	19,143,662	9.3%
(2,242)	-	2,242	100.0%	Prescription Drugs	(11,660)	-	11,660	100.0%
20,460,198	6,956,371	(13,503,827)	(194.1%)	Incentive Payments	55,177,622	28,681,446	(26,496,176)	(92.4%)
5,652,306	7,597,609	1,945,303	25.6%	Medical Management	24,012,316	30,069,570	6,057,254	20.1%
670,041	1,017,041	347,000	34.1%	Other Medical Expenses	141,389,082	4,065,268	(137,323,814)	(3378.0%)
312,991,572	**290,465,157**	**(22,526,415)**	**(7.8%)**	**Total Medical Expenses**	**1,338,590,719**	**1,179,120,972**	**(159,469,747)**	**(13.5%)**
38,898,613	**19,182,366**	**19,716,247**	**102.8%**	**Gross Margin**	**135,111,604**	**93,171,040**	**41,940,564**	**45.0%**
				Administrative Expenses				
10,939,477	11,154,005	214,528	1.9%	Salaries, Wages & Employee Benefits	42,761,262	44,012,752	1,251,490	2.8%
578,810	967,558	388,748	40.2%	Professional Fees	2,040,002	3,860,377	1,820,375	47.2%
1,392,283	1,932,016	539,733	27.9%	Purchased Services	4,236,072	7,485,694	3,249,622	43.4%
265,785	412,310	146,525	35.5%	Printing & Postage	1,611,055	1,791,240	180,185	10.1%
1,016,088	400,000	(616,088)	(154.0%)	Depreciation & Amortization	3,528,579	1,600,000	(1,928,579)	(120.5%)
1,790,436	3,469,760	1,679,324	48.4%	Other Operating Expenses	9,515,752	13,884,986	4,369,234	31.5%
(522,962)	(526,091)	(3,129)	(0.6%)	Indirect Cost Allocation, Occupancy	(2,022,055)	(2,104,364)	(82,309)	(3.9%)
15,459,918	**17,809,558**	**2,349,640**	**13.2%**	**Total Administrative Expenses**	**61,670,666**	**70,530,685**	**8,860,019**	**12.6%**
				Non-Operating Income (Loss)				
15	-	15	100.0%	Other Income/Expense	(830,003)	-	(830,003)	(100.0%)
15	**-**	**15**	**100.0%**	**Total Non-Operating Income (Loss)**	**(830,003)**	**-**	**(830,003)**	**(100.0%)**
23,438,710	**1,372,808**	**22,065,902**	**1607.4%**	**Change in Net Assets**	**72,610,935**	**22,640,355**	**49,970,580**	**220.7%**
88.9%	***93.8%***	***(4.9%)***		***Medical Loss Ratio***	***90.8%***	***92.7%***	***(1.8%)***	
4.4%	***5.8%***	***1.4%***		***Admin Loss Ratio***	***4.2%***	***5.5%***	***1.4%***	

Back to Agenda

MEDI-CAL INCOME STATEMENT– OCTOBER MONTH:

REVENUES of $351.9 million are favorable to budget $42.2 million driven by:

- Favorable volume related variance of $8.9 million
- Favorable price related variance of $33.4 million
  - $22.0 million due to net impact of rate change to Unsatisfactory Immigration Status/ Satisfactory Immigration Status (UIS/SIS)
  - $16.4 million due to Proposition 56 risk corridor
  - Offset by $5.4 million from Enhanced Care Management (ECM) and COVID-19 risk corridor

MEDICAL EXPENSES of $313.0 million are unfavorable to budget $22.5 million driven by:

- Unfavorable volume related variance of $8.3 million
- Unfavorable price related variance of $14.2 million
  - Incentive Payments expense unfavorable variance of $13.3 million driven by updates to Shared Risk Pools to exclude Non-Medical Transportation claims
  - Provider Capitation expense unfavorable variance of $10.0 million due to PY Proposition 56 expenses and Post Pandemic Supplemental
  - Professional Claims expense unfavorable variance of $9.2 million due to increased utilization for Community Support (CS)
  - Offset by:
    - Facilities Claims expense favorable variance of $10.9 million due to lower than budgeted utilization
    - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $4.9 million
    - Medical Management expense favorable variance of $2.2 million

ADMINISTRATIVE EXPENSES of $15.5 million are favorable to budget $2.3 million driven by:

- Non-Salary expenses favorable to budget $2.1 million
- Salaries & Benefit expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is $23.4 million, favorable to budget $22.1 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
17,757	**17,750**	**7**	**0.0%**	**Member Months**	**71,103**	**70,701**	**402**	**0.6%**
				Revenues				
23,532,416	22,719,563	812,853	3.6%	Medicare Part C Revenue	93,180,136	90,999,830	2,180,306	2.4%
9,138,969	8,735,456	403,513	4.6%	Medicare Part D Revenue	34,957,312	34,816,005	141,307	0.4%
32,671,385	**31,455,019**	**1,216,366**	**3.9%**	**Total Operating Revenue**	**128,137,448**	**125,815,835**	**2,321,613**	**1.8%**
				Medical Expenses				
13,069,456	13,013,274	(56,182)	(0.4%)	Provider Capitation	51,768,825	52,124,428	355,603	0.7%
4,015,493	5,369,324	1,353,831	25.2%	Inpatient	20,860,222	20,789,138	(71,084)	(0.3%)
1,467,319	1,480,453	13,134	0.9%	Ancillary	5,645,617	5,835,950	190,333	3.3%
(245,824)	81,825	327,649	400.4%	MLTSS	-	325,935	325,935	100.0%
9,680,066	9,909,012	228,946	2.3%	Prescription Drugs	34,635,423	38,841,730	4,206,307	10.8%
602,269	330,411	(271,858)	(82.3%)	Incentive Payments	1,078,833	1,535,786	456,953	29.8%
953,485	1,267,130	313,645	24.8%	Medical Management	4,033,944	5,010,452	976,508	19.5%
29,542,263	**31,451,429**	**1,909,166**	**6.1%**	**Total Medical Expenses**	**118,022,864**	**124,463,419**	**6,440,555**	**5.2%**
3,129,122	**3,590**	**3,125,532**	**87062.2%**	**Gross Margin**	**10,114,584**	**1,352,416**	**8,762,168**	**647.9%**
				Administrative Expenses				
1,001,893	1,171,054	169,161	14.4%	Salaries, Wages & Employee Benefits	3,948,408	4,632,560	684,152	14.8%
64,445	75,000	10,555	14.1%	Professional Fees	191,583	300,000	108,417	36.1%
120,747	265,942	145,195	54.6%	Purchased Services	601,583	1,063,768	462,185	43.4%
226,700	125,704	(100,996)	(80.3%)	Printing & Postage	404,618	502,816	98,198	19.5%
123,103	77,870	(45,233)	(58.1%)	Other Operating Expenses	262,117	311,480	49,363	15.8%
873,504	948,583	75,079	7.9%	Indirect Cost Allocation, Occupancy	3,494,017	3,794,332	300,315	7.9%
2,410,391	**2,664,153**	**253,762**	**9.5%**	**Total Administrative Expenses**	**8,902,326**	**10,604,956**	**1,702,630**	**16.1%**
718,731	**(2,660,563)**	**3,379,294**	**127.0%**	**Change in Net Assets**	**1,212,258**	**(9,252,540)**	**10,464,798**	**113.1%**
90.4%	***100.0%***	***(9.6%)***		***Medical Loss Ratio***	***92.1%***	***98.9%***	***(6.8%)***	
7.4%	***8.5%***	***1.1%***		***Admin Loss Ratio***	***6.9%***	***8.4%***	***1.5%***	

Back to Agenda

ONECARE INCOME STATEMENT– OCTOBER MONTH:

REVENUES of $32.7 million are favorable to budget $1.2 million driven by:

- Favorable price related variance of $1.2 million

MEDICAL EXPENSES of $29.5 million are favorable to budget $1.9 million driven by:

- Favorable price related variance of $1.9 million

ADMINISTRATIVE EXPENSES of $2.4 million are favorable to budget $0.3 million driven by:

- Salaries & Benefit expense favorable to budget $0.2 million
- Non-Salary expenses favorable to budget $0.1 million

CHANGE IN NET ASSETS is $0.7 million, favorable to budget $3.4 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Four Months Ending October 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	0.0%	**Member Months**	-	-	-	0.0%
				Revenues				
(10,810)	-	(10,810)	(100.0%)	Medi-Cal Revenue	22,753	-	22,753	100.0%
(2,912)	-	(2,912)	(100.0%)	Medicare Part D Revenue	(1,389,879)	-	(1,389,879)	(100.0%)
(13,722)	**-**	**(13,722)**	**(100.0%)**	**Total Operating Revenue**	**(1,367,126)**	**-**	**(1,367,126)**	**(100.0%)**
				Medical Expenses				
(97,153)	-	97,153	100.0%	Facilities Claims	(393,529)	-	393,529	100.0%
127,983	-	(127,983)	(100.0%)	Ancillary	367,162	-	(367,162)	(100.0%)
-	-	-	0.0%	MLTSS	(17,616)	-	17,616	100.0%
(3,605)	-	3,605	100.0%	Prescription Drugs	(1,822,950)	-	1,822,950	100.0%
56,607	-	(56,607)	(100.0%)	Incentive Payments	90,779	-	(90,779)	(100.0%)
83,832	**-**	**(83,832)**	**(100.0%)**	**Total Medical Expenses**	**(1,776,154)**	**-**	**1,776,154**	**100.0%**
(97,554)	**-**	**(97,554)**	**(100.0%)**	**Gross Margin**	**409,028**	**-**	**409,028**	**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%**
(97,554)	**-**	**(97,554)**	**(100.0%)**	**Change in Net Assets**	**413,392**	**-**	**413,392**	**100.0%**
(610.9%)	***0.0%***	***(610.9%)***		***Medical Loss Ratio***	***129.9%***	***0.0%***	***129.9%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.3%***	***0.0%***	***(0.3%)***	

Back to Agenda

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
442	**466**	**(24)**	**(5.2%)**	**Member Months**	**1,740**	**1,838**	**(98)**	**(5.3%)**
				Revenues				
2,895,948	3,021,347	(125,399)	(4.2%)	Medi-Cal Capitation Revenue	11,340,714	11,919,352	(578,638)	(4.9%)
649,544	736,946	(87,402)	(11.9%)	Medicare Part C Revenue	2,514,543	2,940,906	(426,363)	(14.5%)
232,046	212,647	19,399	9.1%	Medicare Part D Revenue	996,299	839,094	157,205	18.7%
3,777,538	**3,970,940**	**(193,402)**	**(4.9%)**	**Total Operating Revenue**	**14,851,557**	**15,699,352**	**(847,795)**	**(5.4%)**
				Medical Expenses				
1,107,172	1,168,255	61,083	5.2%	Medical Management	4,478,206	4,628,730	150,524	3.3%
715,197	915,792	200,595	21.9%	Facilities Claims	2,553,906	3,572,857	1,018,951	28.5%
729,373	883,764	154,391	17.5%	Professional Claims	2,681,300	3,449,027	767,727	22.3%
514,834	467,784	(47,050)	(10.1%)	Prescription Drugs	1,891,936	1,810,490	(81,446)	(4.5%)
110,815	120,369	9,554	7.9%	MLTSS	111,412	472,946	361,534	76.4%
239,145	194,452	(44,693)	(23.0%)	Patient Transportation	887,833	750,784	(137,049)	(18.3%)
3,416,536	**3,750,416**	**333,880**	**8.9%**	**Total Medical Expenses**	**12,604,595**	**14,684,834**	**2,080,239**	**14.2%**
361,002	**220,524**	**140,478**	**63.7%**	**Gross Margin**	**2,246,962**	**1,014,518**	**1,232,444**	**121.5%**
				Administrative Expenses				
167,139	158,311	(8,828)	(5.6%)	Salaries, Wages & Employee Benefits	627,263	625,392	(1,871)	(0.3%)
438	4,904	4,467	91.1%	Professional Fees	1,879	19,616	17,737	90.4%
2,708	8,290	5,582	67.3%	Purchased Services	46,953	33,160	(13,793)	(41.6%)
777	4,112	3,335	81.1%	Printing & Postage	3,506	16,448	12,942	78.7%
1,118	900	(218)	(24.3%)	Depreciation & Amortization	4,494	3,600	(894)	(24.8%)
9,316	9,039	(277)	(3.1%)	Other Operating Expenses	41,453	36,156	(5,297)	(14.7%)
14,059	14,862	803	5.4%	Indirect Cost Allocation, Occupancy	56,178	59,448	3,270	5.5%
195,556	**200,418**	**4,862**	**2.4%**	**Total Administrative Expenses**	**781,726**	**793,820**	**12,094**	**1.5%**
165,445	**20,106**	**145,339**	**722.9%**	**Change in Net Assets**	**1,465,237**	**220,698**	**1,244,539**	**563.9%**
90.4%	***94.4%***	***(4.0%)***		***Medical Loss Ratio***	***84.9%***	***93.5%***	***(8.7%)***	
5.2%	***5.0%***	***(0.1%)***		***Admin Loss Ratio***	***5.3%***	***5.1%***	***(0.2%)***	

Back to Agenda

CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
494	**568**	**(74)**	**(13.0%)**	**Member Months**	**2,000**	**2,272**	**(272)**	**(12.0%)**
				Revenues				
206,752	253,518	(46,766)	(18.4%)	Revenue	851,899	1,014,072	(162,173)	(16.0%)
206,752	**253,518**	**(46,766)**	**(18.4%)**	**Total Operating Revenue**	**851,899**	**1,014,072**	**(162,173)**	**(16.0%)**
				Medical Expenses				
152,447	184,712	32,265	17.5%	Medical Management	616,127	738,848	122,721	16.6%
26,717	32,957	6,240	18.9%	Waiver Services	91,101	131,828	40,727	30.9%
152,447	184,712	32,265	17.5%	Total Medical Management	616,127	738,848	122,721	16.6%
26,717	32,957	6,240	18.9%	Total Waiver Services	91,101	131,828	40,727	30.9%
179,164	**217,669**	**38,505**	**17.7%**	**Total Program Expenses**	**707,227**	**870,676**	**163,449**	**18.8%**
27,588	**35,849**	**(8,261)**	**(23.0%)**	**Gross Margin**	**144,672**	**143,396**	**1,276**	**0.9%**
				Administrative Expenses				
92,792	92,408	(384)	(0.4%)	Salaries, Wages & Employee Benefits	380,424	365,132	(15,292)	(4.2%)
1,333	1,333	(0)	(0.0%)	Professional Fees	5,333	5,332	(1)	(0.0%)
4	-	(4)	(100.0%)	Purchased Services	23	-	(23)	(100.0%)
5,965	7,443	1,478	19.9%	Other Operating Expenses	18,949	29,772	10,823	36.4%
5,900	7,525	1,625	21.6%	Indirect Cost Allocation, Occupancy	23,601	30,100	6,499	21.6%
105,993	**108,709**	**2,716**	**2.5%**	**Total Administrative Expenses**	**428,330**	**430,336**	**2,006**	**0.5%**
(78,405)	**(72,860)**	**(5,545)**	**(7.6%)**	**Change in Net Assets**	**(283,658)**	**(286,940)**	**3,282**	**1.1%**
86.7%	***85.9%***	***0.8%***		***Medical Loss Ratio***	***83.0%***	***85.9%***	***(2.8%)***	
51.3%	***42.9%***	***(8.4%)***		***Admin Loss Ratio***	***50.3%***	***42.4%***	***(7.8%)***	

Back to Agenda

CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2023

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				
47,248	21,873	(25,375)	(116.0%)	Purchased Services	182,649	87,492	(95,157)	(108.8%)
177,525	211,000	33,475	15.9%	Depreciation & Amortization	710,099	844,000	133,901	15.9%
22,758	34,000	11,242	33.1%	Insurance Expense	91,033	136,000	44,967	33.1%
125,997	167,302	41,305	24.7%	Repair & Maintenance	498,476	669,208	170,732	25.5%
59,097	57,859	(1,238)	(2.1%)	Other Operating Expenses	291,103	231,436	(59,667)	(25.8%)
(432,625)	(492,034)	(59,409)	(12.1%)	Indirect Cost Allocation, Occupancy	(1,773,361)	(1,968,136)	(194,775)	(9.9%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2023

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
155,930	133,810	22,120	16.5%	Rental Income	630,274	535,240	95,034	17.8%
155,930	**133,810**	**22,120**	**16.5%**	**Total Operating Revenue**	**630,274**	**535,240**	**95,034**	**17.8%**
				Administrative Expenses				
44,628	7,126	(37,502)	(526.3%)	Purchased Services	84,419	28,504	(55,915)	(196.2%)
34,573	40,000	5,427	13.6%	Depreciation & Amortization	138,292	160,000	21,708	13.6%
7,500	10,091	2,591	25.7%	Insurance Expense	30,002	40,364	10,362	25.7%
78,939	84,860	5,921	7.0%	Repair & Maintenance	197,688	339,440	141,752	41.8%
9,191	24,446	15,255	62.4%	Other Operating Expenses	131,146	97,784	(33,362)	(34.1%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
174,831	**166,523**	**(8,308)**	**(5.0%)**	**Total Administrative Expenses**	**581,546**	**666,092**	**84,546**	**12.7%**
(18,901)	**(32,713)**	**13,812**	**42.2%**	**Change in Net Assets**	**48,728**	**(130,852)**	**179,580**	**137.2%**

Back to Agenda

CalOptima Health
Building 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2023

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				
6,966	56,667	49,701	87.7%	Purchased Services	6,966	56,667	49,701	87.7%
9,397	-	(9,397)	(100.0%)	Depreciation & Amortization	9,397	-	(9,397)	(100.0%)
-	-	-	0.0%	Insurance Expense	-	-	-	0.0%
3,236	-	(3,236)	(100.0%)	Repair & Maintenance	3,236	-	(3,236)	(100.0%)
49	-	(49)	(100.0%)	Other Operating Expenses	49	-	(49)	(100.0%)
19,648	**56,667**	**37,019**	**65.3%**	**Total Administrative Expenses**	**19,648**	**56,667**	**37,019**	**65.3%**
(19,648)	**(56,667)**	**37,019**	**65.3%**	**Change in Net Assets**	**(19,648)**	**(56,667)**	**37,019**	**65.3%**

Back to Agenda

OTHER PROGRAM INCOME STATEMENTS – OCTOBER MONTH:

ONECARE CONNECT

- **CHANGE IN NET ASSETS** is ($0.1) million, unfavorable to budget $0.1 million due to prior year activities

PACE

- **CHANGE IN NET ASSETS** is $0.2 million, favorable to budget $0.1 million

MSSP

- **CHANGE IN NET ASSETS** is ($0.1) million, unfavorable to budget $5,545

NON-OPERATING INCOME STATEMENTS – OCTOBER MONTH

BUILDING 500

- **CHANGE IN NET ASSETS** is ($18,901), favorable to budget $13,812
  - Net of $0.2 million in rental income and $0.2 million in expenses

BUILDING 7900

- **CHANGE IN NET ASSETS** is ($19,648), favorable to budget $37,019

INVESTMENT INCOME

- Favorable variance of $11.8 million due to $12.0 million of interest income and $0.1 million realized and unrealized net loss on investments

GRANT EXPENSE AND OTHER

- Favorable variance of $1.0 million

CalOptima Health
Balance Sheet
October 31, 2023

	October-23	September-23	$ Change	% Change
ASSETS				
Current Assets				
Cash and Cash Equivalents	791,125,217	1,118,731,643	(327,606,426)	(29.3%)
Short-term Investments	1,682,326,188	1,721,466,143	(39,139,955)	(2.3%)
Premiums due from State of CA and CMS	465,651,645	446,631,793	19,019,852	4.3%
Prepaid Expenses and Other	14,985,598	15,905,501	(919,903)	(5.8%)
Total Current Assets	**2,954,088,648**	**3,302,735,079**	**(348,646,432)**	**(10.6%)**
Board Designated Assets				
Cash and Cash Equivalents	1,976,427	2,394,945	(418,518)	(17.5%)
Investments	611,939,276	578,137,094	33,802,182	5.8%
Total Board Designated Assets	**613,915,703**	**580,532,039**	**33,383,664**	**5.8%**
Restricted Deposit	**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net	91,963,653	91,086,936	876,717	1.0%
Total Assets	**3,660,268,003**	**3,974,654,054**	**(314,386,050)**	**(7.9%)**
Deferred Outflows of Resources				
Advance Discretionary Payment	49,999,717	-	49,999,717	100.0%
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**	**25,969,350**	**49,999,717**	**192.5%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	**3,736,237,070**	**4,000,623,404**	**(264,386,333)**	**(6.6%)**
LIABILITIES				
Current Liabilities				
Medical Claims Liability	1,667,742,576	1,952,986,427	(285,243,851)	(14.6%)
Provider Capitation and Withholds	143,261,615	118,767,889	24,493,726	20.6%
Accrued Reinsurance Costs to Providers	3,682,109	3,015,442	666,667	22.1%
Unearned Revenue	33,586,916	65,414,622	(31,827,706)	(48.7%)
Accounts Payable and Other	13,031,171	24,750,272	(11,719,101)	(47.3%)
Accrued Payroll and Employee Benefits and Other	20,780,479	20,569,881	210,598	1.0%
Deferred Lease Obligations	42,626	45,815	(3,189)	(7.0%)
Total Current Liabilities	**1,882,127,491**	**2,185,550,348**	**(303,422,857)**	**(13.9%)**
GASB 96 Subscription Liabilities	15,494,769	14,510,742	984,028	6.8%
Postemployment Health Care Plan	19,157,815	19,110,335	47,480	0.2%
Net Pension Liability	40,465,145	40,465,145	-	0.0%
Total Liabilities	**1,957,245,220**	**2,259,636,570**	**(302,391,350)**	**(13.4%)**
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	111,117,658	109,634,498	1,483,160	1.4%
Funds in excess of TNE	1,656,698,676	1,620,176,820	36,521,856	2.3%
Total Net Position	**1,767,816,334**	**1,729,811,317**	**38,005,016**	**2.2%**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**3,736,237,070**	**4,000,623,404**	**(264,386,333)**	**(6.6%)**

Back to Agenda

BALANCE SHEET – OCTOBER MONTH:

ASSETS of $3.7 billion decreased $264.4 million from September or 6.6%

- Operating Cash and Short-term Investments net decrease of $366.7 million due to payout of Phase II of Calendar Year 2021 Hospital Directed Payments (DP) of $138.2 million and CY 2022 Hospital Quality Assurance Fee (HQAF) funding of $148.4 million (including approximately $1.0 million in prior year adjustments)
- Total Deferred Outflows of Resource increased $50.0 million due to a one-time additional discretionary payment to CalPERS for CalOptima Health's Unfunded Accrued Liability
- Total Board Designated Assets increased $33.4 million due to a $32.0 million transfer from the operating account to meet the minimum tangible net equity requirements
- Premiums due from the State of California (CA) and the Centers for Medicare & Medicaid Services (CMS) increased $19.0 million due to timing of cash receipts

LIABILITIES of $2.0 billion decreased $302.4 million from September or 13.4%

- Medical Claims Liabilities decreased $285.2 million due primarily to payments made for Hospital DP, HQAF and timing of claims payments
- Deferred Revenue decreased $31.8 million due to timing of capitation payments from CMS
- Accounts Payable and Other decreased $11.7 million due to a $10.0 million grant payment to the Coalition of Orange County Community Health Centers
- Provider Capitation and Withholds increased $24.5 million due to Proposition 56

NET ASSETS of $1.8 billion, increased $38.0 million from September or 2.2%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of October 31, 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	250,928,813				
	Tier 1 - MetLife	249,237,040				
Board Designated Reserve		500,165,853	359,099,361	560,620,941	141,066,492	(60,455,088)
	Tier 2 - Payden & Rygel	56,993,520				
	Tier 2 - MetLife	56,756,330				
TNE Requirement		113,749,850	111,117,658	111,117,658	2,632,192	2,632,192
	Consolidated:	**613,915,703**	**470,217,019**	**671,738,599**	**143,698,684**	**(57,822,896)**
	Current reserve level	*1.83*	*1.40*	*2.00*		

Back to Agenda

CalOptima Health
Statement of Cash Flows
October 31, 2023

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	38,005,016	97,810,081
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation & Amortization	1,238,701	4,390,861
Changes in assets and liabilities:		
Prepaid expenses and other	919,903	75,104
Capitation receivable	(19,019,852)	8,272,054
Medical claims liability	(284,577,184)	31,185,921
Deferred revenue	(31,827,706)	(29,855,996)
Payable to health networks	24,493,726	17,817,589
Accounts payable	(11,719,101)	(2,050,772)
Accrued payroll	258,078	(2,369,097)
Other accrued liabilities	980,839	(625,629)
Net cash provided by/(used in) operating activities	(281,247,582)	124,650,116
GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	(49,999,717)	(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	39,139,955	(5,590,124)
Change in Property and Equipment	(2,115,418)	(12,147,009)
Change in Restricted Deposit & Other	-	-
Change in Board designated reserves	(33,383,664)	(37,364,009)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	3,640,872	(55,101,143)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(327,606,426)	19,549,256
CASH AND CASH EQUIVALENTS, beginning of period	$1,118,731,643	771,575,961
CASH AND CASH EQUIVALENTS, end of period	**791,125,217**	**791,125,217**

Back to Agenda

CalOptima Health - Consolidated
Net Assets Analysis
For the Four Months Ending October 31, 2023

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 10/31/2023	**$1,767.8**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**613.9**			**34.7%**
	Capital Assets, net of Depreciation[2]	**92.0**			**5.2%**
Resources Allocated[3]	Homeless Health Initiative[4]	$19.9	$59.9	$40.0	1.1%
	Housing and Homelessness Initiative Program[4]	69.3	97.2	27.9	3.9%
	Intergovernmental Transfers (IGT)	58.6	111.7	53.2	3.3%
	Digital Transformation and Workplace Modernization	66.2	100.0	33.8	3.7%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	6.4	8.0	1.6	0.4%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.7%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.9	1.0	0.1	0.1%
	General Awareness Campaign	0.9	2.7	1.8	0.1%
	Member Health Needs Assessment	0.8	1.0	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	147.8	153.5	5.7	8.4%
	Medi-Cal Annual Wellness Initiative	2.0	3.8	1.8	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.6%
	In-Home Care Pilot Program with the UCI Family Health Center	1.7	2.0	0.3	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.5	5.0	0.5	0.3%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	1.0%
	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	2.8%
	Distribution Event- Naloxone	2.5	15.0	12.5	0.1%
	Garden Grove Bldg Improvement	10.5	10.5	0.0	0.6%
	Post-Pandemic Supplemental	83.2	107.5	24.3	4.7%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	2.1%
	Subtotal:	**$622.9**	**$868.5**	**$245.6**	**35.2%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$439.0**			**24.8%**

[1] Total of Board Designated Reserve and unallocated reserve amount can support approximately 92 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 summary and Allocated Funds for list of Board approved initiatives

Back to Agenda

CalOptima Health
Key Financial Indicators
As of October 2023

Income Statement

Item Name	Month-to-Date (Oct 2023) Actual	Budget	Variance	%		FY 2024 Year-to-Date (Oct 2023) Actual	Budget	Variance	%	
Member Months	969,731	943,283	26,448	2.8%		3,918,738	3,871,201	47,537	1.2%	
*Operating Revenue **	388,532,137	345,327,000	43,205,137	12.5%		1,616,176,101	1,414,821,271	201,354,830	14.2%	
*Medical Expenses **	346,213,367	325,884,671	(20,328,696)	(6.2%)		1,468,149,251	1,319,139,901	(149,009,350)	(11.3%)	
General and Administrative Expense	18,171,859	20,782,838	2,610,979	12.6%		71,778,684	82,359,797	10,581,113	12.8%	
Non-Operating Income/(Loss)	13,858,105	990,731	12,867,374	1298.8%		21,561,915	(15,867,076)	37,428,991	235.9%	
Summary of Income & Expenses	38,005,016	(349,778)	38,354,795	10,965.5%		97,810,080	(2,545,503)	100,355,584	3,942.5%	

Ratios

Medical Loss Ratio (MLR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	89.1%	94.4%	(5.3%)		90.8%	93.2%	(2.4%)	

Administrative Loss Ratio (ALR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	4.7%	6.0%	1.3%		4.4%	5.8%	1.4%	

Key:

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

Investment

Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
@10/31/2023	2,277,575,956	2,280,301,230	(2,725,274)	(0.1%)

Unallocated/Unassigned Reserve Balance	Current Month @ October 2023	Fiscal Year Ending June 2022	Change	%
Consolidated	439,038,489	354,771,258	84,267,230	23.8%
*Days Cash On Hand**	92			

*Total of Board Designated reserve and unallocated reserve amount can support approximatley 92 days of CalOptima Health's current operations.

Back to Agenda

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Four Months Ending October 31, 2023

	FY 2024 Month-to-Date				FY 2024 Year-to-Date				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	**833,287**	**1,748,914**	**915,627**	**52.4%**	**17,141,665**	**6,995,656**	**(10,146,009)**	**-145.0%**	**20,739,716**	**43,841,656**	**23,101,940**	**52.7%**
Operating Expenses:												
Salaries, Wages & Benefits	614,398	609,649	(4,749)	-0.8%	2,434,915	2,438,596	3,681	0.2%	5,853,492	7,730,829	1,877,337	24.3%
Professional Fees	17,021	175,416	158,395	90.3%	26,733	701,664	674,931	96.2%	292,926	2,834,164	2,541,238	89.7%
Purchased Services	-	155,000	155,000	100.0%	-	620,000	620,000	100.0%	-	930,000	930,000	100.0%
Other Expenses	1,213,562	1,278,509	64,947	5.1%	3,885,725	5,114,036	1,228,311	24.0%	6,900,502	8,506,416	1,605,914	18.9%
Total Operating Expenses	**1,844,981**	**2,218,574**	**373,593**	**16.8%**	**6,347,373**	**8,874,296**	**2,526,923**	**28.5%**	**13,046,919**	**20,001,409**	**6,954,490**	**34.8%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2023	10,297,597	47,973,113
FY2024	23,489,038	47,609,899
FY2025		
Ending Funding Balance	**66,213,365**	**4,416,988**

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

Back to Agenda

CalOptima Health

Summary of Homeless Health Initiatives (HHI) and Allocated Funds

As of October 31, 2023

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 Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	662,709	300,552
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine	8,276,652	2,489,000	5,787,652
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 39,981,061**	**$ 60,018,939**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 39,981,061**	**$ 19,918,939**

Notes:

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

Back to Agenda

CalOptima Health

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

As of October 31, 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	2,200,000	-
Pulse For Good	800,000	382,200	417,800
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	1,461,149	2,560,162
Infrastructure Projects	5,832,314	2,785,365	3,046,949
Capital Projects	73,247,369	21,000,000	52,247,369
System Change Projects	10,180,000	-	10,180,000
Non-Profit Healthcare Academy	354,530	56,013	298,517
Total of Approved Initiatives	**$ 97,235,524** [1]	**$ 27,884,727**	**$ 69,350,797**

Notes:

[1]Total funding $97.2M: $40.1M Board-approved reallocation from HHI, $22.3M from CalOptima Health existing reserves and $34.8M from DHCS HHIP incentive payments

CalOptima Health
Budget Allocation Changes
Reporting Changes for October 2023

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 Inview 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	Enterprise Project Management Office – Training & Seminar	Enterprise Project Management Office – Professional Fees	$10,000	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 – 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	Sales & Marketing – Purchased Services	Provider Data Management Services - Purchased Services	$10,000	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

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.

Back to Agenda

Board of Directors Meeting
December 7, 2023

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

- **2023 Compliance Program Effectiveness (CPE) Audit *(applicable to OneCare)*:**

  ***Update*:**
  - CalOptima Health has contracted with an independent consulting firm to conduct a CPE audit of CalOptima Health.
  - Audit Webinar Sessions were held – October 10-13, 2023
  - Exit Conference was held – October 16, 2023
  - The draft CPE Audit Report was received on October 25, 2023, and feedback is due to the auditor by November 17, 2023.

  ***Background*:**
  - CalOptima Health is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis. The audit review period was from February 1, 2023, through August 1, 2023.

- **CY2022 Centers for Medicare & Medicaid Services (CMS) Financial Audit *(applicable to OneCare)*:**

  ***Update*:**
  - 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
    - Enrollment
    - Base year entries on the bids
    - Medical and/or drug expenses
    - Related party transactions
    - General administrative expenses

Back to Agenda

- Direct and Indirect Remuneration (DIR)

➢ CalOptima Health is currently awaiting the document request from Davis Farr LLP, which will formally start the audit process.

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.

- **2024 Medicare Part C and Data 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.
➢ The consulting firm has started training sessions to prepare the plan for the upcoming 2024 MDVA audit season.
➢ The audit will commence in 2024.

Background:

➢ CMS requires MAOs to contract with an independent consulting firm annually to conduct an independent review to validate data reported to CMS by CalOptima Health per the Medicare Part C and Part D Reporting Requirements.

- **2024 Centers for Medicare & Medicaid Services (CMS) Readiness Checklist (*applicable to OneCare*):**

***Update*:**

➢ On October 13, 2023, CMS released the 2024 CMS Readiness Checklist. CalOptima Health is expected to fulfill key operational requirements summarized in the readiness checklist for the 2024 benefit year.
➢ A kickoff email was sent on October 27, 2023, to the respective operational areas to begin the validation process.

Background:

The 2024 Readiness Checklist is a tool for organizations to use in preparation for the upcoming year. It does not supersede requirements as established in statutes or regulations as they relate to Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), 1876 Cost Plans. CMS recommends that organizations review this checklist and take the necessary steps to fulfill requirements for CY 2024.

Back to Agenda

2. Medi-Cal

- **2024 Managed Care Plan (MCP) Operational Readiness Contract:**

Update:
As of August 31, 2023:
- **226 deliverables have been submitted** for 2024 MCP operational readiness.
- **217 items have received approval** at this point.
  - Remaining deliverables are awaiting a response from the Department of Health Care Services (DHCS) or under review by CalOptima Health as part of an additional information request made by DHCS.
  - CalOptima Health is on-track for all remaining deliverables.

Background – FYI Only
Throughout CY 2022 and CY 2023, MCPs, including CalOptima Health are required to submit a series of contract readiness deliverables to DHCS for review and approval. Staff will implement the broad operational changes and contractual requirements outlined in the Operational Readiness agreement to ensure compliance with all requirements by January 1, 2024, contract effective date.

- **2023 Department of Health Care Services (DHCS) Routine Medical Audit:**

Update: On 10/13/23, CalOptima Health submitted its monthly update to the initial corrective action plan, as requested by DHCS. CalOptima Health will continue to provide monthly updates and responses to DHCS and track all milestone deliverables until CAP closure. The next monthly update is due to DHCS on 11/15/23; all deliverables remain on track.

Background – FYI Only
On 8/18/23, DHCS provided CalOptima Health with the final Medical Audit reports and formal request for corrective action. The final reports reflect the results:
- 2023 Medical Audit Report: 2 findings

The summary of the draft findings in Category 2 are as follows:
- **2.1.1 Provision of Initial Health Assessment (IHA)**
  DHCS Finding #1: The Plan did not ensure that an IHA was performed by the member's primary care providers, perinatal care providers, and non-physician mid-level practitioners.
  - DHCS Recommendation: Revise and implement policies and procedures to ensure compliance and the provision of the Plan's contracted PCPs to perform IHA to new members.
- **2.2.1 - Performance of Pediatric Risk Stratification Process (PRSP)**
  DHCS Finding #2: The Plan did not ensure that members who did not have medical utilization data, claims processing data history, or other assessments or survey information available for PRSP were automatically categorized as high risk until further assessment data was gathered to make an additional risk determination.

Back to Agenda

- DHCS Recommendation: Revise and implement policies and procedures to ensure compliance with PRSP performance to WCM members.

Annual (routine) Audit Scope:

- Utilization management
- Case management and coordination of care
- Availability and accessibility
- Member rights
- Quality management
- Administrative and organizational capacity

Focused Audit:

- Scope included:
  - Transportation
  - Behavioral Health
- Staff interviews were conducted February 27 through March 8, 2023.
- No soft exit.
- Once DHCS concludes its focused audit reviews of all MCPs, a report is anticipated to be released by Q2 2024. More information to follow as DHCS finalizes and communicates next steps.

B. Regulatory Notices of Non-Compliance

- CalOptima Health did not receive any notices of non-compliance from its regulators for the month of October 2023.

C. Updates on Health Network Monitoring and Audits

- **Health Network Audits:**

  - CalOptima Health's Delegation Oversight (DO) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:
    - Noble Mid Orange County, July 1, 2022 – June 30, 2023
  - Audit tools and elements were derived from accrediting, regulatory and CalOptima Health contractual standards. For areas that scored below the 100% threshold, DO issued a corrective action plan (CAP) request, and is actively working with each health network to remediate findings.
  - The audit included review of specific P&Ps and sample files.
  - A number of areas were identified as opportunities to improve processes and timeliness of notifications to achieve 100% compliance.
  - CalOptima Health will validate the effectiveness of corrective actions once implementation is complete.

D. Internal Audit Updates

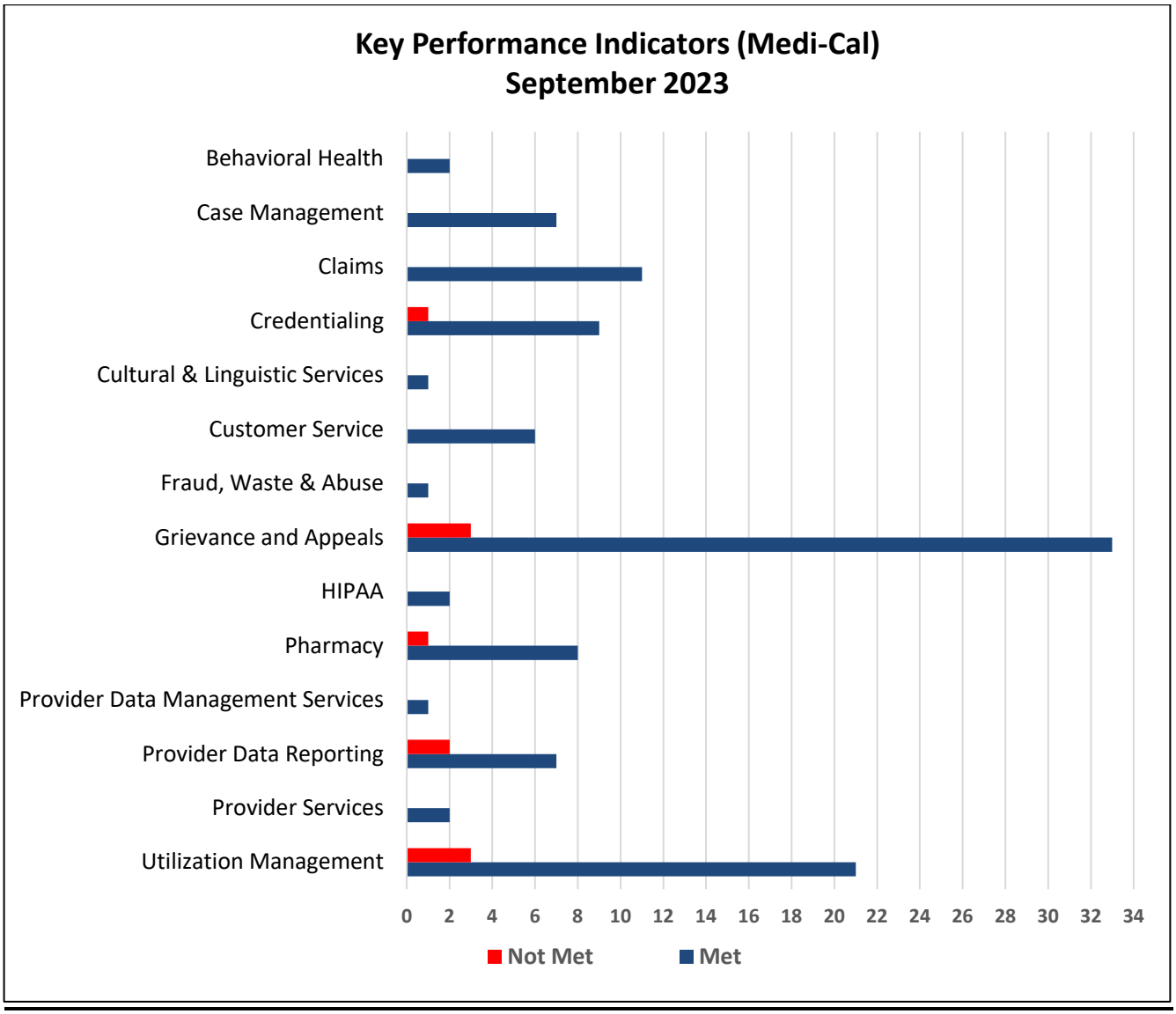
- **Internal Annual Audit:**

  - CalOptima Health's Internal Audit department is currently engaged in three (3) internal audits to assess regulatory compliance with universe, timeliness, clinical decision-making, and processing requirements.
  - The following audits (Line of Business) are currently in progress:
    - Utilization Management (Medi-Cal)
      - Lookback Period: January 1, 2023, to May 31, 2023
      - Corrective Actions: TBD
    - Utilization Management (OneCare)
      - Lookback Period: January 1, 2023, to June 30, 2023
      - Corrective Actions: TBD
    - Grievance and Appeals (Medi-Cal)
      - Lookback Period: January 1, 2023, to July 31, 2023
      - Corrective Actions: TBD
  - The following audits (Line of Business) have been completed
    - Customer Service (Medi-Cal)
      - Lookback Period: January 1, 2023, to April 30, 2023
      - Corrective Actions: Remediated and Closed
    - Grievances and Appeals (OneCare)
      - Lookback Period: January 1, 2023, to April 30, 2023
      - Corrective Actions: Remediated and Closed

- **Internal Key Performance Indicators (KPIs):**

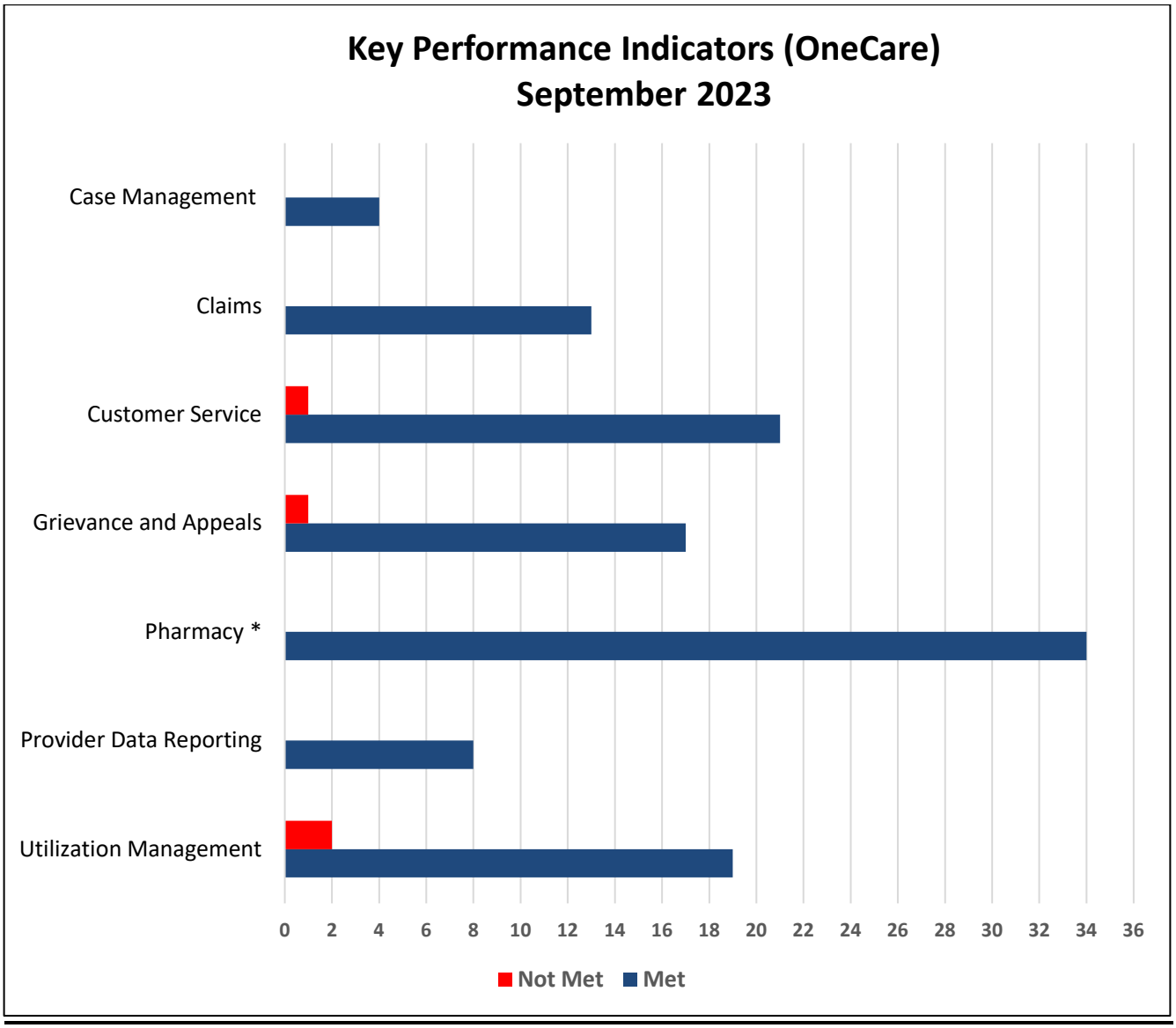
  - The KPI's are collected monthly from the internal departments.
  - A corrective action plan (CAP) is issued to the department when a measurement scores below the department's threshold for three consecutive months. The Internal Audit department actively works with the department to remediate non-compliant scores.
  - The charts below illustrate the number of KPIs for each functional area.
    - Red bar indicates the number of KPIs not met
    - Blue bar indicates the number of KPIs met

Medi-Cal



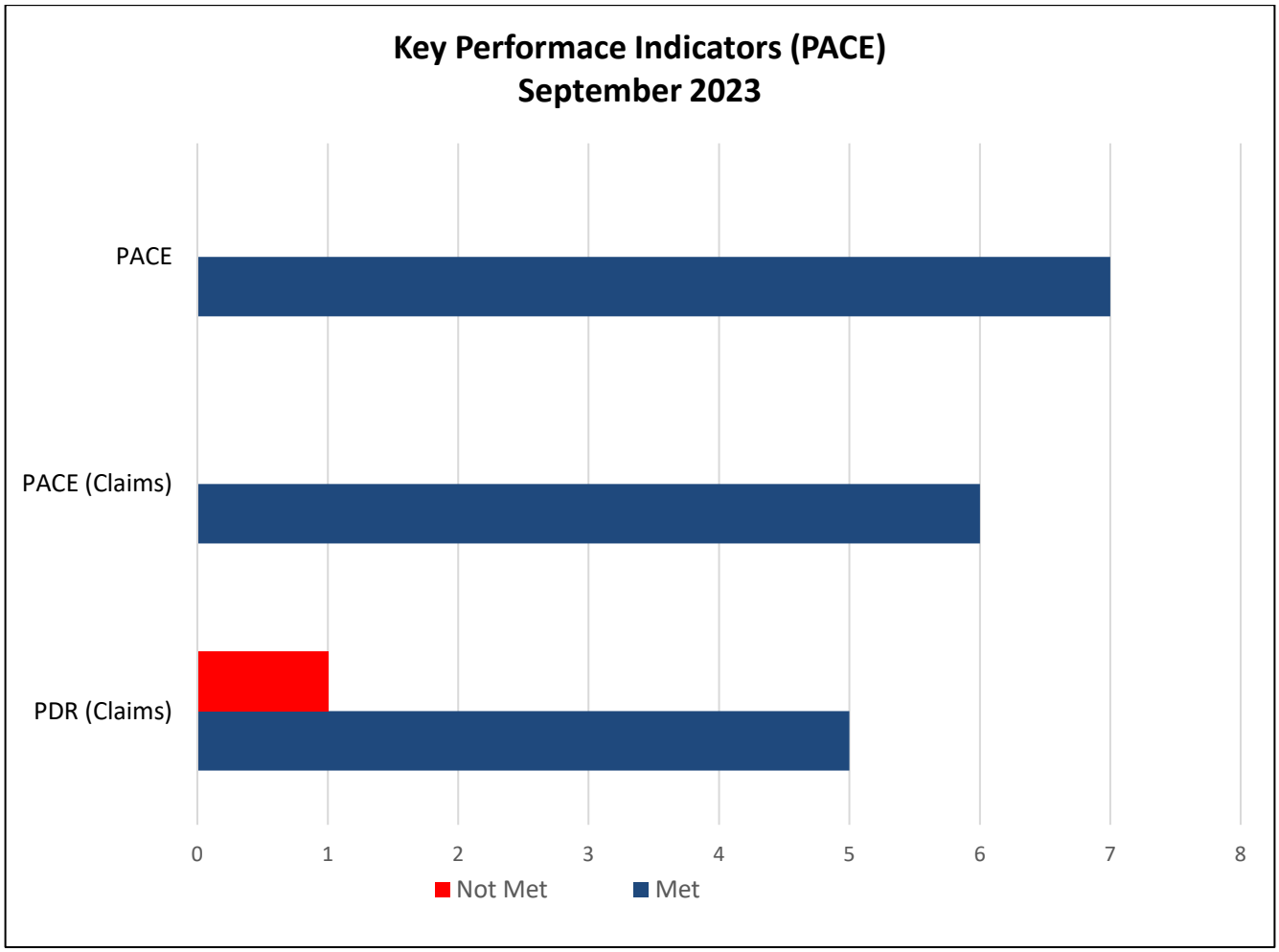
Back to Agenda

OneCare



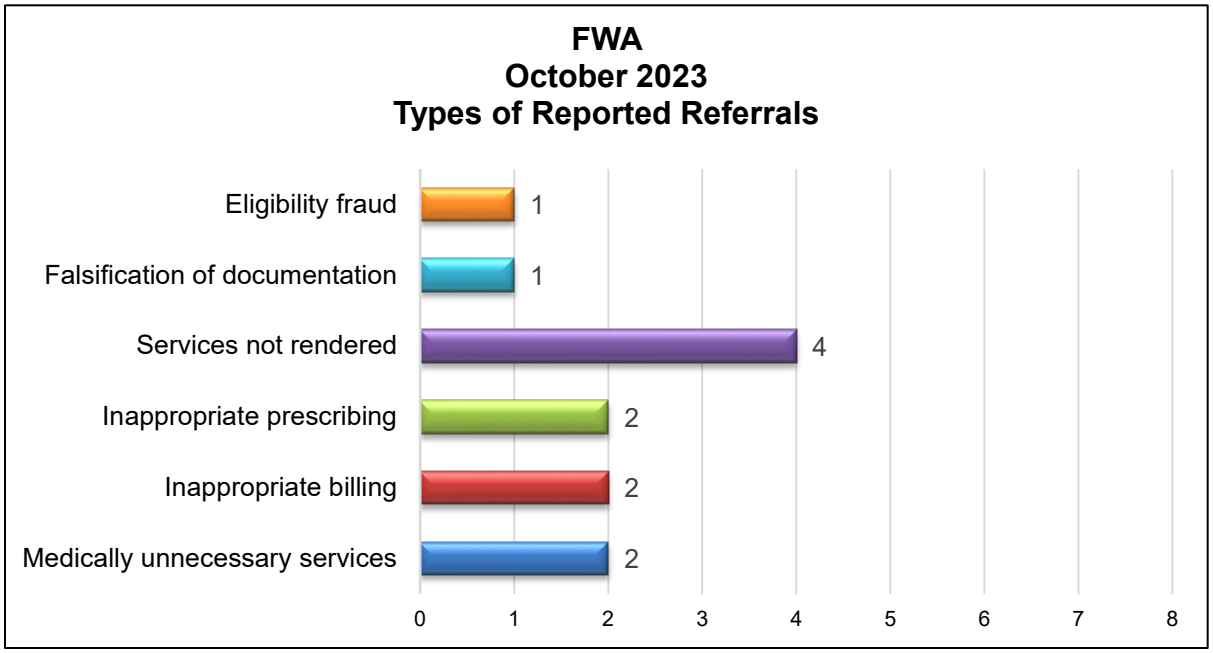
*August Pharmacy Data. September data will be available after 11/15/2023

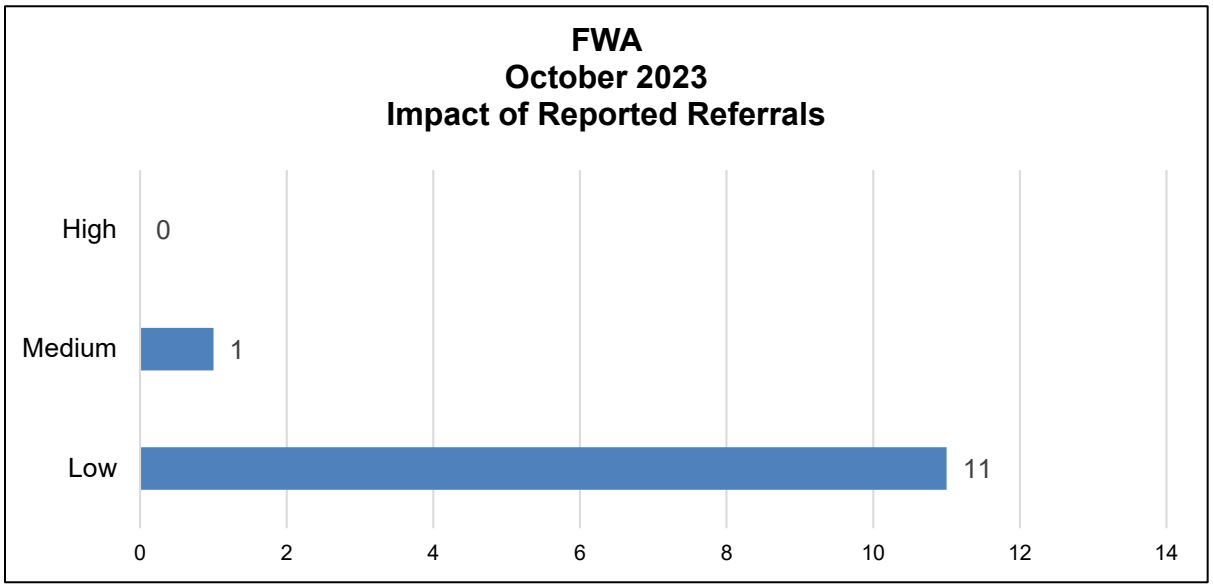
PACE



Back to Agenda

E Fraud, Waste & Abuse (FWA) Investigations (October 2023)

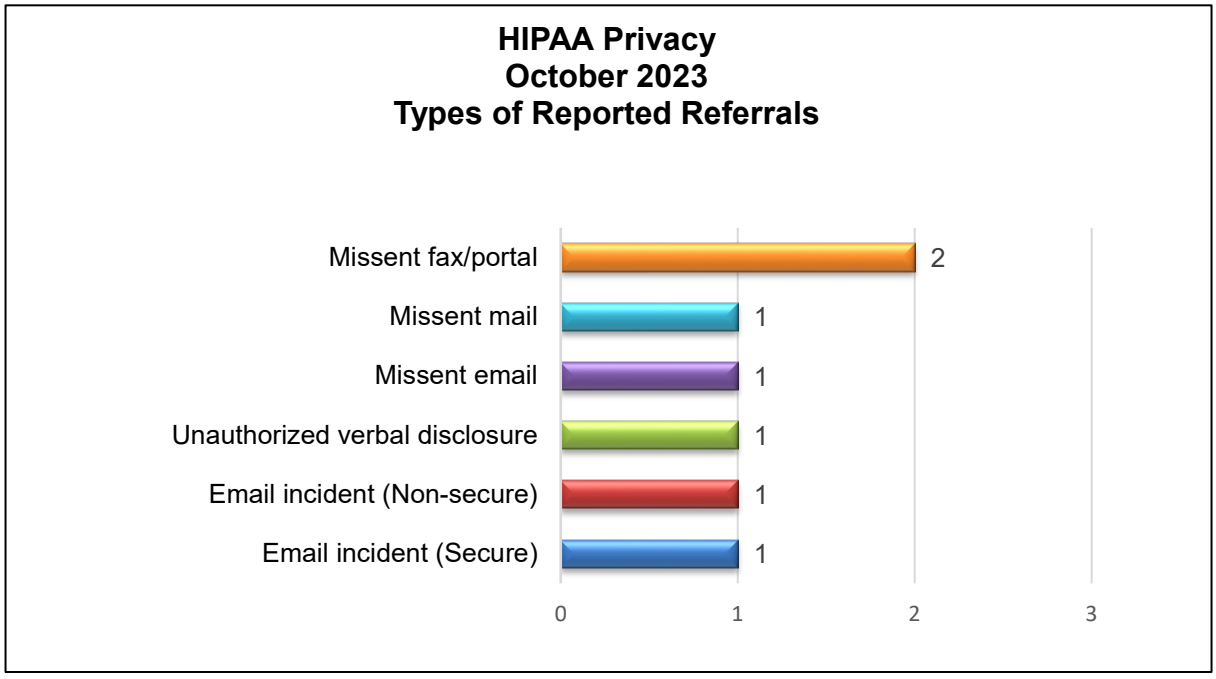


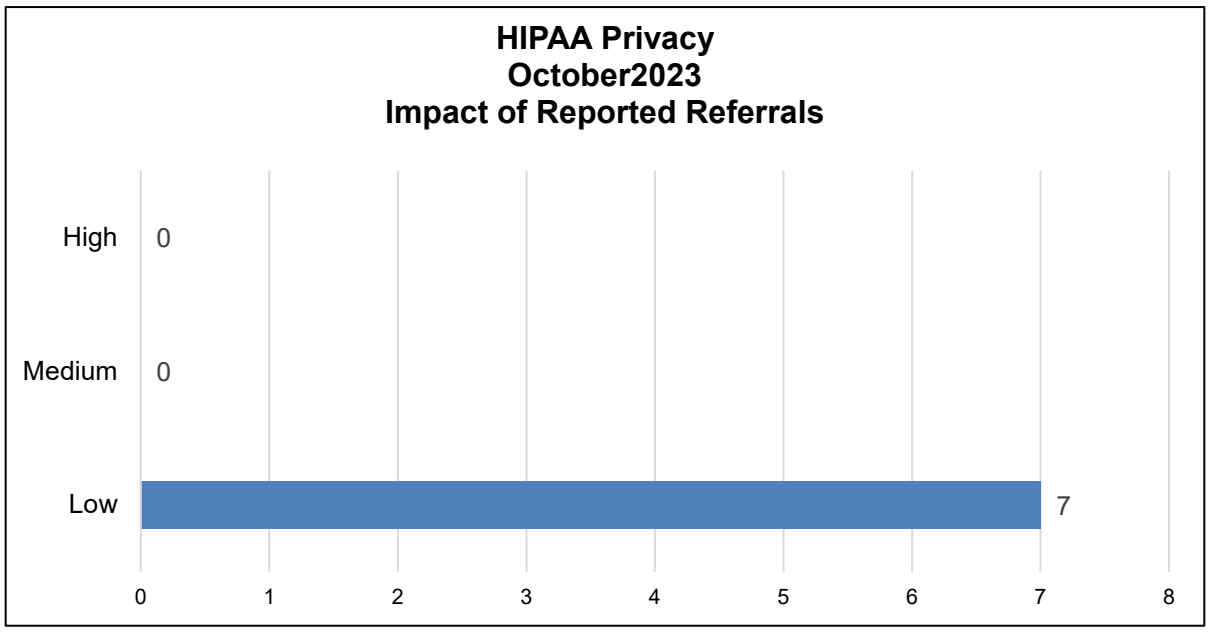


Total Number of New Cases Referred to DHCS (State)	12
Total Number of New Cases Referred to DHCS and CMS*	2
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**12**

* Any potential FWA *with impact to Medicare* is reported to CMS within 30 days of the start of an investigation.

F. Privacy Update: (October 2023)





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

POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

November 10, 2023

To: CalOptima Health

From: Potomac Partners DC & Strategic Health Care

Re: November Board of Directors Report

SPEAKER OF THE HOUSE MIKE JOHNSON (R-LA)

After a long selection process in the House Republican Caucus, the House elected Rep. Mike Johnson (R-LA) as Speaker of the House. Speaker Johnson was elected to Congress in 2016, having previously served in the Louisiana Legislature and as a Constitutional Attorney. Speaker Johnson outlined his priorities for the House in his first speech to the chamber, saying that he wishes to return to regular order on appropriations (passing each bill individually), get the legislative schedule back on track, and "decentralize" the leadership structure in the House by giving Members more opportunities for input. It's too early to tell what Speaker Johnson will do on health care policy, which he has not covered since being in Congress. However, he did chair the Republican Study Committee from 2019 to 2021, when that group issued a 58-page framework for changing the American healthcare system. It involves unwinding much of government-led health care (e.g., the Affordable Care Act).

FISCAL YEAR 2024 APPROPRIATIONS

With a new speaker in place, the House and Senate have begun moving quickly on Fiscal Year 2024 (FY24) appropriations. The House is scheduled to consider the Labor–Health and Human Services–Education (LHHSE) appropriations bill on the week of November 13th. The House will still need to negotiate with the Senate during conference negotiations, and another Continuing Resolution (CR) is expected on or before November 17th. If the government is not fully funded by January 1st, a 1% discretionary spending cut will occur across the board. If a sequestration occurs, it will only affect discretionary spending, but it would be an across-the-board cut. The table that will be used to determine the cuts is available here. An Office of Management and Budget (OMB) report from August on potential cuts is available here. Many programs like Medicaid, Medicare, Social Security, and large portions of the Supplemental Nutrition Assistance Program (SNAP) should be unaffected. House Republicans have proposed a CR that would last until January, while the Senate is seeking a CR that lasts until December.

Back to Agenda

The White House has also complicated negotiations with a $105 billion supplemental spending request providing aid to Ukraine, Israel, the Southern Border, and more. The domestic supplemental funding request also requests funding for grants to States, Territories, and Tribes through the U.S. Department of Health & Human Services's (HHS) State Opioid Response (SOR) grant program. Of the $56 billion request for domestic programs, $1.55 billion specifically targeted opioid use disorder treatment, evidence-based harm reduction services, overdose prevention measures like naloxone, and recovery support services. The full request to Congress is available here. The White House fact sheet is available here.

MEDICARE ADVANTAGE

With more than half of seniors on Medicare Advantage (MA) plans, the Better Medicare Alliance has offered seven policy solutions to Congress to improve MA. The solutions include ways to improve data collection and evaluation, strengthen in-home health risk assessments, increase access to mental and behavioral health care, and streamline prior authorization, among others. The executive summary is available here, along with a report here. The Medicare Payment Advisory Commission (MedPAC) will have a session on MA's favorable selection, which suggests that MA payments are far higher than comparable fee-for-service (FFS) spending. More information is available here. Senate Finance Committee Democrats sent a letter urging the Administration to take more action to protect Medicare beneficiaries from "deceptive marketing scams" in MA.

On November 15th, HHS will publish a Proposed Rule and open a 60-day comment period on changes to the MA Program (Part C), Medicare Prescription Drug Benefit Program (Part D), Medicare Cost Plan Program, Program of All-Inclusive Care for the Elderly (PACE), and Health Information Technology Standards and Implementation Specifications. The rule will be available here when published. The draft Proposed Rule is available for viewing here.

TELEHEALTH PATIENT PRIVACY

HHS has released two documents aimed at helping patients understand the privacy and security risks of using telehealth services. The first resource is for health care providers on "Educating Patients about Privacy and Security Risks to Protected Health Information when Using Remote Communication Technologies for Telehealth." Although health care providers are not required by the HIPAA Rules to provide this education, the resource supports the continued and increased use of telehealth by providing information to help health care providers who choose to discuss telehealth privacy and security with patients. The Guidance on Educating Patients about Privacy and Security Risks to Protected Health Information when Using Remote Communication Technologies for Telehealth is available here. The Guidance on Telehealth Privacy and Security Tips for Patients is available here.

DOCTOR'S PAY POLICY PROPOSAL

Last week, the GOP Doctors Caucus unveiled a policy proposal aimed at overhauling how Medicare pays doctors. The proposal seeks to provide more flexibility in Medicare spending by revising the Physician Fee Schedule, which is currently constrained by a budget neutrality requirement. Additionally, it would update the calculation of practice costs to address concerns raised by doctors regarding declining Medicare rates. The draft legislation aligns with doctors' groups' lobbying efforts, but its fate in a final legislative package remains uncertain as the year-end approaches. The proposed legislation is available here.

TREATS ACT

U.S. Senators Sheldon Whitehouse (D-RI), Lisa Murkowski (R-AK), Mark Warner (D-VA), and Marsha Blackburn (R-TN) have reintroduced the Telehealth Response for E-prescribing Addiction Therapy Services (TREATS) Act. This bipartisan legislation aims to increase access to telehealth services for opioid use disorder by waiving regulatory restrictions and preserving flexibilities implemented during the COVID-19 pandemic. The TREATS Act seeks to make these changes permanent, allowing providers to use audio-only or audio-visual telehealth technology to prescribe medication instead of requiring an in-person visit. The legislation has received endorsements from several medical and addiction treatment organizations. A press release with more information and a list of cosponsors is available here.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
November 27, 2023

General Update

Legislators are in their districts during interim recess (September 14 – January 3). Things have been busy, however, on the Assembly side of the house. On November 21, Speaker Robert Rivas (D-Hollister) announced his leadership team and Committee Chairs. Many were anticipated, but there were certainly some surprises.

Legislative Women's Caucus Wins Big

The biggest takeaway from the appointments was that the Legislative Women's Caucus fared very well. The Women's Caucus was key in Rivas's selection as Speaker, and they were focused on equalizing their leadership roles — which Rivas obliged. Rivas chose 17 women to chair standing committees, representing more than half of the current 33 committees, and set a record for women serving in these roles. There are also two women chairing budget subcommittees and three women in leadership positions.

Orange County Delegation Selected for Assembly Committee Chairs

Four of the Orange County Assembly delegation members were assigned chairmanships, bringing them expanded budgets, additional staff, and increased responsibilities. Rivas will now work with the new chairs and the Minority Leader to finalize the vice-chairmanships (usually, Republican caucus members) and the committee rosters. Most committee memberships are expected to remain intact.

Orange County Delegation Committee Chairs	
Orange County Assemblymember	Assembly Committee Chairmanship
Assemblymember Blanca Pacheco (D-Downey)	Rules Committee
Assemblymember Cottie Petrie-Norris (D-Irvine)	Utilities and Energy Committee
Assemblymember Sharon Quirk-Silva (D-Fullerton)	Budget Subcommittee No. 5 (State Administration)
Assemblymember Avelino Valencia (D-Anaheim)	Budget Subcommittee No. 7 (Accountability and Oversight)

Assembly Health Committee Chair Changeover

One surprise of note was the appointment of Assemblymember Mia Bonta (D-Alameda) as the Assembly Health Committee Chair. She will replace Assemblymember Jim Wood (D-Healdsburg) who has served as Chair since 2016. On November 10, Wood announced he would not seek re-election. Rivas then appointed Wood, a close confidant, as Speaker pro Tem for his final year in office. Bonta was not previously on the health committee and has had a low profile on health policy issues. One major focus for her has been the concept of "food as medicine" to ensure lower-income communities have access to healthy food. This falls in line with Rivas's focus on making nutritious food a top health policy priority.

Assemblymember Akilah Weber, M.D. (D-La Mesa) will remain Chair of Budget Subcommittee No. 1 (Health). As a current member of the Health Committee, she was seen as a possible successor to Wood as Chair. However, she is running for State Senate and is considered a frontrunner to replace Senate President pro Tem Toni Atkins in her Senate seat when Atkins terms out of office next year.

Back to Agenda

Other Key Assembly Chair Changeovers

Key Assembly Chair Changes	
Assemblymember	Assembly Committee Chair Assigned
Assemblymember Jesse Gabriel (D-Encino)	Budget
Assemblymember Buffy Wicks (D-Oakland)	Appropriations
Assemblymember Chris Ward (D-San Diego)	Housing and Community Development
Assemblymember Alex Lee (D-Milpitas)	Human Services
Assemblymember Ash Kalra (D-San Jose)	Judiciary
Assemblymember Liz Ortega (D-Hayward)	Labor and Employment
Assemblymember Gregg Hart (D-Santa Barbara)	Joint Legislative Audit Committee
Assemblymember Corey Jackson (D-Moreno Valley)	Budget Subcommittee No. 2 (Human Services)

State Capitol Update

Proposition 1 — "Treatment not Tents"

Governor Newsom has launched the campaign in support of Proposition 1 on the March 5, 2024, ballot (treatmentnottents.com). Prop 1 proposes an overhaul of California's mental health funding system (SB 326) as well as a new $6.4 billion bond for facilities (AB 531). Proponents say it will expand mental health and addiction services, build supportive housing, provide treatment over incarceration, help homeless veterans, and address shortages of mental health workers all while requiring strict accountability.

Health Care Worker $25/Hour Minimum Wage

The minimum wage bill for health care workers (SB 525) was signed into law by Governor Newsom on October 13. It creates three pay increase schedules based on provider type, ramping all workers in a covered health care entity to $25 per hour before 2030. In one of his first acts as Speaker, Rivas helped broker the final deal between the bill's sponsor, Service Employees International Union (SEIU), and opponents — California Hospital Association (CHA), California Primary Care Association (CPCA), and the dialysis community. The deal removed significant opposition but created future state costs estimated in the billions of dollars. The Governor signed the bill, contingent on an early action bill in January to address several concerns. The cleanup bill is likely to include clarity around "covered entities and employees" to address significant anticipated state costs, as the budget tightens.

"Protect Access to Health Care Act of 2024" Ballot Initiative — Managed Care Organization Tax

The Attorney General's office has released the "Title and Summary" for the Managed Care Organization (MCO) Tax initiative. This clears the way for the "Coalition to Protect Access to Care" to collect and verify approximately 550,000 signatures by July 2024 to qualify for the November 5, 2024, ballot. The coalition includes California Medical Association, CHA, CPCA, Planned Parenthood, AFSCME, and SEIU, among others. The initiative follows the current MCO tax's spending plan that was negotiated and adopted as part of the Fiscal Year 2023–24 budget. However, passage of this initiative would be the first time the tax, which leverages federal reimbursement dollars, is made permanent on health plans. Specifically, the initiative would increase reimbursement rates for Medi-Cal providers, expand education/training for health care providers, fund mental health programs, expand access to health care, and enable California to manufacture its own insulin and other prescription drugs at lower costs.

Back to Agenda

2023–24 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
S. ____ Discussion Draft 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.	**11/08/2023** Passed Senate Finance Committee; referred to Senate floor	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 43 Eggman	**Gravely Disabled Definition:** Effective January 1, 2026, expands the definition of "gravely disabled" to include a condition resulting from a severe SUD, or a co-occurring mental health disorder and a severe SUD, as well as chronic alcoholism. Also requires the California Department of Health Care Services (DHCS) to submit a report to include the number of persons admitted or detained for grave disability. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health Medi-Cal members newly considered as gravely disabled.	**10/10/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 326 Eggman	**The Behavioral Health Services Act:** Places this act on the March 5, 2024, statewide primary election ballot. If approved by voters, would rename the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA), expand services to include SUDs, revise the distribution of up to $36 million for behavioral health workforce funding and remove provisions related to innovative programs by, instead, establishing priorities and a program — administered by counties — to provide a housing support service. ***Potential CalOptima Health Impact****:* Increased resources and access to behavioral health services and housing interventions for CalOptima Health members.	**10/12/2023** Signed into law	CalOptima Health: Watch
SB 363 Eggman	**Behavioral Health Facilities Database:** No later than January 1, 2026, would require the 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; referred to Assembly	CalOptima Health: Watch
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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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.	**03/14/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 531 Irwin	**The Behavioral Health Infrastructure Bond Act of 2023:** Places this bond act on the March 5, 2024, statewide primary election ballot. If approved by voters, would authorize $6.4 million in bonds to fund conversion, rehabilitation or new construction of supportive housing and community-based treatment facilities for those experiencing or at risk of homelessness and living with behavioral health challenges. ***Potential CalOptima Health Impact*:** Increased behavioral health services and community supports for some CalOptima Health members.	**10/12/2023** Signed into law	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.	**04/11/2023** Assembly Health Committee hearing canceled by author	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.	**04/10/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1451 Jackson	**Urgent and Emergency Mental Health and SUD Treatment:** By January 1, 2024, would have required health plans to provide coverage for the treatment of urgent and emergency mental health and SUDs without prior authorization. ***Potential CalOptima Health Impact*:** Increased scope of and/or modified utilization management (UM) procedures for behavioral health services provided to CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch
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
Budget			
H.R. 5860 Granger (TX)	**Continuing Appropriations Act, 2024 and Other Extensions Act:** Enacts a Continuing Resolution (CR) to extend Fiscal Year (FY) 2023 federal spending levels from September 30 through November 17, 2023. ***Potential CalOptima Health Impact:*** Continuation of current federal spending on programs impacting CalOptima Health members.	**09/30/2023** Signed into law	CalOptima Health: Watch
H.R. 6363 Granger (TX)	**Further Continuing Appropriations and Other Extensions Act, 2024:** Enacts a CR to further extend FY 2023 federal spending levels from November 17, 2023, through either January 19, 2024, or February 2, 2024, depending on the funded agency. In addition, reauthorizes the Supplemental Nutrition Assistance Program (SNAP) — known as CalFresh in California — through FY 2024 ending on September 30, 2024. ***Potential CalOptima Health Impact:*** Continuation of current federal spending on programs impacting CalOptima Health members.	**11/16/2023** Signed into law	CalOptima Health: Watch
SB 101 Skinner **AB 102** Ting	**Budget Act of 2023:** Makes appropriations for the government of the State of California for FY 2023–24. Total spending is $310.8 billion, of which $226 billion is from the General Fund. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**7/10/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 118 Committee on Budget	**Health Trailer Bill:** Consolidates and enacts certain budget trailer bill language containing the policy changes needed to implement health-related expenditures in the FY 2023-24 state budget. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**07/10/2023** Signed into law	CalOptima Health: Watch
AB 119 Committee on Budget	**Managed Care Organization (MCO) Provider Tax Trailer Bill:** Renews the MCO provider tax, retroactively effective April 1, 2023, through December 31, 2026, and restructures the tax tiers and amounts. Also creates the Managed Care Enrollment Fund to fund Medi-Cal programs. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**06/29/2023** Signed into law	CalOptima Health: Watch
California Advancing and Innovating Medi-Cal (CalAIM)			
AB 586 Calderon	**Community Support: Climate Change or Environmental Remediation Devices:** Would add "climate change or environmental remediation devices" as a 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).	**04/11/2023** Passed Assembly Health Committee; referred to Assembly Appropriations 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 Community Support option. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address SDOH.	**04/18/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
Covered Benefits			
SB 257 Portantino	**Mammography:** Beginning January 1, 2025, would have required health plans to cover, without cost sharing, screening mammography and medically necessary diagnostic breast imaging, including following an abnormal mammography result and for individuals with a risk factor associated with breast cancer. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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):** Would require the Medi-Cal program to cover PrEP and PEP furnished by a pharmacist for up to a 90-day course. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**09/01/2023** Passed Assembly Appropriations Committee; referred to Assembly floor **05/22/2023** Passed Senate floor	CalOptima Health: Watch
SB 496 Limón	**Biomarker Testing:** No later than July 1, 2024, adds biomarker testing — subject to UM controls — including whole genome sequencing, as a covered Medi-Cal benefit for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a disease or condition to guide treatment decisions, if the test is supported by medical and scientific evidence, as prescribed. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**10/07/2023** Signed into law	CalOptima Health: Watch CAHP: Oppose Unless Amended
SB 694 Eggman	**Self-Measured Blood Pressure (SMBP) Devices and Services**: Would have added two SMBP device-related services — patient training and device calibration as well as 30-day data collection — as covered Medi-Cal benefits to promote the health of beneficiaries with high blood pressure (hypertension) or another diagnosis that supports the use of an at-home blood pressure monitor. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch CalPACE: Support
AB 47 Boerner Horvath	**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.	**04/20/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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.	**06/21/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CalPACE: Support
AB 425 Alvarez	**Pharmacogenomics Advancing Total Health for All Act:** Effective July 1, 2024, adds pharmacogenomic testing as a covered Medi-Cal benefit, defined as laboratory genetic testing to identify how an individual's genetics may impact the efficacy, toxicity and safety of medications. ***Potential CalOptima Health Impact:*** E covered benefit for CalOptima Health Medi-Cal members.	**10/07/2023** Signed into law	CalOptima Health: Watch
AB 608 Schiavo	**Perinatal Services**: Would have required DHCS to cover additional perinatal assessments, individualized care plans and other services during the one-year postpartum Medi-Cal eligibility period at least proportional to those available during pregnancy and the initial 60-day postpartum period. DHCS would have been required to collaborate with the California Department of Public Health (CDPH) and stakeholders to determine the specific levels of additional coverage. Would have also allowed perinatal services to be rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site. Lastly, would have allowed such workers to be supervised by a community-based organization or local health jurisdiction. ***Potential CalOptima Health Impact:*** Expanded covered benefit and associated provider network for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch
AB 847 Rivas, L.	**Pediatric Palliative Care Services**: Authorizes extended Medi-Cal coverage for palliative care and hospice services after 21 years of age for individuals deemed eligible prior to that age. ***Potential CalOptima Health Impact:*** Expanded covered benefit for certain CalOptima Health Medi-Cal members.	**10/13/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 907 Lowenthal	**PANDAS and PANS**: Beginning January 1, 2024, would have required 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. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch CAHP: Oppose
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.	**04/18/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 1060 Ortega	**Naloxone Hydrochloride:** Would have added prescription and non-prescription naloxone hydrochloride or another drug approved by the U.S. Food and Drug Administration as a covered benefit under the Medi-Cal program for the complete or partial reversal of an opioid overdose. ***Potential CalOptima Health Impact:*** New Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch CAHP: Oppose Unless Amended
AB 1085 Maienschein	**Housing Support Services**: Would have required DHCS, if the state has sufficient network capacity, to add housing support services as a covered Medi-Cal benefit for individuals experiencing or at risk of homelessness, consistent with the following Community Supports offered through CalAIM: • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services ***Potential CalOptima Health Impact:*** Formalization of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch CalPACE: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
Medi-Cal Eligibility and Enrollment			
S. 423 Van Hollen (MD) **H.R. 1113** Bera (CA)	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, the Children's Health Insurance Program (CHIP) or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they were subject to a zero net premium. Would also make individuals eligible for Medicaid or CHIP based on a prior finding of eligibility for the Temporary Assistance for Needy Families program or the Supplemental Nutrition Assistance Program. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment of CalOptima Health members.	**02/14/2023** Introduced; referred to committees	CalOptima Health: Watch
AB 1481 Boerner	**Medi-Cal Presumptive Eligibility for Pregnancy**: Expands Medi-Cal presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). If an application for full-scope Medi-Cal benefits is submitted between the date of a PE4PP determination and the last day of the subsequent month, PE4PP coverage will be effective until the Medi-Cal application is approved or denied. ***Potential CalOptima Health Impact:*** Improved Medi-Cal enrollment process and timelier access to covered benefits for eligible pregnant individuals.	**10/07/2023** Signed into law	CalOptima Health: Watch
AB 1608 Patterson	**Regional Center Clients:** Would exempt from mandatory Medi-Cal MCP enrollment any dual-eligible and non-dual-eligible Medi-Cal beneficiaries who receive services from a regional center and use the Medi-Cal fee-for-service (FFS) delivery system as secondary form of health coverage. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members.	**03/27/2023** Amended and re-referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Operations and Administration			
H.R. 2811 Arrington (TX)	**Limit, Save, Grow Act of 2023:** Would require Medicaid beneficiaries ages 19–55 without dependents to work, complete community service and/or participate in a work training program for at least 80 hours per month for at least three months per year. Exemptions would be provided for those who are pregnant, physically or mentally unfit for employment, complying with work requirements under a different federal program, participating in a drug or alcohol treatment program, or enrolled in school at least half-time. The U.S. Department of Health and Human Services 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 770 Wiener	**Unified Health Care Financing System:** Directs the CalHHS Secretary to research, develop and pursue discussions of a waiver framework with the federal government to create a health care system that incorporates a comprehensive package of medical, behavioral health, pharmacy, dental and vision benefits, without a share of cost for essential services. No later than January 1, 2025, the Secretary must submit an interim report to the Legislature, including proposed statutory language to authorize submission of a waiver application. No later than June 1, 2025, a draft waiver framework must be completed and made available to the public for a 45-day public comment period. No later than November 1, 2025, the finalized waiver framework must be submitted to the governor and Legislature for review. ***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.	**10/07/2023** Signed into law	CalOptima Health: Watch
AB 557 Hart	**Brown Act Flexibilities:** Permanently extends current Brown Act teleconferencing flexibilities — when a declared state of emergency is in effect — beyond January 1, 2024. Also extends the period for a legislative body to make findings related to a continuing state of emergency from every 30 days to every 45 days. ***Potential CalOptima Health Impact:*** Extended teleconferencing flexibilities for Board and advisory committee meetings.	**10/08/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 719 Boerner Horvath	**Public Transit Contracts**: Would have required Medi-Cal managed care plans to contract with public paratransit operators for nonmedical transportation (NMT) and nonemergency medical transportation (NEMT) services. Would have required reimbursement to be based on the Medi-Cal FFS rates for those services. ***Potential CalOptima Health Impact:*** Execution of additional NMT and NEMT contracts; increased transportation options for CalOptima Health Medi-Cal members.	**10/07/2023** Vetoed *(see veto message)*	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
AB 1202 Lackey	**Health Care Services Data for Children, Pregnancy and Postpartum:** No later than January 1, 2025, would have required DHCS to report to the Legislature the results of an analysis to identify the number and geographic distribution of Medi-Cal providers needed to ensure compliance with time and distances standards for pediatric primary care. The report would have also included data on the number of children, pregnant and postpartum individuals receiving certain Medi-Cal services. ***Potential CalOptima Health Impact:*** Increased network analysis and reporting to DHCS.	**10/08/2023** Vetoed *(see veto message)*	CalOptima Health: Watch
AB 1690 Kalra	**Universal Health Care Coverage**: States the intent of the Legislature to guarantee accessible, affordable, equitable and high-quality health care for all Californians through a comprehensive universal single-payer health care program. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal and commercial health care delivery systems, including changes to administration, covered benefits, financing and organization.	**02/17/2023** Introduced	CalOptima Health: Watch
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 Centers for Medicare and Medicaid Services (CMS) for CalOptima Health OneCare members.	**03/28/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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
SB 311 Eggman	**Medicare Part A Buy-In:** Requires DHCS to submit a Medicaid state plan amendment to enter into a Medicare Part A buy-in agreement with CMS, effective January 1, 2025, or DHCS's readiness date, whichever is later. This will allow DHCS to automatically enroll individuals with a Part A premium into Part A on their behalf. ***Potential CalOptima Health Impact:*** Simplified Medicare enrollment and increased financial stability for dual-eligible CalOptima Health members with Part A premium requirements.	**10/10/2023** Signed into law	CalOptima Health: Watch LHPC: Support CalPACE: Support
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.	**03/02/2023** Referred to 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.	**03/13/2023** Amended and re-referred to 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.	**04/20/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch LHPC: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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
SB 598 Skinner **SB 516** 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.	**09/13/2023** 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 CAHP: Oppose LHPC: 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 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 **05/04/2023** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 236 Holden	**Provider Directory Audits:** Would require health plans to annually audit and delete inaccurate listings from its provider directories. Would also require a provider directory to be 60% accurate by January 1, 2024, with increasing percentage accuracy each year until the directories are 95% accurate by January 1, 2027. In addition, plans would be subject to penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. Finally, beginning July 1, 2024, would require plans to delete a provider from its directory if a plan has not reimbursed the provider in the prior year. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**03/14/2023** Passed Assembly Health Committee; referred to Assembly Appropriations 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 CAHP: Concerns LHPC: Oppose Unless Amended
AB 904 Calderon	**Doula Access**: Beginning January 1, 2025, requires a health plan to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. ***Potential CalOptima Health Impact:*** Increased access to prenatal care for eligible CalOptima Health Medi-Cal members; additional provider contracting and credentialing; additional staff time for program management.	**10/07/2023** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 931 Irwin	**Physical Therapy Prior Authorization**: Beginning January 1, 2025, would have prohibited health plans from requiring prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch CAHP: Oppose
AB 1241 Weber	**Medi-Cal Telehealth Access:** Requires Medi-Cal telehealth providers to maintain and follow protocols to either offer in-person services or arrange a referral to in-person services. However, this does not require a provider to schedule an appointment with a different provider on behalf of a patient. ***Potential CalOptima Health Impact:*** Continued flexibility to access in-person, video and audio-only health care services for CalOptima Health Medi-Cal members.	**09/08/2023** Signed into law	CalOptima Health: Watch
AB 1288 Reyes	**Medication-Assisted Treatment Prior Authorization**: Would have prohibited 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.	**10/08/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch CAHP: Oppose
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

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.	**03/24/2023** Passed by House Energy and Commerce Committee; referred to House floor	CalOptima Health: Watch
SB 282 Eggman	**Federally Qualified Health Center (FQHC) 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.	**07/12/2023** 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 525 Durazo	**Health Care Workers Minimum Wage:** Establishes three separate minimum wage schedules for covered health care employers, including integrated health care delivery systems; health care systems; dialysis clinics; health facilities owned, affiliated, or operated by a county; licensed skilled nursing facilities; and clinics that meet certain requirements. ***Potential CalOptima Health Impact:*** Increased direct wage costs for certain CalOptima Health PACE employees to be incorporated into DHCS rates; increased indirect costs from contracted providers subject to wage increases**.**	**10/13/2023** Signed into law	CalOptima Health: Watch
SB 870 Caballero	**MCO Tax:** Would renew the MCO tax on health plans, which expired on January 1, 2023, to an unspecified future date. Would also modify the tax rates to unspecified percentages that are based on the Medi-Cal membership of the health plan. ***Potential CalOptima Health Impact:*** Increased tax liability on CalOptima Health.	**04/26/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations 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.	**03/27/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 576 Weber	**Abortion Reimbursement**: Would have required DHCS to fully reimburse Medi-Cal providers for providing medication to terminate a pregnancy that aligns with clinical guidelines, evidence-based research and provider discretion. ***Potential CalOptima Health Impact:*** Increased financial stability for eligible CalOptima Health contracted providers.	**10/07/2023** Vetoed *(see **veto message**)*	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 of CalOptima Health's contracted FQHCs.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 1698 Wood	**Medi-Cal Funding**: States the intent of the Legislature to enact future legislation to increase overall funding and reimbursement for the Medi-Cal program. ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health and its contracted providers.	**02/17/2023** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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
H.R. 3746 McHenry	**Fiscal Responsibility Act (FRA) of 2023:** Suspends the $31 trillion debt limit until January 1, 2025, and includes additional policies to cap discretionary spending limits and modify work reporting requirements for certain safety net programs. Most notably, modifies work requirements for SNAP. Specifically, through October 1, 2030, raises the age of SNAP recipients subject to work requirements from 18–49 to 18–55 years old but also creates new exemptions that waive SNAP work requirements for veterans, individuals experiencing homelessness and young adults ages 18–24 years old who are aging out of the foster care system. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health members eligible for CalFresh.	**06/03/2023** Signed into law	CalOptima Health: Watch
AB 85 Weber	**SDOH Screenings:** Would have added SDOH screenings as a covered Medi-Cal benefit. Would have also required health plans to provide primary care providers with adequate access to community health workers, social workers and peer support specialists. Would have also required 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.	**10/07/2023** Vetoed *(see **veto message**)*	CalOptima Health: Watch CAHP: Oppose
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.	**03/07/2023** Failed passage in Assembly Public Safety Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 271 Quirk-Silva	**Homeless Death Review Committee:** Authorizes counties to establish a homeless death review committee for the purpose of gathering information to identify the root causes of the deaths of homeless individuals and to determine strategies to improve coordination of services for the homeless population. ***Potential CalOptima Health Impact:*** Increased coordination and data review between the County of Orange and CalOptima Health.	**09/01/2023** Signed into law	**03/02/2023** CalOptima Health: SUPPORT

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: November 22, 2023

2023 Federal Legislative Dates

January 3	118th Congress, 1st Session convenes
July 31–September 4	Summer recess for Senate
July 31–September 11	Summer recess for House
December 15	1st Session adjourns

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

2023 State Legislative Dates

January 4	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 17	Last day for legislation to be introduced
March 30–April 10	Spring recess
April 28	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 5	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 19	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
May 30–June 2	Floor session only
June 2	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 14–August 14	Summer recess
September 1	Last day for fiscal committees to report bills in their second house to the Floor
September 5–14	Floor session only
September 8	Last day to amend bills on the Floor
September 14	Last day for each house to pass bills; final recess begins upon adjournment
October 14	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2023 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through three major programs: Medi-Cal, OneCare (HMO D-SNP) and the Program of All-Inclusive Care for the Elderly (PACE).

FY 2023–24 Enacted State Budget Analysis

Table of Contents

Background

On January 10, 2023, Gov. Gavin Newsom released the Fiscal Year (FY) 2023–24 Proposed State Budget, effective July 1, 2023. The proposed budget's total spending of $297 billion ($223.6 billion General Fund [GF]) reflected an estimated $22.5 billion deficit and a 9.8% decrease in overall spending compared to the FY 2022–23 Enacted Budget.

On May 12, Gov. Newsom released the FY 2023–24 Revised Budget Proposal, also known as the May Revise, with total funding at $306 billion, including $224 billion GF. As tax revenues continued to decline, the projected budget deficit increased by $9.3 billion compared to January Proposed Budget — totaling a $31.5 billion deficit. Nevertheless, the governor continued to present a balanced budget — largely without program cuts — through spending delays, shifts to funding sources, pullbacks of unused expenditures, new revenue sources, borrowing and limited reserve withdrawal.

To meet the constitutionally obligated deadline to pass a balanced budget, on June 15, the State Senate and State Assembly both passed Senate Bill (SB) 101, a placeholder budget representing the Legislature's joint counterproposal to the May Revise. Once a final budget agreement deal was reached between the governor and legislative leaders, the governor signed into law the placeholder state budget (SB 101) on June 27 and the final, agreed-upon budget revisions (Assembly Bill [AB] 102) on July 10. In addition to the budget, the governor also signed the Managed Care Organization (MCO) Tax Trailer Bill (AB 119) on June 29 and the consolidated Health Trailer Bill (AB 118) on July 10, which contain the policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2023–24 Enacted Budget.

Overview

As the second largest budget in California history, the FY 2023–24 Enacted Budget sits at $310.8 billion, including nearly $226 billion GF spending, which attempts to close the gap on a $32 billion deficit while safeguarding $37.8 billion in reserve funds. This represents a 4.4% decrease in GF spending compared to the FY 2022–23 Enacted Budget ($234.4 billion GF). To achieve a balanced budget this FY, certain commitments will be delayed or added to the FY 2024–25 budget as a future investment.

The enacted budget estimates Medi-Cal spending of $151.2 billion ($37.6 billion GF), an 11.7% total increase (21.7% GF increase) from FY 2022–23, despite the fact that average Medi-Cal caseload in FY 2023–24 is expected to decrease by 7.2% to 14.2 million beneficiaries

as redeterminations resume following the end of the COVID-19 public health emergency (PHE). Total COVID-19-specific impacts on the Medi-Cal budget impacts are projected to decline overall, but GF costs are predicted to increase due to the phase-out of federal relief funding related to the PHE.

Managed Care Organization (MCO) Provider Tax

With renewed commitments to Medi-Cal spending, the enacted budget retroactively implements a new MCO Provider Tax, effective April 1, 2023, through December 31, 2026. Over the period of the tax, a total of $19.4 billion in net benefits will be generated — with $8.3 billion allocated for GF offsets to support a balanced budget and the remaining $11.1 billion for historic new investments in the Medi-Cal program, including targeted increases to Medi-Cal rates, access and provider participation.

In facilitating the $11.1 billion allocation, the new Medi-Cal Provider Payment Reserve Fund will support investments in Medi-Cal that maintain and expand programs by increasing quality of health care delivery and reducing barriers to care. These funds will preserve eligibility and benefit expansions in the Medi-Cal program, strengthen the program's participation, especially in underserved areas and in primary and preventive care, and maximize opportunities to draw additional federal matching funds to the Medi-Cal program. While a detailed plan for most investments will be submitted as part of the FY 2024–25 budget next year, specific limited investments beginning in FY 2023–24 can be found below:

Rate Increases in the Medi-Cal Program: No sooner than January 1, 2024, reimbursement rates for primary care services (including nurse practitioners and physician assistants), maternity care (including obstetric and doula services), and certain outpatient non-specialty mental health services will increase to at least 87.5% of Medicare rates. This is an adjustment to base rates that takes into account current Proposition 56 supplemental payments and the elimination of AB 97 rate reductions for these services. Estimated costs to increase provider rates are $237.4 million ($98.2 million Medi-Cal Provider Payment Reserve Fund) in FY 2023–24 and $580.5 million ($240.1 million Medi-Cal Provider Payment Reserve Fund) annually thereafter.

Distressed Hospital Loan Program: $300 million is allocated to support not-for-profit and public hospitals facing closure or facilitating the reopening of a hospital. The Department of Health Care Access and Information (HCAI) and California Health Facilities Financing Authority will provide one-time interest-free cashflow loans of up to $150 million from the Medi-Cal Provider Payment Reserve Fund in FY 2023–24 and up to $150 million from the GF in the previous FY 2022–23 to distressed hospitals in need.

Small and Rural Hospital Relief Program: $52.2 million will support rural hospitals to meet compliance standards with the State's seismic mandate with $50 million one-time from the Medi-Cal Provider Payment Reserve and $2.2 million from the Small and Rural Hospital Relief Fund for assessment and construction.

Graduate Medical Education Program: In an effort to increase the number of primary and specialty care physicians in the state — based on demonstrated workforce needs and priorities — $75 million will be expended for the University of California to expand graduate medical education programs and annually thereafter.

Behavioral Health

The state budget continues to address gaps through renewed commitments to modernize current programs in the mental health continuum. The enacted budget includes $40 million ($20 million Mental Health Services Fund; $20 million federal funds) to continue reforming the behavioral health system. As part of the final budget agreement, DHCS will work to implement the governor's proposal to modernize the Mental Health Services Act as well as authorize a general obligation bond to fund the following:

- Unlocked community behavioral health residential settings
- Permanent supportive housing for people experiencing or at risk of homelessness who have behavioral health conditions
- Housing for veterans experiencing or at risk of homelessness who have behavioral health conditions

988 Suicide and Crisis Program: $13.2 million in special funds and federal funds will support a five-year implementation plan for a comprehensive 988 system. Under the health trailer bill language, prior authorization will no longer be required for behavioral health crisis stabilization services and care but authorizes prior authorization for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis provided through the 988 system. Additionally, a plan that provides behavioral health crisis services and is contacted by a 988 center or mobile crisis team must authorize post-stabilization care or arrange for prompt transfer of care to another provider within 30 minutes

of initial contact.

Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule Third Party Administrator (TPA): As part of the CYBHI mandate, an established statewide all-payer fee schedule will reimburse school-linked behavioral health providers who deliver services to students at or near a school-site. $10 million from the Mental Health Services Fund will be expended in support of the statewide infrastructure that will consolidate provider management operations to include credentialing, quality assurance, billing and claims.

CalHOPE: The CalHOPE program is a vital element of the statewide crisis support system. $69.5 million total funding will assist in continuing operations, including media messaging to destigmatize stress and anxiety as well as CalHOPE web services, warm line and partnership opportunities with up to 30 community-based organizations and over 400 peer crisis counselors.

CalFresh

CalFresh — California's implementation of the federal Supplemental Nutrition Assistance Program (SNAP) — sees $35 million in funding for the California Nutrition Incentive Program, which helps members purchase healthy food from farmers' markets. The Legislature also included a line item for $16.8 million in one-time funding to extend the sunset dates for a CalFresh fruit and vegetable pilot EBT program Market Match. For every benefit dollar spent, participants receive an additional dollar to spend on fruits and vegetables at a market within set parameters. The deal also includes $915,000 to trial monthly minimum CalFresh benefit increase from $23 to $50.

California Advancing and Innovating Medi-Cal (CalAIM)

Transitional Rent: DHCS successfully sought an amendment to the CalAIM Transitional Rent Waiver with a commitment of $17.9 million ($6.3 million GF) for an additional community support that may be offered by Medi-Cal MCPs. Under the DHCS budget, the new "Transitional Rent" community support would allow the provision of up to six months of rent or temporary housing to eligible individuals experiencing homelessness or at risk of homelessness and transitioning out of institutional levels of care, a correctional facility, or the foster care system.

Relatedly, the budget also includes an additional $40 million GF for the Provider Access and Transforming Health (PATH) initiative to assist providers with implementing community supports and enhanced care management (ECM) through CalAIM in clinics.

Justice Involved: CalAIM receives a commitment of $9.9 million total funding ($3.8 million GF) in FY 2023–24 for pre-release services, with an additional $225 million estimated subsidy through the PATH program to support correctional agencies in collaborating with county social services department planning and implementation of pre-release Medi-Cal enrollment services.

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT): Formerly referred to as the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration, BH-CONNECT receives $6.1 billion total ($306.2 million GF; $87.5 million Mental Health Services Fund; $2.1 billion Medi-Cal County Behavioral Health Fund; $3.6 billion federal funds) over a span of five years for DHCS and the California Department of Social Services (DSS) to implement this CalAIM program as soon as January 1, 2024. BH-CONNECT includes statewide and county opt-in components, including rent and temporary housing for up to six months for certain high-needs beneficiaries as well a behavioral health workforce initiative to expand provider capacity and services. DHCS will also seek federal approval of a Medicaid Section 1115 demonstration waiver to expand behavioral health services for Medi-Cal members living with serious mental illness and serious emotional disturbance.

As part of CalAIM Behavioral Health Payment Reform, the budget also provides $250 million GF one-time to support the non-federal share of behavioral health-related services. These funds will help mitigate a significant cash flow concern for counties as they transition from cost-based reimbursement to a fee schedule.

Community Assistance, Recovery and Empowerment (CARE) Act

With a renewed pledge to serve California's most severely impaired population who often struggle with homelessness or incarceration without treatment, the CARE Act receives funding of $52.3 million GF in FY 2023–24, $121 million GF in FY 2024-25 and $151.5 million GF in FY 2025–26 to support ongoing county behavioral health department costs. The CARE Act facilitates delivery of mental health and substance use disorder services to individuals with schizophrenia spectrum or other psychotic disorders who lack medical decision-making competences. The program would connect a person in crisis with a court-ordered

care plan for up to 24 months as a diversion from homelessness, incarcerations, or conservatorship.

Medi-Cal Eligibility

Enrollment Navigators: In addition to the $60 million appropriated in FY 2022–23, $10 million from the GF will be invested into the Health Enrollment Navigators Project (AB 74) over four years. The project aims to promote outreach, enrollment and retention activities in vulnerable populations through partnerships with counties and community-based organizations. Target populations of priority include but are not limited to persons with mental health disorder needs, persons with disabilities, older adults, unhoused individuals, young people of color, immigrants and families of mixed immigration status.

Medi-Cal Expansion to Undocumented Individual: The enacted budget maintains $1.4 billion ($1.2 billion GF) in FY 2023–24 and $3.4 billion ($3.1 billion GF) at full operation, inclusive of In-Home Supportive Services (IHSS) costs, to expand full-scope Medi-Cal eligibility to all income-eligible adults ages 26–49, regardless of immigration status, on January 1, 2024.

Newborn Hospital Gateway: The Newborn Hospital Gateway system provides presumptive eligibility determinations through an electronic process for families to enroll a deemed eligible newborn into the Medi-Cal program from hospitals that elected to participate in the program. Effective July 1, 2024, all qualified Medi-Cal providers participating in presumptive eligibility programs must utilize the Newborn Hospital Gateway system via the Children's Presumptive Eligibility Program portal to report a Medi-Cal-eligible newborn born in their facilities within 72 hours after birth or one business day after discharge.

Whole Child Model (WCM): As part of the budget, WCM will be extended to 15 additional counties no sooner than January 1, 2025. Currently implemented in 21 counties, WCM integrates children's specialty care services provided in the California Children's Services (CCS) program into Medi-Cal managed care plans (MCPs). WCM is already implemented in Orange County. The budget also requires a Medi-Cal MCP participating in WCM to ensure that a CCS-eligible child has a primary point of contact that will be responsible for the child's care coordination and support the referral pathways in non-WCM counties.

Miscellaneous

The enacted budget includes several other adjustments and provisions that potentially impact CalOptima Health:

- **COVID-19 Response:** a one-time funding of $126.6 million will continue ongoing efforts to protect the state's public health against COVID-19 – including maintenance of reporting systems, lab management and CalCONNECT — for oversight case and outbreak investigation.
- **Hepatitis C Virus Equity:** $10 million one-time GF spending, spanning over five years, to expand Hepatitis C Virus services — including outreach, linkage and testing — among high priority populations including young people who use drugs, indigenous communities and those experiencing homelessness.
- **Medi-Cal Rx Naloxone Access Initiative:** a one-time $30 million Opioid Settlements Fund expenditure to support the creation or procurement of a lower cost generic version of naloxone nasal product.
- **Medi-Cal Rx Reproductive Health Costs:** a one-time $2 million GF reappropriation and permissive use of funds for reproductive health care – including statutory changes to provide flexibility for the Medi-Cal Rx program to acquire various pharmaceutical drugs — Mifepristone or Misoprostol — to address urgent and emerging reproductive health needs.
- **Public Health Workforce:** upholds $97.5 million GF over four years for various public health workforce training and development programs.
- **Reproductive Waiver:** $200 million total funds to implement the Reproductive Health Services 1115 demonstration waiver that will support access to family planning and related services for Medi-Cal members as well as support sustainability and system transformation for California's reproductive health safety net.

Next Steps

State agencies will begin implementing the policies included in the enacted budget. Staff will continue to monitor these polices and provide updates regarding issues that have a significant impact to CalOptima Health. In addition, the Legislature will continue to advance policy bills through the legislative process.

Bills with funding allocated in the enacted budget are more likely to be passed and signed into law. The Legislature has until September 14 to pass legislation, and Gov. Newsom has until October 14 to either sign or veto that legislation.

About CalOptima Health

CalOptima Health, a county organized health system (COHS), is the single plan providing guaranteed access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima Health is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions, please contact GA@caloptima.org.

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

21. Authorize Adult Expansion Outreach Strategy to Make Eligible Adults Ages 26 Through 49 Aware of the Opportunity to Apply for Full-Scope Medi-Cal Regardless of Immigration Status.

Contacts

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Recommended Actions

1. Authorize implementation of an Adult Expansion Outreach Strategy to promote enrollment of eligible adults ages 26-49 into full-scope Medi-Cal, regardless of immigration status;
2. Authorize unbudgeted expenditures and appropriate up to ~~$2,500,000~~ $5,000,000 from existing reserves to implement the Adult Expansion Outreach Strategy; and
3. Authorize the Chief Executive Officer to execute agreements for expenditures as necessary to implement proposed activities.

Rev 12/7/2023

Background

Beginning January 1, 2024, a new law in California will provide adults 26-49 years of age access to full-scope Medi-Cal services, regardless of immigration status. All other eligibility rules, including income limits, will still apply. This Medi-Cal initiative, called the Age 26 through 49 Adult Full Scope Medi-Cal Expansion (Adult Expansion), is modeled after the Young Adult Expansion and the Older Adult Expansion, which extended full-scope Medi-Cal to all other age ranges, regardless of immigration status.

If an individual without satisfactory immigration status for full coverage Medi-Cal is between 26 and 49 years old and qualifies for Medi-Cal, they will get restricted coverage now and full coverage beginning in January 2024.

CalOptima Health estimates that the County of Orange Social Services Agency (SSA) may enroll 40,000 to 70,000 individuals into Adult Expansion in the first year. These new enrollees will become CalOptima Health members.

Discussion

Similar to CalOptima Health's efforts to bring awareness to the community and its members about Medi-Cal renewal and CalFresh enrollment, CalOptima Health will partner with the County of Orange SSA on Adult Expansion. The state has developed and released very clear messages about Adult Expansion, and staff plans to customize these for the Orange County Community in CalOptima Health's threshold languages, Spanish, Vietnamese, Korean, Chinese, Arabic, and Farsi.

Back to Agenda

Adult Expansion Outreach Strategy efforts will employ a multi-prong approach to identify and reach potentially eligible residents throughout the county, including:

- Multi-language media campaign targeting in-language print, radio, digital and broadcast media outlets throughout the county;
- Press release(s), social media promotion, and information on the CalOptima Health website;
- Toolkit materials (*e.g.*, flyers, posters, newsletter articles, social media posts) in multiple languages for use by providers, community health centers, community-based organizations and other community stakeholders; and
- Community outreach and enrollment events in partnership with trusted community partners, engaging potential members where they are, in their preferred language.

Staff requests Board approval of the Adult Expansion Outreach Strategy to identify, engage, and promote enrollment of eligible residents into full-scope Medi-Cal. Staff will provide the Board with routine updates on the enrollment outreach efforts and progress in conjunction with SSA. The total estimated cost for implementing these strategies is approximately $2.5 million for the period January 1, 2024 through June 30, 2025. These are estimated costs only and final costs will be dependent on final vendor negotiations, event locations, and additional marketing costs. Staff will procure vendor contracts in accordance with CalOptima Health Policy GA.5002: Purchasing Policy and will return to the Board if additional funding is needed.

The following table provides details on each activity:

Activities	**Estimated Costs**
Printed Materials ▪ Flyers/posters	Up to $150,000
Community Enrollers ▪ Enrollment support services in all threshold languages	Up to $750,000
Community Events ▪ Rentals, supplies, equipment and logistics	Up to $150,000
Marketing ▪ Development of advertising and marketing materials in all threshold languages	Up to $450,000
Advertising ▪ Radio, digital, broadcast, print and other media in all threshold languages	Up to $1,000,000
Total Estimated Costs	**$2,500,000**

Fiscal Impact

The recommended action is unbudgeted. An appropriation of up to $5,000,000 ~~2,500,000~~ from existing reserves will fund this action.

Rev 12/7/2023

Back to Agenda

Rationale for Recommendation

CalOptima Health is working collaboratively with the County of Orange SSA to ensure a successful implementation of Medi-Cal Adult Expansion. Staff recommends the use of funds to support the implementation of the Adult Expansion Outreach Strategy to enroll eligible adults ages 26 through 49 into full-scope Medi-Cal.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

/s/ Michael Hunn *11/30/2023*

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.

Back to Agenda

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.

Back to Agenda

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.

Back to Agenda

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

Back to Agenda

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**

Back to Agenda

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

Back to Agenda

Back To Item

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

Back to Agenda Back To Item

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.

Back to Agenda Back to Item

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 December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
23. Authorize a Contract with Behavioral Health Virtual Visits Vendor

Contacts
Richard Pitts, D.O., PhD, Chief Medical Officer, (714) 246-8491
Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration, (714) 796-6168

Recommended Actions
1. Execute a contract with TeleMed2U to provide virtual behavioral health (BH) care services for all CalOptima Health Medi-Cal and OneCare members (except Kaiser and PACE). The contract is to be effective April 1, 2024, for a three (3) year term with two (2) additional one-year extension options, each exercisable at CalOptima Health's sole discretion.
2. Allocate up to $2.7 million to fund this engagement through June 30, 2024.

Background
As outlined in the Department of Health Care Services' (DHCS) Medi-Cal Transformation Goals, strengthening mental health services and integrating them better with physical health care is more important than ever. To align with this statewide goal, CalOptima Health recognizes the need to implement 24 hours per day, 7 days per week BH care for all of its members (Medi-Cal and OneCare).

CalOptima Health aims to increase options for members to access BH care services when they need them and in the way that is most comfortable. Having a panel of virtual BH providers will help achieve this goal. CalOptima Health issued a request for proposals (RFP) in the first quarter of 2023 to select a vendor partner that can provide virtual and culturally competent BH care for its members, including interpreter services and access for people with blindness, hearing impairments, visual impairments, or dual sensory impairments.

The primary goals of virtual visits are to:
1. Increase CalOptima Health's members' access to urgent/emergent BH care demands, avoid unnecessary emergency department (ED) visits, and increase follow-up visits after discharge (while waiting to be connected to a provider).
2. Increase options for outpatient therapy appointments to comply with regulatory requirements and program guidelines.
3. Help improve the following Healthcare Effectiveness Data and Information Set (HEDIS) measures:
   - Follow-Up After ED Visit for Mental Illness (FUM).
   - Follow-Up After Hospitalization for Mental Illness (FUH).

Discussion
CalOptima Health staff received a total of three (3) proposals in response to the RFP. Based on the weighted scores and evaluation team discussion, CalOptima Health's Virtual Visits RFP workgroup recommends that the Board authorize a contract with TeleMed2U. The proposal overall weighted scores are listed below:

Back to Agenda

Vendor	Weighted Score
TrueCare24	18.87
TeleMed2U	17.75
Five Acres	17.45

The scores and pricing between the top two vendors were close, so the evaluation team met with both vendors to further research which entity would be a good fit for CalOptima Health's members. After follow-up discussions with both vendors, the evaluation team recommends selecting TeleMed2U as the virtual visits vendor for the following reasons:

- TeleMed2U has a robust BH provider network of over 275 providers across over 20 medical and BH specialties.
- TeleMed2U's leadership and administrative team meets CalOptima Health's functional requirements, as it comprises full administrative, sales and marketing, operations, credentialing, technology, billing and accounting, technical support, and physician recruiting departments.
- TeleMed2U provides a complete and comprehensive solution that includes the technology and specialist physicians to provide BH care to CalOptima Health's members. TeleMed2U's primary service offerings include synchronous telemedicine, asynchronous consultations, and inpatient consultations through telemedicine.
- TeleMed2U has the potential to expand its services to general medicine (*e.g.*, acute nonemergency medical care) in the future.
- TeleMed2U has substantial experience working with other managed care plans.

Based on standard procurement processes and in conjunction with CalOptima Health Policy GA.5002: Purchasing, the evaluation team identified TeleMed2U as the vendor that best meets CalOptima Health members' need for an experienced, regulatorily compliant, and cost-effective virtual visits vendor. Accordingly, staff recommends contracting with TeleMed2U for an initial three (3) year term with the option to extend the contract for two (2) additional one-year terms.

Fiscal Impact

The recommended action is an unbudgeted item. The estimated fiscal impact for the three-month period in the current fiscal year is $2.7 million. The total cost for the three-year contract with TeleMed2U is estimated at $22.6 million, with approximately $5.4 million for year 1, $7.3 million for year 2, and $9.9 million for year 3. Management will include medical expenses for subsequent contract years in future operating budgets.

Rationale for Recommendation

Based on the review of the possible vendors, staff recommends contracting with TeleMed2U to provide additional access to quality BH care for CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Back to Agenda

Attachments

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Telemedicine Group PC d.b.a. TeleMed2U	3400 Douglas Blvd., Suite 225	Roseville	CA	95661
TrueCare24, Inc.	8270 Woodland Center Blvd	Tampa	FL	33614
Five Acres – The Boys' and Girls' Aid Society of Los Angeles County	760 W. Mountain View Street	Altadena	CA	91001

Back to Item

Back to Agenda

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

24. Approve CalOptima Health Measurement Year 2024 and Modification to Measurement Year 2023 Medi-Cal and OneCare Pay-for-Value Programs

Contacts

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

Recommended Actions

1. Approve Measurement Year 2024 Medi-Cal Pay for Value Performance Program for the measurement period effective January 1, 2024, through December 31, 2024.
2. Approve Measurement Year 2024 OneCare Pay for Value Performance Program for the measurement period effective January 1, 2024, through December 31, 2024.
3. Approve the use of unearned Measurement Year 2023 and 2024 Pay for Value Performance Program funds for quality initiatives and grants.
4. Authorize unbudgeted expenditures in an amount up to $23.3 million from existing reserves to fund Measurement Year 2023 unearned incentive payments for quality initiatives and grants.

Background

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

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

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

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

CalOptima Health staff have obtained feedback from HNs on recommendations to refine and improve

Back to Agenda

the P4V Program by aligning with industry-based programs and by providing rewards for year-over-year improvement. These recommendations are incorporated into the Calendar Year 2024 program elements discussed below.

Discussion

Medi-Cal Pay for Value Program

Staff recommends implementing Measurement Year (MY) 2024 Medi-Cal P4V Program with the following program components:

1. Adopt the Integrated Healthcare Association (IHA) pay for performance methodology to assess performance.

    - The methodology uses both attainment and improvement to assess performance and is based on the CMS hospital value-based purchasing model.
    - The greater of either the attainment or improvement score is used to calculate incentive payments.

2. Utilize the MY 2024 DHCS MCAS measures held to MPL for the HEDIS measurement set. MY 2024 Medi-Cal P4V Program will have a total of 18 HEDIS measures.

3. Continue to include CAHPS composites and overall ratings as member experience measures. Utilize results from the survey with the most reportable rates for composites and overall ratings, either child or adult CAHPS. If the adult and child survey rates have the same number of reportable rates, CalOptima Health will use the average performance of the adult and child survey results.

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

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

6. Minimum Performance Requirement:
   HNs and CCN PCPs that score below the 50th percentile on a measure will be required to submit an improvement plan for that measure to CalOptima Health. HNs below the MPL may be subject to either receive a sanction or deduction of their incentive payment.

7. Application of DHCS Quality Withhold:
   Starting January 1, 2024, DHCS will start with a quality withhold of 0.5% of capitation payments from each Medi-Cal managed care plan. DHCS may apply a higher withhold percentage in future Medi-Cal managed care plan contracts.

   Based on the DHCS quality measures, CalOptima Health will be assessed for the amount of withhold payments that may be earned back. The unearned percentage will be applied in CalOptima Health's P4V Program calculation across all HNs. Staff recommends deducting the percent of unearned DHCS withhold from each HN's earned P4V Program payment.

Back to Agenda

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

OneCare Pay for Value Program
Staff recommends implementing MY 2024 OneCare P4V Program with the following program components:

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

2. Utilize select CMS Part C and D measures for the P4V Program measurement set.

3. Continue to leverage CMS Star measures cut points as benchmarks.

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

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

Measurement Process
CalOptima Health staff calculates the quality rating score for each HN and CCN PCP annually. For MY 2024, staff will use the IHA methodology for both Medi-Cal and OneCare. This will enable CalOptima Health to use an industry standard methodology and improve efficiencies by using one standard quality rating methodology. The performance score is derived from the most recently available audited, plan level HEDIS results.

MY 2023 and MY 2024 Unearned Incentive Dollars
P4V Program funds that remain unused – due to HNs failing to earn the maximum incentive possible or due to forfeitures based on CalOptima Health's failure to achieve the MPL – may be used for quality improvement initiatives. Grants will be available from unearned funds for both Medi-Cal and OneCare.

HNs may apply for grants to utilize incentive dollars for quality improvement initiatives. Grants may be awarded for individual measures or groups of measures targeting similar member populations, for example, well-child visits and childhood immunizations. Grant amounts may range from $50,000 to $250,000 per measure/measure group. Total grant funds to an individual HN shall not exceed the HN's maximum pool funding incentive for each MY, including deduction for DHCS quality withhold application. Grants may not be used to fund administrative staffing but may be used for staff who directly provide or coordinate patient care under the quality improvement initiatives.

Staff proposes modifying the MY 2023 Medi-Cal and OneCare P4V Programs to allow the use of unearned incentive funds for the implementation of quality initiatives and grants. The unearned incentive funding will also be applicable for MY 2024. Staff will provide grant oversight pursuant to CalOptima Health Policy AA.1400p: Grants Management and will return to the Board of Directors to provide updates on the status of these grants at future meetings.

Back to Agenda

Eligibility for Incentive Payments
Performance incentive payments are distributed upon final calculation and validation of each measurement rate. To qualify for payments, a HN or CCN PCP must be contracted with CalOptima Health during the entire measurement period (January 1, 2024, through December 31, 2024) and the calculation period (July 1, 2024, through June 30, 2025) and in good standing with CalOptima Health, as determined by the Audit and Oversight Department, at the time of disbursement of payment.

Fiscal Impact

Medi-Cal P4V Program
Staff estimates that the fiscal impact for the MY 2024 P4V Program will be no more than ten percent (10%) of the professional capitation (base rate only) or approximately $73.9 million.

The Fiscal Year (FY) 2023-24 Operating Budget included $51.7 million, based on 70% of earnable incentive payments, for Medi-Cal. The remaining unearned amount from the incentive pool for quality initiatives and grants is unbudgeted. An appropriation of up to $22.2 million from existing reserves will fund the remaining unearned amount for MY 2023. Staff will include 100% of pool funding for MY 2024 P4V Program initiatives and grant activities in the FY 2024-25 Operating Budget.

OneCare P4V Program
Staff estimates that the fiscal impact for the MY 2024 OneCare P4V Program will be no more than $20 PMPM or approximately $4.3 million.

The FY 2023-24 Operating Budget included $3.2 million, based on 75% of earnable incentive payments, for OneCare. The remaining unearned amount from the incentive pool for quality initiatives and grants is unbudgeted. An appropriation of up to $1.1 million for existing reserves will fund the remaining unearned amount for MY 2023. Staff will include 100% of pool funding for MY 2024 P4V Program initiatives and grant activities in the FY 2024-25 Operating Budget.

Rationale for Recommendation

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

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Back to Agenda

Attachments

1. CalOptima Health's Measurement Year 2024 Medi-Cal and OneCare Pay for Value Programs
2. Measurement Year 2024 Pay for Value Program Proposal

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

MY 2024 Medi-Cal Pay for Value (P4V)

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

Recommended for MY 2024 Medi-Cal P4V

1. Include measures held to an MPL in the MY2024 MCAS measure set.

MY 2024 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Chlamydia Screening in Women
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Postpartum Care
Pharmacotherapy for Opioid Use Disorder	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Child and Adolescent Well-Care Visits	Breast Cancer Screening
Childhood Immunization Status- Combination 10	Cervical Cancer Screening
Development Screening in the First Three Years of Life	Colorectal Cancer Screening
Immunizations for Adolescents- Combination 2	CAHPS- Rating of Health Plan: Adult and Child
Lead Screening in Children	CAHPS- Getting Needed Care: Adult and Child
Topical Fluoride in Children	CAHPS- Getting Care Quickly: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Asthma Medication Ratio	CAHPS- Coordination of Care: Adult and Child
Controlling High Blood Pressure*	CAHPS- Rating of Health Care: Adult and Child
Hemoglobin A1c Control for Patients with Diabetes- HbA1c Poor Control (>9%) lower is better*	CAHPS- Rating of Health Plan: Adult and Child

- Utilize both Child and Adult CAHPS scores.
  - To calculate performance average scores based on proportion of member population.

2. Maintain program funding methodology at ten percent (10%) of professional capitation (base rate only).
3. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS measures weighted 1.0.
  - CAHPS measures weighted 1.5.
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

Back to Item

Back to Agenda

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

OneCare Pay for Value Program (P4V)

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

Recommended for MY 2024 OneCare P4V

Alignment with the CMS Star program and the following components:

1. Utilize the following CMS Star Part C and Part D measures, measure weights, and Star thresholds as benchmarks:

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

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS measures weighted 1.0.
  - CAHPS measures weighted 1.5.
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

3. Apply a program funding methodology of $20 PMPM

MY2024 Pay for Value Program Proposal

Board of Directors Meeting

December 7, 2023

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.

Back to Item

Back to Agenda

Evolution of CalOptima Health's Pay for Value Program

Back to Item

Back to Agenda

MY2016-2023 P4V Programs

MY2016
- Points based on comparison to NCQA National Medicaid 50th, 75th, and 90th percentiles
- Points awarded for increased performance; points subtracted for decreased performance
- Transitioned from OneCare to OneCare Connect Pay for Value Program

MY2017-2019
- No substantive changes

MY2020
- Use NCQA quality rating methodology which assigns points on a scale from the 10th to 90th percentiles
- Include all MCAS MPL measures for Medi-Cal

MY2021
- No substantive changes

MY2022
- Last year of OneCare Connect Pay for Value Program

MY2023
- Doubled Medi-Cal P4V Program funding from $5pmpm to 10% of base professional capitation
- Added OneCare Pay for Value Program funded at $20pmpm

Back to Item

Back to Agenda

CalOptima Health

CalOptima Health
P4V Program Principles

Back to Agenda

Back to Item

CalOptima Health

CalOptima Health P4V Program Principles

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

MY2024 P4V Program Components

Back to Item

Back to Agenda

CalOptima Health

MY2024 Incentive Pool

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

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

Back to Item

Back to Agenda

MY2024 P4V Program Elements

- Measure Sets
  - Medi-Cal: Align with DHCS MCAS MPL and Quality Withhold measures
    - Utilize both Child and Adult CAHPS rates
      - Average rates based on proportion of member population
  - OneCare: Align with CMS Star measures
- Measure Weights
  - Align with industry measure weights, where applicable
  - Clinical measures = 1.0
  - Medi-Cal Member experience measures = 1.5
  - OneCare Member experience measures = 2.0*
- Data Collection Methodology
  - To promote adoption of electronic clinical data sets, utilize administrative data
  - Add hybrid lift for select measures

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

Back to Item
Back to Agenda

Performance Methodology and Benchmarks

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

Back to Item

Back to Agenda

Sample Scorecard- CCN MY2022

CCN Clinical Measure	MY2021 Rate	MY2022 Rate	Denom	Weight	Improv Points	Attain Points	Earned	Quality Compass MY2021	
								50th	95th
Breast Cancer Screening (BCS)	54.60%	56.96%	9,864	1	2.18	4.74	4.74	50.95%	65.42%
Cervical Cancer Screening (CCS)	57.84%	57.79%	42,721	1	0.00	1.11	1.11	57.64%	69.85%
Child and Adolexcent Well-Care Visits (WCV)	44.81%	44.31%	26,094	1	0.00	0.00	0.00	48.93%	68.88%

CAHPS Measure	MY21 Rate	Rate	Denom	Weight	Improv Points	Attain Points	Earned	50th	95th
Adult Care Coordination (Usually + Always)	76.32%	75.76%	66	1.5	0.0	0.0	0.0	84.46%	89.74%
Adult Customer Service (Usually + Always)	87.06%	87.18%	71	1.5	0.2	0.0	0.3	89.65%	92.64%
Adult Rating of Health Care (9+10)	51.88%	55.64%	133	1.5	2.6	0.0	3.9	56.73%	66.20%

Health Network	# Measures	Total Weight	Total Points	Rating
CCN	22	26.0	42	1.6

Health Network	10% Capitation	Performance	
		Rating MY 2022	Earned Payment
CCN	$13,934,682	1.6	$2,786,936

	Number of Measures	Max Points
HEDIS	14	140
CAHPS	8	120
Total	22	260

Total Performance Threshold		Total Points Earned	% Incentive Earned
Avg > 90th percentile	>=	7.00	100%
	>=	5.50	80%
Avg > 75th percentile	>=	4.00	60%
	>=	2.50	40%
Avg >= 50th percentile	>=	1.00	20%
	<	1.00	0%

Back to Item

Back to Agenda

CalOptima Health

Health Network Corrective Action

- Financial Sanction: HNs below the MPL that would not have earned an incentive either receive a sanction or deduction of their incentive
- Corrective action: HN scoring below the MPL must submit a corrective action plan

Unearned Incentive Dollars

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

Back to Item

Back to Agenda

Appendix

Back to Agenda

Back to Item

CalOptima Health

MY2024 Medi-Cal Measurement Set

Measure	DHCS MPL	DHCS Quality Withhold	PV4 Program
Follow-up After ED Visit for Mental Illness- 30 days	X		**X**
Follow-Up After ED Visit for Substance Abuse- 30 days	X		**X**
Pharmacotherapy for Opioid Use Disorder	X		
Child and Adolescent Well-Care Visits	X	X	**X**
Childhood Immunization Status- Combination 10	X	X	**X**
Development Screening in the First Three Years of Life	X		**X**
Immunizations for Adolescents- Combination 2	X	X	**X**
Lead Screening in Children	X		**X**
Topical Fluoride in Children	X		**X**
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	X	X	**X**
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	X	X	**X**
Asthma Medication Ratio	X		**X**
Controlling High Blood Pressure*	X	X	**X**

*Measure rate may include findings from medical record review

Measure set subject to change until DHCS issues final MY24 MCAS MPL set

Back to Item

Back to Agenda

CalOptima Health

MY2024 Medi-Cal Measurement Set

Measure	DHCS MPL	DHCS Quality Withhold	PV4 Program
Hemoglobin A1c Control for Patients with Diabetes- HbA1c Poor Control (>9%) lower is better*	X	X	X
Chlamydia Screening in Women	X		X
Prenatal and Postpartum Care: Postpartum Care	X	X	X
Prenatal and Postpartum Care: Timeliness of Prenatal Care	X	X	X
Breast Cancer Screening	X		X
Cervical Cancer Screening	X		X
Colorectal Cancer Screening	X		
CAHPS- Rating of Health Plan: Adult and Child		X	X
CAHPS- Getting Needed Care: Adult and Child		X	X
CAHPS- Getting Care Quickly: Adult and Child			X
CAHPS- Rating of Personal Doctor: Adult and Child			X
CAHPS- Rating of Specialist Seen Most Often: Adult and Child			X
CAHPS- Coordination of Care: Adult and Child			X
CAHPS- Rating of Health Care: Adult and Child			X
CAHPS- Rating of Health Plan: Adult and Child			X

*Measure rate may include findings from medical record review

Measure set subject to change until DHCS issues final MY24 MCAS MPL set

Back to Item

Back to Agenda

CalOptima Health

MY2024 OneCare Measurement Set

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

*Measure rate may include findings from medical record review

Back to Item
Back to Agenda

MY2024 OneCare Measurement Set

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

Back to Agenda
Back to Item

Performance Scoring Methodology

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

Back to Item
Back to Agenda

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Back to Item

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

25. Approve Actions Related to the Housing and Homelessness Incentive Program for Transitional Housing

Contacts

Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Appropriate up to $25 million from existing reserves to provide additional support for Housing and Homeless Incentive Program (HHIP) Priority 3: Partnerships and capacity to support referrals for services, which includes capital projects.
2. Authorize CalOptima Health staff to develop a scope of work to be used in a notice of funding opportunity for transitional housing programs as a focus of Priority 3.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

CalOptima Health has earned $34.9 million of the up-to-$83 million it is eligible for from the California Department of Health Care Services (DHCS) through HHIP. With consideration of the broad investment strategies presented to CalOptima Health's Board of Directors (Board) in September 2022 and the significant efforts needed to achieve the HHIP outcomes, the Board has allocated an additional $62.4 million toward this effort ($40.1 million in September 2022 and $22.3 million in June 2023). Staff requests that the Board consider allocating an additional $25 million in existing reserves to HHIP efforts, specifically transitional housing development under Priority 3: Partnerships and capacity to support referrals for service. This would bring the total investment in HHIP, earned dollars plus reserves dedicated, to $122.3 million.

Discussion

In October 2023, the Board approved $52.3 million in investments toward affordable and permanent supportive housing development. During that notice of funding opportunity process, it was recognized that support for the other components of the homeless services continuum, namely transitional housing, was also needed. Therefore, staff is asking the Board to consider an additional $25 million in existing reserves be allocated to HHIP efforts.

CalOptima Health staff are proposing to release an HHIP notice of funding opportunity to solicit proposals for transitional housing development projects under HHIP Priority 3: Partnerships and capacity to support referrals for service. It is anticipated this NOFO will be released in January 2024 and selected proposals will be brought to the Board for approval in April 2024.

Back to Agenda

Fiscal Impact
An appropriation of up to $25 million from existing reserves will fund additional support for the Board-approved HHIP Priority 3: Partnerships and capacity to support referrals for services.

Rationale for Recommendation
Funding these programs and projects will aid CalOptima Health in meeting HHIP measures through which CalOptima Health can receive additional funding that will enable even more investments in the community to address homelessness. Staff will bring additional recommendations to the Board for review and approval in the future.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None.

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
9/1/2022	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$40.1 million
12/1/2022	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$36.5 million
3/2/2023	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$63.5 million
6/1/2023	Approve Actions Related to the Housing and Homelessness Incentive Program	-	

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
26. Approve Actions Related to the Incentive Payment Program for Community Health Worker Academy

Contacts
Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Authorize CalOptima Health staff to conduct a notice of funding opportunity (NOFO) process related to the Community Health Worker (CHW) Academy, administer grant agreements, and release award payments to up to 20 selected entities in an amount of up to $100,000 per grantee:
    a. Up to five current contracted providers of CHW services (as of January 1, 2024); and
    b. Up to 15 organizations with expertise in CHW services that are not yet contracted with CalOptima Health.
2. Approve allocation of up to $2 million in Incentive Payment Program (IPP) funds for Program Year (PY) 1 for the Delivery System Infrastructure IPP priority area to provide capacity building support to CHW Academy participants.

Background
In preparation for the start of CalAIM's Enhanced Care Management (ECM) and Community Supports (CS) programs on January 1, 2022, the California Department of Health Care Services (DHCS) provided managed care plans with performance incentives through the IPP to promote provider participation and capacity building. CalOptima Health was awarded $44,954,059 for PY 1 (2022) paid in two equal installments in May 2022 and July 2023.

The initial PY 1 funding priority areas included:
- Delivery System Infrastructure;
- ECM Provider Capacity Building;
- CS Provider Capacity Building and managed care plan take-up; and
- Quality "Pay for Reporting" measures (which will be incorporated in the ECM provider capacity and CS provider capacity building priorities).

CalOptima Health submitted an initial "Gap Assessment and Gap Filling Plan" in Fall 2021 and has completed subsequent IPP measurement submissions 1, 2A, 2B, 3 and is in the process of completing submission 4, which is due February 28, 2024.

Discussion
Since the launch of the IPP, and in alignment with the funding priority areas indicated, CalOptima Health has distributed one-time incentive funding to health networks for their initial roll-out of ECM

Back to Agenda

services, newly on-boarded community organizations as ECM providers through the ECM Academy, and all CS providers who were contracted during PY 1, as detailed in the December 20, 2021, Board-approved COBAR. As of October 2023, there is approximately $6.8 million in IPP PY 1 funding remaining to be allocated. CalOptima Health will also distribute one-time incentive funding to CS providers who were contracted during PY 2 in the coming months. These incentives were generally provided to assist organizations in building internal capacity to meet contracting requirements from CalOptima Health, submit billing, and create internal workflows and mechanisms to roll out these new services.

As CalOptima Health continues to implement the new CalAIM benefits and monitor progress with IPP measurement submissions, areas for improvement are identified. The roll-out of the CHW benefit is one area with potential for improvement. CalOptima Health staff is proposing the IPP CHW NOFO to solicit organizations to participate in a CHW Academy that will provide the training and support for these organizations to become contracted for and roll out the CHW benefit. Each selected organization will be offered up to $100,000 in capacity building funds through a grant agreement. CalOptima Health staff anticipates selecting:

a. The five current contracted providers of CHW services (as of January 1, 2024); and
b. Up to 15 organizations with expertise in CHW services that are not yet contracted.

It is anticipated that this IPP CHW NOFO would be live in early December 2023 and final decisions would be brought back to the board for approval in March 2024.

Fiscal Impact

The recommended action has no additional fiscal impact beyond prior Board action. The allocation of up to $2 million from the PY 1 CalAIM IPP balance will fund grants in an amount up to $100,000 to up to 20 CHW providers and organizations participating in the CHW Academy.

Rationale for Recommendation

Funding these programs and projects will aid CalOptima Health in meeting IPP measures, through which CalOptima Health can receive additional funding that will enable even more investments in the provider network.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action

Back to Agenda

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 20, 2021	Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for All Health Networks, Except AltaMed Health Services Corporation, Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C.	-	$45,000,000 (in aggregate)
December 20, 2021	Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C.	-	$45,000,000 (in aggregate)
December 20, 2021	Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for AltaMed Health Services Corporation		$45,000,000 (in aggregate)

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

Attachment to the December 7, 2023 Board of Directors Meeting – Agenda Item 26

CONTRACTED/IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Abrazar, Inc.	7101 Wyoming St.	Westminster	CA	92683
Latino Center for Prevention and Action in Health and Welfare dba Latino Health Access	450 W. 4th St.	Santa Ana	CA	92701
MOMS OC	1128 W Santa Ana Blvd	Santa Ana	CA	92703
Sowing Seeds	4902 Irvine Center Dr., Suite 105	Irvine	CA	92604
Western Youth Services	23461 South Pointe Dr. Suite 220	Laguna Hills	CA	92653

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
27. Approve Actions Related to the Street Medicine Program City Expansion

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Actions
1. Approve the Notice of Interest Opportunity Evaluation Committee recommendation for two additional host-cities for the expansion of CalOptima Health's Street Medicine Program.

Background
On March 17, 2022, CalOptima Health's Board (Board) committed $8 million from the Homeless Health Initiatives Reserve for purposes of Street Medicine. On May 5, 2022, the Board approved the Street Medicine scope of work (SOW). On November 3, 2022, the Board authorized the Chief Executive Officer to execute a contract with Healthcare In Action to provide street medicine canvasing-based services. The pilot launched in Garden Grove on April 1, 2023. On October 5, 2023, the Board authorized CalOptima Health staff to release a Notice of Interest Opportunity to Orange County cities to find interested cities to host the expansion of CalOptima Health's Street Medicine Program. The opportunity was open to cities from October 6 to November 8, 2023. A committee of evaluators from CalOptima Health have reviewed and scored the four submitted applications received.

Discussion
Street medicine includes health and social services developed specifically to address the unique needs and circumstances of unsheltered individuals. The fundamental approach of street medicine is to engage people experiencing homelessness where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through services. Working in collaboration with various county, city, and community organizations, the Street Medicine Program's ultimate goal is to address and improve the overall health outcomes of the unsheltered, unhoused individuals served.

In order to expand CalOptima Health's existing Street Medicine Program, the evaluation committee is recommending that the cities of Anaheim and Costa Mesa be selected as host cities. With Board approval, CalOptima Health staff will begin collaborating with the selected cities to ensure seamless integration of its Street Medicine Program with consideration of the cities' broader endeavors to address homelessness. Further, CalOptima Health staff will invite the selected cities to provide feedback on the top two provider proposals for their city. CalOptima Health staff will return to the Board in February 2024 with recommendations on program details, including qualified providers to host the two additional provider teams in the selected cities.

Fiscal Impact
There is no fiscal impact.

Back to Agenda

Rationale for Recommendation

In order to engage CalOptima Health members experiencing homelessness where they are and on their own terms and to reduce or eliminate barriers to medical and social care, CalOptima Health staff would like to expand its Street Medicine Program to the cities of Anaheim and Costa Mesa in 2024.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

28. Approve Actions Related to the Homeless Clinic Access Program

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741

Recommended Actions

1. Approve CalOptima Health staff recommendations to administer two-year grant agreements and award payments to selected grant recipients (listed in Attachment 1) for the Homeless Clinic Access Program (HCAP).
    a. Federally Qualified Health Centers (FQHC) and Community Health Centers (CHC) will provide health care services to all individuals experiencing homelessness, regardless of CalOptima Health membership through mobile unit or onsite medical room.
        i. Total of payments recommended for clinics: $1,000,000 over two years totaling $2,000,000.
    b. Orange County shelter operators will provide support to partnered FQHC and CHC.
        i. Total of payments recommended for shelters: $500,000 over two years totaling $1,000,000.
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

On April 4, 2019, the Board approved $100 million to create a restricted Homeless Health Initiatives (HHI) Reserve to support delivery of care to Medi-Cal members experiencing homelessness. HCAP is part of HHI and was approved by the Board in August 2019. Through HCAP, FQHCs and CHCs were able to receive an incentive for providing scheduled preventive services at shelters and hotspots. FQHCs and CHCs provided this service at local homeless shelters through December 31, 2022.

In February 2023, the CalOptima Health Board reallocated $6.7 million within the restricted HHI Reserve to extend and expand the HCAP program for 36 months effective February 1, 2023, or until funding is exhausted, whichever is earlier. The board also authorized the chief executive officer to negotiate and execute contracts with CHCs, homeless shelters, and other community partners to implement the extended and expanded HCAP.

Discussion

CalOptima Health conducted a series of feedback sessions with FQHCs, CHCs, and local homeless shelter operators, to solicit feedback on the original HCAP design and to understand where improvements could be made. In addition, staff learned from those sources that HCAP has been successful in helping to meet urgent care needs for members experiencing homelessness while seeking shelter. It has also supported relationship building between individuals experiencing homelessness and

Back to Agenda

FQHC and CHC providers, encouraging the use of appropriate levels of care. Furthermore, this program operates in unison with CalOptima Health's Street Medicine Program, ensuring medical providers are successfully connecting with members experiencing homelessness in their own environment.

Through that process, CalOptima Health has revised the eligibility criteria, expected outcomes, reporting functions and incentive levels of HCAP to ensure demonstrable outcomes and impact for CalOptima Health members. Further, the revised HCAP recognized the role of both homeless shelter operators and FQHCs and CHCs as partners to provide these medical services on-site in shelters for individuals experiencing homelessness.

A notice of funding opportunity (NOFO) was released to the public on September 1, 2023, via distribution lists and on the CalOptima Health website. CalOptima Health staff conducted an information session for all interested FQHCs, CHCs, and shelters describing the grant application process, program requirements, applicant eligibility criteria, and responded to questions ahead of the open-portal application period, which ran from September 1, 2023, to October 2, 2023. In total, CalOptima Health received and reviewed 15 completed proposals from 7 unique FQHCs and CHCs. This represents a very robust reach into the community to identify potential projects and partners. An internal committee of evaluators from CalOptima Health reviewed and scored the submitted proposals; 12 of the applications will be recommended for the two-year program.

Staff will provide oversight of the grants pursuant to CalOptima Health Policy AA.1400p: Grants Management and will return to the Board to provide updates on the status of these grants at future meetings. With Board approval, staff would like to proceed with prompt development and execution of two-year grant agreements with the organizations listed in Attachment 1.

Fiscal Impact

The recommended action has no additional fiscal impact. A previous Board action on February 2, 2023, reallocated up to $6.7 million within the restricted HHI Reserve to fund the extension and expansion of the HCAP. Upon Board approval, up to $3.0 million will fund the two-year HCAP grant agreements.

Rationale for Recommendation

CalOptima recognizes the value HCAP-participating FQHCs, CHCs, and shelters bring as they provide vital preventive, urgent care, and on-call services to individuals experiencing homelessness. Pairing traditional canvassing-based street medicine with shelter-based services ensures CalOptima Health providers have adequate opportunity to connect with members experiencing homelessness.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Back to Agenda

Attachments

1. Entities Covered by this Recommended Action
2. FQHC/CHC Contract Amendment for HCAP

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
2/22/2019	Consider Authorizing Actions Related to Homeless Health Care Delivery, Including, but not limited to, Funding and Provider Contracting		
4/4/2019	Consider Actions Related to Delivery of Care for Homeless CalOptima Members • Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot		$100 million
6/27/2019	Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal ($60 million identified for specific initiatives)		
8/1/2019	Consider Development of a CalOptima Homeless Clinic Access Program for Homeless Health Initiative		$1 million
3/5/2020	Consider Actions Related to Homeless Health Care Pilot Initiatives [extended CFTPP pilots through 12/31/2020]		
4/16/2020	Consider Authorizing Modifications to the CalOptima Homeless Clinic Access Program Homeless Health Initiatives in Response to COVID-19		$1 million
12/3/2020	Consider Approval of Actions Related to Homeless Health Care Pilot Initiatives [extended CFTPP pilots through 12/31/2021]	1 year	
12/20/2021	Consider Approval of Actions Related to Homeless Health Care Pilot Initiatives [extended CFTPP through 12/31/2022]	1 year	
5/5/2022	Consider Approval of Actions Related to Homeless Health Care Initiatives [approve additional funding for HCAP]		$700,000
2/2/2023	Consider Approval of Actions Related to Homeless Health Care Initiatives [Authorize allocation of funds to extend and expand HCAP]		$6.74 million

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

Attachment to the December 7, 2023 Board of Directors Meeting – Agenda 28

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Federally Qualified Health Centers (FQHCs)/Community Health Centers (CHCs):

Name	Address	City	State	Zip Code
Families Together of Orange County	661 W. 1st Street	Tustin	CA	92780
Illumination Foundation Medical Group	3535 W Commonwealth Ave	Fullerton	CA	92833
KCS Health Center (Korean Community Services)	451 W. Lincoln Ave	Anaheim	CA	92805
Family Health Matters Community Health Center	1182 N. Euclid St	Anaheim	CA	92801
Serve the People Community Health Center	1206 17th St	Santa Ana	CA	92701
Share Our Selves	20151 SW Birch Street	Newport Beach	CA	92660-1794

Shelter Operators:

Name	Address	City	State	Zip Code
PATH	340 N Madison Ave	Los Angeles	CA	90004
Illumination Foundation	3535 W Commonwealth Ave	Fullerton	CA	92833
Mercy House	17631 Cameron Lane	Huntington Beach	CA	92647
The Salvation Army (TSA) Anaheim Emergency Shelter	1455 S. Salvation Place	Anaheim	CA	92805
Mental Health Association of Orange County	1971 East 4th Street	Santa Ana	CA	92705

Shelter Locations:

Name	Address	City	State	Zip Code
Friendship Shelter	20652 Laguna Canyon Rd	Laguna Beach	CA	92651
Yale Navigation Center	2229 S Yale St.	Santa Ana	CA	92704
Carnegie Shelter	1815 Carnegie Ave	Santa Ana	CA	92705
Buena Park Navigation Center	6494 Caballero Blvd	Buena Park	CA	90620
Placentia Navigation Center	401 E Chapman Avenue	Placentia	CA	92870
The Salvation Army (TSA) Anaheim Emergency Shelter	1455 S. Salvation Place	Anaheim	CA	92805
Mental Health Association of Orange County	1971 East 4th Street	Santa Ana	CA	92705
Hub Resource Center	517 W Struck Ave	Orange	CA	92867
Casa Querencia	2151 E 1st St	Santa Ana	CA	92705
Costa Mesa Bridge Shelter	3175 Airway Ave	Costa Mesa	CA	92626
Huntington Beach Navigation Center	17631 Cameron Lane	Huntington Beach	CA	92647
Bridges at Kraemer Place	1000 N Kraemer Pl	Anaheim	CA	92806

Back to Item

Back to Agenda

AMENDMENT # TO

PROFESSIONAL SERVICES CONTRACT

THIS AMENDMENT # TO THE PROFESSIONAL SERVICES CONTRACT ("Amendment") shall be effective on the first day of the first month following execution of this Amendment, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima Health"), and **Professional name** ("Professional"), with respect to the following facts:

RECITALS

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

B. CalOptima and Professional desire to amend this Contract to include services related to Homeless Clinic Access Program (HCAP) as identified in Article 3 Attachment A of this Amendment___.

NOW, THEREFORE, the parties agree as follows:

1. Attachment A, "Contracted Services", shall be deleted in its entirety and replaced with a new Attachment A, "Contracted Services", attached hereto.

2. Attachment B-2, "Compensation for Clinical Field Team Services", shall be deleted in its entirety and replaced with a new Attachment B-2, "Compensation for Homeless Clinic Access Program (HCAP)", attached hereto.

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

IN WITNESS WHEREOF, CalOptima and Professional have executed this Amendment.

FOR PROFESSIONAL:

{{_es_:signer1:signature}}

Signature
{{*Name_es_:signer1 }}
Print Name
{{*_es_:signer1:title }}
Title
{{*_es_:signer1:date }}
Date

FOR CALOPTIMA:

{{_es_:signer2:signature}}

Signature
{{N_es_:signer2:fullname }}
Print Name
{{*_es_:signer2:title }}
Title
{{*_es_:signer2:date }}
Date

ATTACHMENT A
CONTRACTED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS AND SERVICES

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

X OneCare Program (Medicare Advantage) Clinical Field Team Services only

X Medi-Cal Program (Community Network and COD Administrative)

_____ PACE Program

1.1 Physician Services. Professional shall furnish:

X Primary Care Provider Covered Services to eligible Members in the CalOptima program who are assigned to Professional.

X Homeless Clinic Access Program (HCAP) Services identified in Article 3, to individuals experiencing homelessness.

ARTICLE 2
GENERAL RESPONSIBILITIES

In addition to the CalOptima Provider Manual, the following general responsibility shall apply. Refer to the Provider Manual for specific program instructions and guidelines.

2.1 Physician Services. Physician Services for CalOptima Members are those Covered Services set forth in the CalOptima Program in which the Member is assigned.

Services include, but are not limited to, health promotion, disease prevention, health maintenance, counseling, patient education, and the diagnosis and treatment of acute and chronic illness, and that are:
(a) included as covered services under the applicable Government Contract, (b) within Professional's normal scope of practice, and (c) Medically Necessary.

2.1.1 The actual provision of any Physician Service is subject to CalOptima's Utilization Management Policies and Procedures and the Medical Necessity of the service. Professional shall provide assessment and evaluation services ordered by a court or legal mandate.

2.1.2 Decisions concerning whether to provide or authorize covered Physician Services shall be based solely on Medical Necessity. Disputes between the Professional and Members about Medical Necessity can be appealed pursuant to CalOptima Policies.

2.2 Days to Appointment. Professional shall ensure that appointments for non-Emergency or non-Urgent Care Covered Services are scheduled within ten (10) business days for Primary Care Provider and fifteen (15) business days for Specialist Physician of a Member's request; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Member's request for an appointment, and that, if Professional supplies maternity Covered Services, Physician Group 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. Professional shall also have a process in place for follow-up on Member missed appointments.

2.3 Office Waiting Times. Professional shall ensure that office wait times will be kept to a maximum of forty- five (45) minutes.

2.4 Health Education and Prevention. Professional shall provide Members with health education during office visits in accordance with CalOptima Policies. Professional shall also refer Members to CalOptima's health education referral line for classes provided to Members.

2.5 Coordination and Continuation of Care. Referrals for Medically Necessary specialty Covered Services must follow CalOptima Policies and Provider Manual for Prior Authorization. All Prior Authorizations shall be made through CalOptima's Utilization Management Department. Professional agrees to refer Members to other Participating Providers in all circumstances except when an authorization has been granted in advance by CalOptima to refer to a Non-Participating Provider, or when necessary due to an Emergency Medical Condition.

2.6 Approved Drug List Compliance. Professional shall comply with the CalOptima Approved Drug List and its associated drug utilization or disease management guidelines and protocols. Medications not included on the Approved Drug List shall require Prior Authorization by CalOptima. The prescribing Physician must obtain authorization in accordance with CalOptima's Policies. The prescribing Physician shall provide CalOptima with all information necessary to process Prior Authorization requests.

2.6.1 Professional shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

2.6.2 Professional shall participate in any CalOptima pharmacy cost containment programs as developed.

2.6.3 Professional shall provide all information requested by CalOptima, including, but not limited to Medical Necessity documentation, which pertains to a Member's condition and drug therapy regimen, untoward effects or allergic reactions.

2.7 Obstetrical Services for Medi-Cal Members. If Professional provides obstetrical services, Professional is required to complete the program specific CalOptima Pregnancy Notification Report (PNR) for all pregnant CalOptima Members. PNRs must be received by CalOptima within five (5) days following initiation of obstetrical-related services.

2.8 Referrals. Professional shall refer Members to Participating Providers in accordance with CalOptima referral Policies.

2.9 Professional shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member's medical needs, initiating referrals of Members for specific Covered Services to Participating Providers, monitoring progress of Members' care and coordinating utilization of services to facilitate the return of Member's care to their assigned PCP as soon as medically appropriate.

2.10 Professional shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Professional shall ensure that Members with disabilities have access to effective communication methods when making health care decisions and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

2.11 Professional 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.

2.12 PCP should be informed of the progress of a referred Member's care. Professional shall forward the results of diagnostic procedures and consultations to Member's assigned PCP in a timely manner in order to ensure that the Member's care is efficiently coordinated and that the responsibility for care is returned to PCP as soon as medically appropriate.

2.13 Additional Responsibilities of Primary Care Provider for Medi-Cal Members

2.13.1 PCP shall be responsible for coordinating care of certain services including:

a) Participating Providers shall document all Pediatric Preventive Services (CHDP) on the CMS-1500, UB-04 claim form, or electronic equivalent. Participating Providers shall submit the CMS-1500, UB-04 claim form, or electronic equivalent to CalOptima within thirty (30) calendar days following the month of service.

b) PCP providing Pediatric Preventive Services agrees to coordinate with the Orange County CHDP Program.

c) PCP shall comply with CalOptima's Policies and for periodicity and content of pediatric health assessments.

d) PCP shall make referrals to the Women, Infants and Children Food Supplementation Program ("WIC") in accordance with WIC program Policies and Procedures.

e) PCP shall make referrals to the Regional Center of Orange County when appropriate.

f) PCP shall refer all Members between the ages of three (3) and twenty-one (21) to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment.

g) PCP may provide Outpatient Mental Health Services within the scope of his/her practice. PCP shall refer Members with mild to moderate impairment in functioning requiring mental health Covered service beyond or outside the scope of PCP's practice to CalOptima for referral to CalOptima's contracted mental health specialists. PCP shall refer Members with significant impairment in functioning and Members requiring emergency or inpatient mental health care, to the Orange County Health Care Agency (HCA) or other agency as appropriate.

h) PCP shall refer Members requiring alcohol and drug treatment to CalOptima for referral to Short-Doyle Medi-Cal alcohol and drug treatment programs.

i) PCP shall refer all Members in the Seniors and Persons with Disability (SPD) aid codes, which is 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, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system to CalOptima.

2.13.2 Appointment Pediatric Preventive Covered Services. Primary Care Provider shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule. Immunizations are to be provided according to the latest guidelines published by the AAP and Advisory Committee on Immunization Practices (ACIP). If there is a conflict in the recommendations, the higher standard will be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

2.13.3 Alcohol and Substance Use Disorder Treatment Services. Physician shall ensure the SBIRT services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond SBIRT. Physician shall document SBIRT services in Members Medical Record.

2.14 Professional shall also provide services to COD-Administrative Members under this Contract. The scope of such services shall be as defined in the CalOptima Medi-Cal Provider Manual and CalOptima Policy, rather than as set forth in Article 2 of this Attachment A.

2.15 Health Risk Assessments (HRAs) - Professional will be required to complete HRAs in accordance with each of CalOptima Programs requirements and CalOptima Policy.

2.16 Professional shall comply with CalOptima's Model of Care specified for each of CalOptima programs.

2.17 Professional shall cooperate and coordinate Mental Health and Behavioral Health in accordance with each of CalOptima's Programs and CalOptima Policy.

2.18 Professional shall cooperate with CalOptima's Personal Care Coordinator or "PCC" in accordance with CalOptima's PCC Program Policies and guidance.

2.19 Professional shall participate with CalOptima's Interdisciplinary Care Team "ICT" and contribute to the Individualized Care Plan or "ICP" in accordance with CalOptima's Program guidelines, Policies and Procedures.

2.20 Initial Health Assessment Appointment. If Professional is a Member's Primary Care Provider, Professional 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 twenty-one (21) years of age and include annual dental referrals made with the eruption of the child's first tooth or at twelve (12) months of age, whichever occurs first. Professional shall ensure that Members are referred to appropriate Medi-Cal 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. Professional's failure to perform at or in excess of minimum performance requirements shall subject Professional to sanctions in accordance with this Contract and CalOptima Policies. Physician shall ensure that health assessment information shall be recorded in the Member's Medical Record.

ARTICLE 3
SCOPE OF SERVICE
Homeless Clinic Access Program (HCAP)
(Effective September 1, 2023 through August 31, 2025)

The primary goal of the Homeless Clinic Access Program (HCAP) is to provide reliable, quality medical care for individuals experiencing homelessness in Orange County by coordinating mobile clinics at shelters. Professional will offer individuals experiencing homelessness a comprehensive suite of services in support of caring for the whole person and addressing other social determinants of health.

In addition to all general responsibilities under Article II, as applicable, Professional shall provide the following additional services under the Homeless Clinic Access Program (HCAP):

3.1 Professional Obligations.

3.1.1 Professional shall:

a) Partner, at a minimum, with one homeless shelter ("**Partner Shelter**").
b) Have a brick-and-mortar location within 5-mile radius from Partner Shelter to receive incentive. If there are no locations for the Professional within a 5-mile radius of a shelter, CalOptima shall make an exception.
c) Provide service to individuals experiencing homelessness, regardless of Member status, primary care assignment, or health network affiliation.
d) Maintain a set service schedule at the partner location via mobile unit or using a satellite clinic housed within shelter, meeting minimum scheduling requirements of at least 16 hours a week over a minimum of 2 days.
e) Meet (or exceed) minimum medical service thresholds: 1) Provide medical care to at least 16 individuals per week, and 2) See no less than 4 individuals per 4 hours during scheduled day.
f) Ensure the shelter site has space to accommodate mobile units or a space within their location appropriate to provide services.
g) Fulfill all reporting and claims submission requirements by using the program specific billing guidelines and/ or CalOptima reporting templates. Only claims for medical services count toward meeting service thresholds.

h) Maintain/establish any agreements or memorandum of understanding (MOU) with Partner Shelter(s), as needed by either partner.

i) Participate in quarterly meetings with the Partner Shelter and CalOptima.

3.1.2 Professional Deliverables.

a) By March 31, 2024, Professional shall provide wrap-around services to one or more Partner Shelter(s) in Orange County spending at least 16 hours a week with a minimum of 2 days at each Partner Shelter site, serving at least 16 individuals per week per site.

b) By August 31, 2024, Professional will have provided services to at least 250 unduplicated individuals.

c) By August 31, 2024, Professional will have submitted claims demonstrating the level of service provision of 16 individuals served on average each week, as applicable, and in accordance with criteria listed in this Amendment #.

3.2 CalOptima Obligations.

3.2.1 CalOptima shall:

a) Facilitate quarterly group meetings with Professional to ensure measures are being met.

b) Provide onboarding training to Professional and Partner Shelters.

3.3 Performance Measure.

a) Performance will be measured based on successful completion of all deliverables within the timeframes indicated in section 3.1.2; and whether objectives in section 3.2 were fully met, as noted in monthly progress reports.

3.4 Payment.

3.4.1 CalOptima will grant an incentive payment to the Professional in the amount of one-hundred thousand dollars ($100,000.00) annually, and shall be the maximum amount payable for the program per year and shall be paid following execution of this Amendment # in the time and manner set forth below:

a) To be eligible for incentive, Professional must meet threshold service minimum; incentive payment will be paid quarterly upon confirmation that claims submissions matched the minimum amount of service required.

b) Monthly progress reporting will be sent via WizeHive to track individuals count, hours of service, and location. Training will be given upon onboarding.

c) 16 hours minimum a week.

d) Minimum of 16 patients served per week (2 per hour) as demonstrated by claims submission.

3.4.2 Payments will be made after each quarter once service thresholds have been reported and confirmed.

3.5 Reporting.

3.5.1 Professional shall submit monthly progress report and claims. Professional must complete the Project Report Form provided through WizeHive with CalOptima's California Advancing and Innovating Medi-Cal Program Development department.

ATTACHMENT B-2

COMPENSATION FOR HOMELESS CLINIC ACCESS PROGRAM (HCAP)
EFFECTIVE SEPTEMBER 1, 2023 THROUGH AUGUST 31, 2025

1. In addition to the Homeless Clinic Access Program (HCAP) incentive payment, CalOptima will reimburse Professional for CalOptima Members regardless of Health Network affiliation or primary care provider assignment for Services provided under Attachment A, Article 3, Homeless Clinic Access Program (HCAP).

   1.1 For Medical Services provided by the Professional to CalOptima Medi-Cal Members, regardless of Health Network affiliation, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or one hundred twenty three percent (123%) of the Current CalOptima Medi-Cal Fee Schedule on a fee-for-service basis as defined in the CalOptima Policies.

   1.2 For Medical Services provide by the Professional to CalOptima OneCare Members, regardless of Health Network affiliation, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or one hundred percent (100%) of the current year CalOptima Medicare Allowable Participating Provider Fee Schedule for locality 26.

2. Billing Requirements: As applicable, Medi-Cal and Medicare billing rules and payment Policies and guidelines for billing and payment will apply.

   2.1 All claims for services provided by Professional must include the following:

   NPI
   1366702961

   Primary Diagnosis
   Z59.0 Homelessness

   Place of Service
   04 –Homeless Shelter

3. Services with Unestablished Fees. If a fee has not been established by Medi-Cal or Medicare as applicable, for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines.

   3.1 "By Report & Unlisted" codes will be paid at forty percent (40%) of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of services provided.

   3.2 Professional shall utilize current payment codes and modifiers for Medi-Cal or Medicare as applicable.

   3.3 CPT or HCPCS codes not contained in the Medi-Cal or Medicare, as applicable, fee schedule at the time of service are not reimbursable.

   3.4 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.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

29. Approve Amendment to Extend CalOptima Health Public Health Services Contract with the County of Orange and Add Provisions for New CalAIM Services

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 (CEO) to execute an amendment to CalOptima Health's Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency (County), to:

1. Extend the contract term through December 31, 2026.
2. Add provisions reflecting the addition of the following two new community supports services under the California Advancing and Innovating Medi-Cal (CalAIM) program, effective January 1, 2024:
    a. Community/Nursing Facility Transition to a Home Service; and
    b. Nursing Facility Transition/Diversion Services.
3. Approve addition of Exhibit E, Business Associate Agreement (BAA).

Background and Discussion

Staff requests the CalOptima Health Board of Directors (Board) authorize the CEO to execute the above-mentioned amendment to CalOptima Health's contract with the County, effective January 1, 2024. The contract, which coordinates public health benefits and services provided jointly between CalOptima Health and the County, expires on December 31, 2023.

At present, the California Department of Health Care Services (DHCS) is in the process of developing new boilerplate MOU templates to be used for each program covered within the current contract. These boilerplates are scheduled to be completed by 2025. Until the final boilerplate templates are provided by DHCS, an extension of the contract is needed to ensure the continuity of program benefits currently received by CalOptima Health members. A three-year contract extension will allow sufficient time for DHCS and managed care plans to operationalize the new DHCS requirements mandated across managed care plans in 2024 and 2025. The additional year will allow for the mitigation of any unforeseen circumstances arising from this transition. CalOptima Health will return to the Board prior to the 2026 expiration date if additional time is needed.

CalOptima Health will also begin providing two new community supports services under the CalAIM program beginning in January 2024. Community/nursing facility transition to a home service and nursing facility transition/diversion services will be new benefits provided within the contract, with added provisions in the amendment reflecting such. Additionally, the proposed amendment includes the addition of a BAA, effective January 1, 2024, to the Coordination and Provision of Public Health Care Services Contract. The BAA allows for mutual coordination involving the use, creation,

Back to Agenda

maintenance, transmission, access, or disclosure of information between CalOptima Health and the Health Care Agency to more efficiently and effectively coordinate member care.

To allow time for DHCS to complete its changes related to public health services programs, including implementation of new templates, coordination of new CalAIM services, and enter into the BAA, staff requests Board authorization of the amendment to CalOptima Health's Coordination and Provision of Public Health Care Services Contract with the County, effective January 1, 2024.

Fiscal Impact

The recommended action to amend the Coordination and Provision of Public Health Care Services Contract with the County to add two new community supports services under the CalAIM program effective January 1, 2024, is a budgeted item with no additional fiscal impact anticipated. Management has included projected expenses associated with community support services in the CalOptima Health Fiscal Year 2023-24 Operating Budget. There is no additional fiscal impact related to the addition of Exhibit E, BAA to the contract.

Rationale for Recommendation

The above amendment will allow for continued continuation of member benefits under the Public Health Services contract during the time that DHCS is finalizing changes related to these programs, and provision of new community supports service under the CalAIM program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Draft proposed amendment to the Coordination and Provision of Public Health Care Services Contract

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
County of Orange Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

AMENDMENT 13

TO THE

COORDINATION AND PROVISION OF PUBLIC HEALTH CARE SERVICES CONTRACT

This Amendment 13 to the Coordination and Provision of Public Health Care Services Contract ("Amendment 13") is entered into by and between the Orange County Health Authority, a public agency, dba CalOptima Health ("CalOptima"), and the County of Orange, a political subdivision of the State of California, through its division the Orange County Health Care Agency ("County"), and shall become effective on the first day of the first month following execution of this Amendment ("Effective Date"), with respect to the following:

RECITALS

A. CalOptima and County entered into a Coordination and Provision of Public Health Care Services Contract ("Contract") effective June 1, 2013, to set forth the manner in which their respective services shall be coordinated, and outline the specific services for which County will be reimbursed by CalOptima as required by CalOptima's contract with the Department of Health Care Services ("DHCS").

B. CalOptima and County desire to extend the Coordination and Provision of Public Health Care Services Contract, expiring December 31, 2023, for three (3) years through the terms and conditions set forth herein.

C. On January 8, 2021, DHCS released a revised California Advancing and Innovating Medi-Cal ("CalAIM") proposal that takes a whole-person care approach to improving health outcomes for Medi-Cal members by incorporating both clinical and nonclinical services. Implementation of CalAIM initiatives by managed care plans began on January 1, 2022.

D. Several CalAIM Community Supports were added to the Contract via Amendment 11 effective October 1, 2022. CalOptima and County desire to amend this Contract to include two (2) additional Community Supports, update two (2) Community Support rates, and extend Enhanced Care Management through the terms and conditions set forth herein.

E. CalOptima and County wish to incorporate a Business Associate Agreement to perform the necessary terms and conditions set forth therein.

NOW, THEREFORE, the parties agree as follows:

1. Section 8.1 "Term" shall be deleted in its entirety and replaced with the following:

   "8.1. Term. The Term of this Contract shall be from June 1, 2013, through December 31, 2026."

2. Delete Attachment A, Part XIV "CalAIM Transition Coordination Services" in its entirety and replace it with the attached new Attachment A, Part XIV – Amendment 13 "CalAIM Enhanced Care Management Services"

3. Add the following new Sections H and I to Section I "SCOPE OF WORK" of Attachment A, Part XV "CalAIM Community Supports Services".

   H. Community/Nursing Facility Transition to a Home

   Description/Overview

A. Community Transition /Nursing Facility Transition to a Home Services, as described in this Section 1, help Members live in the community and avoid further institutionalization.

B. Community Transition/Nursing Facility Transition to a Home Services cover non-recurring setup expenses for Members who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a Member to establish a basic household that do not constitute room and board and include:

i. Assessing the Member's housing needs and presenting options. Refer to the Housing Transition/Navigation Services and/or Housing Tenancy/Sustaining Services Community Supports for additional details.

ii. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

iii. Communicating with the landlord (if applicable) and coordinating the move.

iv. Establishing procedures and contacts to retain housing.

v. Identifying, coordinating, securing, or funding non-emergency, nonmedical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.

vi. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility. Refer to the Housing Transition/Navigation Services and/or Housing Tenancy/Sustaining Services for additional details.

vii. Identifying the need for and coordinating funding for services and modifications necessary to enable a Member to establish a basic household refers to funding that does not constitute room and board, such as security deposits required to obtain a lease on an apartment or home; setup fees for utilities or service access; first-month coverage of utilities, including telephone, electricity, heating, and water; funds for services necessary for the Member's health and safety, such as pest eradication and one-time cleaning prior to occupancy; funds for home modifications, such as an air conditioner or heater; and funds for other medically necessary services, such as hospital beds and Hoyer lifts, etc. to ensure access and reasonable accommodations. Refer to the Environmental Accessibility Adaptations and/or Asthma Remediation Community Supports for additional details.

Eligibility

A. Is currently receiving medically necessary nursing facility level of care ("LOC") services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;

B. Has lived 60+ days in a nursing home and/or medical respite setting;

C. Is interested in moving back to the community; and

D. Is able to reside safely in the community with appropriate and cost-effective supports and

services.

Restrictions/Limitations

A. Community Transition/Nursing Facility Transition to a Home Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.

B. Community Transition/Nursing Facility Transition to a Home Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the Member is compelled to move from a Provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.

C. Community Transition/Nursing Facility Transition to a Home Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re-institutionalization.

D. Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM special terms and conditions ("STCs") and federal and DHCS guidance.

Licensing/Allowable Providers

A. Community Supports Providers must have experience and expertise with providing these unique services. The list is provided to show examples of the types of Community Supports Providers that may provide Community Transition/Nursing Facility Transition, but it is not an exhaustive list of Providers that may offer the services.

i. Case management agencies

ii. Home health agencies

iii. Medi-Cal managed care plans

iv. County mental health providers

v. 1915c home and community-based alternatives/assisted living waiver providers

vi. California community transitions/money follows the person providers

Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

I. Nursing Facility Transition/Diversion Services

Description/Overview

A. Nursing Facility Transition/Diversion Services, as defined in this Section 1, help Members live in the community and/or avoid institutionalization when possible.

B. The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care ("LOC"). Members have the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

C. The assisted living Provider is responsible for meeting the needs of the Member, including helping with Activities of Daily Living ("ADLs") and Instrumental ADLs ("IADLs") and providing meals, transportation, and medication administration, as needed.

D. Nursing Facility Transition/Diversion Services are for individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facility for the Elderly ("RCFE") or an Adult Residential Facility ("ARF"). They include wraparound services such as assistance with ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming, provided in a home-like environment. It also includes 24- hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence and to provide supervision, safety, and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including but not limited to:

i. Assessing the Member's housing needs and presenting options. Refer to Housing Transition/Navigation Services Community Support for additional details.

ii. Assessing the service needs of the Member to determine whether the Member needs enhanced on-site services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF.

iii. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

iv. Communicating with facility administration and coordinating the move.

v. Establishing procedures and contacts to retain facility housing.

vi. Coordinating with CalOptima to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ARF settings have Community Supports services and/or ECM services that provide the necessary enhanced services.

a. CalOptima may also fund RCFE/ARF operators directly to provide these enhanced services.

Eligibility

A. For Nursing Facility Transition Services:

i. Has resided 60+ days in a nursing facility;

ii. Is willing to live in an assisted living setting as an alternative to a nursing facility; and

iii. Is able to reside safely in an assisted living facility with appropriate and cost- effective supports.

B. For Nursing Facility Diversion Services:

i. Is interested in remaining in the community;

i. Is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

ii. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and, in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an assisted living facility.

Restrictions/Limitations

A. Members are directly responsible for paying their own living expenses.

B. Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM special terms and conditions ("STCs") and federal and DHCS guidance.

Licensing/Allowable Community Supports Providers

A. Community Supports Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided to show examples of the types of Community Supports Providers that may provide Nursing Facility Transition/Diversion Services but is not an exhaustive list of Community Supports Providers that may offer the services.

i. Case management agencies

ii. Home Health Agencies

iii. Medi-Cal managed care plans

iv. ARF/RCFE operators

B. Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

C. RCFEs/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing Division.

3. Delete Attachment B – Amendment 10 "Compensation" in its entirety and replace it with the attached new Attachment B – Amendment 13 "Compensation".

4. Exhibit E, Business Associate Agreement, attached to this Amendment and incorporated into the Contract by this reference..

5. This Amendment may be executed in multiple counterparts, and counterpart signature pages may be assembled to form a single, fully executed document.

6. Except as specifically amended by this Amendment 13, all other conditions contained in the Contract as previously amended shall continue in full force and effect. After the Amendment 13 Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment 13. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment 13 and those contained within the Contract, the terms and conditions of this Amendment 13 shall prevail. Capitalized terms not otherwise defined in this Amendment 13 shall have the meanings ascribed to them in the Contract. This Amendment 13 is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and County have executed this Amendment 13.

FOR COUNTY:	FOR CALOPTIMA:
	Veronica Carpenter (Nov 17, 2023 12:48 PST)
Signature	Signature
Debra Baetz	Veronica Carpenter
Print Name	Print Name
Interim Director, Health Care Agency	Chief of Staff
Title	Title
	Nov 17, 2023
Date	Date

Approved as to form:
County Counsel
County of Orange, California

DocuSigned by:
By: Brittany McLean
9713A4061D4343D...
11/17/2023
Date:
Brittany McLean

Attachment A, Part XIV – Amendment 13
CalAIM Enhanced Care Management Services

CalAIM Program Services to be provided by County for CalOptima Medi-Cal Members

I. SCOPE OF WORK---

Service Categories: ECM Services to be provided by County for CalOptima Members who are experiencing SMI/SUD inclusive of other related population of focus criteria to be effective January 1, 2022 under CalOptima's CalAIM program such as homelessness and high utilizers (CalAIM Program enrolled Members only).

A. Enhanced Care Management (ECM)

1. ECM Core Services – Upon authorization by CalOptima Member's assigned Health Network and acceptance by County, County will perform the following core ECM Services to CalOptima Members who are enrolled in CalAIM Program and are experiencing SMI and/or SUD inclusive of other related population of focus criteria to be effective January 1, 2022 under CalOptima's CalAIM program such as homelessness and high utilizers (adults and children/youth), per policy GG.1354 Enhanced Care Management Eligibility and Outreach:

    a. Outreach and engagement;

    b. Comprehensive assessment and care management plan;

    c. Enhanced coordination of care;

    d. Health promotion;

    e. Comprehensive transitional care;

    f. CalOptima Member and family supports; and

    g. Coordination of and referral to community and social support services.

2. ECM Provider Requirements – County, shall satisfy the ECM Provider requirements for County identified, CalAIM enrolled and CalOptima authorized Members as set forth in CalOptima Policies and as follows:

    2.1 County shall have experience serving CalOptima Members experiencing SMI and/or SUD inclusive of other related population of focus criteria to be effective January 1, 2022 under CalOptima's CalAIM program such as homelessness and high utilizers and experience and expertise with the services County will provide.

    2.2 County 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.

    2.3 County shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying CalOptima Members to critical appointments when

necessary. County shall be able to communicate in culturally and linguistically appropriate and accessible ways.

2.4 County shall have agreements, procedures, and processes in place to engage and cooperate with CalOptima, CalOptima Health Networks, area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including Community Supports Providers, to coordinate care as appropriate to each CalOptima Member. County shall comply with CalOptima's applicable process for vetting providers, which may extend to the individuals employed by or delivering services on behalf of County, to ensure the providers can meet the capabilities and standards required to be an ECM Provider.

2.5 County 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 CalOptima Member goals and goal attainment status; develop and assign care team tasks; define and support CalOptima Member care coordination and care management needs; gather information from other sources to identify CalOptima Member needs and support care team coordination and communication and support notifications regarding CalOptima Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

3. Identifying CalOptima Members for ECM – CalOptima and County shall proactively identify CalOptima Members who are eligible for ECM Services and would benefit from ECM outreach. CalOptima Members identified by County shall be communicated to CalOptima on a monthly basis consistent with CalOptima's process, as described in CalOptima Policy GG.1354: Enhanced Care Management Eligibility and Outreach.

4. County Responsibilities for Assigned ECM Members.

4.1 Upon authorization of ECM by CalOptima and acceptance by County, County shall ensure each assigned ECM Member has a Lead Care Manager who interacts directly with the ECM Member and/or their family member(s), guardian, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any Community Supports, and other services that address social determinants of health needs, regardless of setting.

4.2 County shall:

(i) Advise the ECM Member on the process for changing ECM Providers, which is permitted at any time;

(ii) Advise the ECM Member on the process for switching ECM Providers, if requested; and

(iii) Notify CalOptima if the ECM Member wishes to change ECM Providers. CalOptima shall implement any requested ECM Provider change within thirty (30) calendar days.

5. County Staffing – At all times, County shall have adequate staff to ensure its ability to carry out responsibilities for each assigned ECM Member consistent with this Contract, applicable CalOptima Policies, DHCS ECM Provider Standard Terms and Conditions, the DHCS-CalOptima ECM and Community Supports Contract and any other related DHCS guidance.

6. County Outreach and Member Engagement – County shall be responsible for conducting outreach to each assigned ECM Member, in accordance with CalOptima Policy GG.1354: Enhanced Care Management Eligibility and Outreach.

   6.1 County shall conduct outreach primarily through in-person interaction where ECM 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. County may supplement in-person visits with secure teleconferencing and telehealth, where appropriate, with the ECM Member's consent, and in compliance with applicable CalOptima Policies. County shall use the following modalities, as appropriate and as authorized by the ECM Member, if in-person modalities are unsuccessful or to reflect an ECM Member's stated contact preferences: (i) Mail; (ii) Email; (iii) Texts; (iv) Telephone calls; and (v) Telehealth.

   6.2 County shall comply with applicable non-discrimination requirements set forth in State and federal law and this Contract.

   6.3 CalOptima and County will coordinate to ensure that ECM Members who the parties know meet exclusionary criteria as defined in CalOptima Policy GG.1354: Enhanced Care Management Eligibility and Outreach do not receive ECM Services.

7. Initiating Delivery of ECM Services – County shall obtain, document, and manage ECM Member authorization for the sharing of personally identifiable information between CalOptima and ECM, Community Supports, and other Providers involved in the provision of ECM Member care to the extent required by federal law.

   7.1 ECM Member authorization for ECM-related data sharing is not required for County to initiate delivery of ECM Services unless such authorization is required by federal law. When federal law requires authorization for data sharing, County shall communicate that it has obtained ECM Member authorization for such data sharing back to CalOptima.

   7.2 County shall notify CalOptima to discontinue ECM under the following circumstances: (i) The ECM Member has met their care plan goals for ECM; (ii) The ECM Member is ready to transition to a lower level of care and/or services; (iii) The ECM Member no longer wishes to receive ECM Services or is unresponsive or unwilling to engage; and/or (iv) County has not had any contact with the ECM Member despite multiple attempts.

   7.3 When ECM is discontinued, or will be discontinued for the ECM Member, CalOptima is responsible for sending a notice of action notifying the ECM Member of the discontinuation of the ECM benefit and ensuring the ECM Member is informed of the right to appeal and the appeals process as instructed in the notice of action. County shall communicate to the ECM Member other benefits or programs that may be available to the ECM Member, as applicable (e.g., ECM Complex Case Management, ECM Basic Case Management, etc.).

8. County and CalOptima Coordination – Both County and CalOptima including its Health Networks will coordinate all aspects of the CalOptima Members enrollment, navigation, and care coordination within the community in a direct and collaborative model to ensure the CalOptima Member is benefiting from all services.

9. ECM Requirements – County 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 CalOptima Health Networks. County shall ensure the approach is person-centered, goal oriented, and culturally appropriate.

9.1 Subject to all applicable requirements set forth in this Contract (including, but not limited to, subcontracting requirements), if County subcontracts with other entities to administer ECM functions, County shall ensure agreements with each entity bind the entities to the applicable terms and conditions set forth in this Contract and applicable CalOptima Policies and that its Subcontractors comply with all applicable requirements in DHCS County Standard Terms and Conditions and the DHCS-CalOptima ECM and Community Supports Contract. Notwithstanding any subcontracting arrangements, County shall remain responsible and accountable for any subcontracted ECM functions.

9.2 County shall: (i) Ensure each ECM 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.

9.3 County shall collaborate with area hospitals, Primary Care Providers CalOptima and CalOptima's Health Networks, 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.

9.4 County 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.

9.5 County shall complete a health needs assessment and develop a comprehensive, individualized, person-centered care plan for each ECM Member. County 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.

10. Training – County 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. County 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.

11. Data Sharing to Support ECM – CalOptima, including its Health Networks, and County agree to exchange available information and data as required by DHCS guidance and as reasonably required by CalOptima Policies, including but not limited to notification of hospital emergency department visits, inpatient admissions and discharges, health history, behavioral health history, and other agreed upon information to support the physical and mental health of ECM Members. CalOptima, including its Health Networks, and County shall conduct such 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, County 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, County may not release such information without the ECM Member's valid authorization.

11.1 CalOptima will provide to County the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable:

(i) CalOptima Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to County;

(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 CalOptima Members, as available; and

(iv) Reports of performance on quality measures and/or metrics, as requested.

12. Claims Submission and Reporting – County shall submit claims or invoices for provision of ECM Services to CalOptima using the national standard specifications and code sets defined by DHCS. In the event County is unable to submit claims to CalOptima for ECM Services using the national standard specifications and DHCS-defined code sets, County shall submit an invoice to CalOptima with a minimum set of data elements (as defined by DHCS) necessary for CalOptima to convert the invoice to an encounter for submission to DHCS.

13. Quality and Oversight – County acknowledges that CalOptima will conduct oversight of County's provision of ECM Services under this Contract to ensure the quality of ECM Services and compliance with program requirements, which may include audits and/or corrective actions. County shall respond to all reasonable requests from CalOptima for information and documentation related to County's provision of ECM Services.

14. ECM Data and Reports – County shall submit to CalOptima complete, accurate, and timely ECM data and reports in the manner and form reasonably acceptable to CalOptima as required by applicable CalOptima Policies or otherwise required by DHCS in order for CalOptima to monitor and meet the following: (i) program performance targets; and (ii) its data reporting requirements to DHCS.

15. County Agent Qualifications – County shall verify that the qualifications of County staff and agents on behalf of County providing ECM Services under this Contract comply with the requirements of this Contract and applicable CalOptima Policies and DHCS guidance. In addition, for County staff and agents providing services on behalf of County who enter CalOptima Members' homes or have face-to-face interactions with CalOptima Members, County shall also conduct background investigations, including, but not limited to, County, State and Federal criminal history and abuse registry screening. County shall comply with all applicable laws in conducting background investigations and shall exclude unqualified persons from providing services under this Contract.

16. County will provide ECM Services from January 2022, through the Term of the Contract.

II. CRITERIA FOR REIMBURSEMENT---

A. CalOptima shall reimburse County for ECM provided to a CalOptima Member, subject to authorization from CalOptima.

III. DEFINITIONS SPECIFIC TO THIS ATTACHMENT A, PART XIV---

A. "CalAIM (California Advancing and Innovating Medi-Cal") is a multi-year initiative by DHCS to improve the quality of life and health outcomes of County of Orange population by implementing broad delivery system, program, and payment reform across the Medi-Cal program. The major components of CalAIM build upon the successful outcomes of various pilots (including but not limited to the Whole Person

Care Pilots (WPC), Health Homes Program (HHP), and the Coordinated Care Initiative) from the previous federal waivers and will result in a better quality of life for Medi-Cal members as well as long-term cost savings/avoidance.

B. "Homeless" means a CalOptima Member who, as defined in 24 C.F.R section 91.5, lacks a fixed, regular, and adequate nighttime residence, or who will imminently lose their primary nighttime residence; or are an unaccompanied CalOptima Member under twenty-five (25) years of age; or a CalOptima Member who is fleeing dangerous or life-threatening conditions, has no other residence, and lacks the resources to obtain permanent housing.

C. "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in CalOptima.

D. "WPC (Whole Person Care)" means the program administered by the Orange County Health Care Agency, providing infrastructure and integrated systems of care to coordinate services for vulnerable Medi-Cal beneficiaries experiencing homelessness.

ATTACHMENT B – AMENDMENT 13

COMPENSATION

I. COMPENSATION

A. Medi-Cal Program

1. With the exception of the services and reimbursement rates specified in Sections I.B, I.C, and I.D of this Attachment B – Amendment 13, CalOptima or a Member's Health Network shall reimburse County, and County shall accept as payment in full from CalOptima, the lesser of:

   a. billed charges, or:

   b. the following rates:

      1) 123% of the Current CalOptima Medi-Cal Fee Schedule on a fee-for-service basis for **physician services**, as defined in the Provider Manual.

      2) 100% of the Current CalOptima Medi-Cal Fee Schedule on a fee-for-service basis for **non-physician services**, as defined in the Provider Manual.

      3) 100% of the Current CalOptima Medi-Cal Fee Schedule on a fee-for-service basis, as defined in the Provider Manual **for Child Health and Disability Prevention (CHDP) services** provided by County.

      4) 140% of the Current CalOptima Medi-Cal Fee Schedule on a fee-for-service basis, as defined in the Provider Manual **for professional services provided by a qualifying CCS paneled specialist** to a Member less than 21 years of age.

2. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for County to provide such service, CalOptima shall reimburse County under the following guidelines:

   a. "By Report & Unlisted" codes that CalOptima has provided authorization for County to provide such service will be paid at forty percent (40%) of billed charges and must follow Medi-Cal billing rules, policies and guidelines. When billing CalOptima for these codes, County shall include documentation of Covered Services provided.

   b. County shall utilize current billing codes and modifiers for Medi-Cal.

   c. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

   d. 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 provider for additional justification and these will be handled on a case-by-case basis.

B. WPC/HHP Crossover Services

1. REIMBURSEMENT--- County shall be reimbursed for its services provided on or before December 31, 2021, according to the monthly rates listed below:

Services	HHP Enrollment Status	Rate per Month (per Member)
Targeted Engagement	Eligible	$207.50
Housing Navigation and Sustainability	Enrolled	$960.00

2. INVOICE SUBMISSION--- On a monthly basis, County shall submit an invoice to CalOptima at the address specified below for reimbursement of services provided to CalOptima Members during the previous month. The invoice shall include member details which can be utilized by CalOptima to prepare DHCS reporting, including member-identifying information and which services were provided to each member during that month.

CalOptima
Attn: Accounts Payable
505 City Parkway West
Orange, CA 92868

C. CalAIM Enhanced Care Management Services

1. REIMBURSEMENT--- County shall be reimbursed for its services according to the monthly rates listed below:

Services	CalAIM Eligible or Enrolled	Rate
Enhanced Care Management Services (SMI/SUD) and inclusive of other related population of focus criteria to be effective January 1, 2022 under CalOptima's CalAIM program such as homelessness and high utilizers	Enrolled and Authorized by CalOptima	$553.83 Per Enrollee Per Month (PEPM) for each CalOptima Member who receives two (2) or more hours of ECM Services in a given month as identified by twelve (12) or more units. For purposes of Attachment B – Amendment 13, the term "Per Enrollee Per Month" means an all-inclusive case rate that applies whenever County, has provided the minimum level of service payment to an enrolled CalOptima Member. This rate is paid on the basis of submitted invoices and is not considered a capitation payment.

2. INVOICE SUBMISSION--- On a monthly basis, County shall submit an invoice to CalOptima at the address specified below for reimbursement of services provided to CalOptima Members during the previous month. The invoice shall include member details which can be utilized by CalOptima to prepare DHCS reporting, including member-identifying information and which services were provided to each member during that month.

CalOptima
Attn: Accounts Payable
505 City Parkway West
Orange, CA 92868

D. PACE Program Services

1. For Covered Services provided to PACE Members, CalOptima shall reimburse County, and County shall accept as payment in full from CalOptima, the lesser of:

    a. billed charges, or

    b. 100% of the current Medicare Allowable Participating Provider Fee Schedule for locality 26.

2. Prior authorization rules apply for payment of services.

3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.

4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse County under the following guidelines:

    a. "By Report & Unlisted" codes that CalOptima has provided authorization for County to provide such service will be paid at **forty percent (40%)** of billed charges and must follow Medicare billing rules and guidelines. When billing CalOptima for these codes, County shall include documentation of Covered Services provided.

    b. County shall utilize current payment codes and modifiers for Medicare.

    c. CPT or HCPC codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

    d. 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 County for additional justification and these will be handled on a case-by-case basis.

5. Should Medicare consider a service as non-covered, then Medi-Cal guidelines shall be applied. County may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

E. CalAIM Community Supports Services

1. REIMBURSEMENT -- County shall be reimbursed for its services according to the rates and effective dates listed below:

Housing Deposits – Effective 10/01/2022.

Service	Lifetime maximum of $5,000.00. The amount of the Housing Deposit, up to the maximum allowed
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Housing Transition Navigation Services Service Rate - Effective 10/01/2022.

Bundled Payments (per Enrollee per Month (PEPM))	$449.00 PEPM

Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Housing Tenancy and Sustaining Services Service Rate - Effective 10/01/20221

Bundled Payments (per Enrollee per Month (PEPM))	$475.00 PEPM
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Recuperative Care (Medical Respite) Service Rate - Effective 10/01/2022

Service Rate	$226.00 Per Day, All Inclusive
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Medically Tailored Meals Service Rate - Effective as of the Effective Date of this Amendment.

Service Rate	$12.00 Per Delivered Meal $66.00 Per Weekly Grocery Box Delivered $38.00 Per Nutritional Assessment
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Day Habilitation Programs Service Rate - Effective 7/01/2022

Service Rate	$67.30 Per Day, All Inclusive
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Short-Term Post-Hospitalization Housing Service Rate - Effective as of the Effective Date of this Amendment.

Service Rate	$119.00 Per Day, All Inclusive
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Community/Nursing Facility Transition to a Home Service Rate - Effective as of the Effective Date of this Amendment.

Service Rate	Lifetime maximum of $7,500.00. The amount of Community/Nursing Facility Transition to Home Services, up to the maximum allowed.
Billing Code(s): including modifiers	See DHCS guidance for specific billing codes and modifiers

Nursing Facility Transition/Diversion Services Service Rate - Effective as of the Effective Date of this Amendment.

Bundled Payments (per Enrollee per Month (PEPM))	$496.00 PEPM
Billing Code(s): including modifiers	See DHCS guidance for specific billing codes and modifiers

BILLING -- County shall submit Community Supports Services claims to CalOptima's Claims Department in accordance with DHCS billing guidelines specific to Community Supports. Billing and payment provisions in Sections II.E and II.F of Attachment A – Part XV "CalAIM Community Supports Services" of this Contract also apply.

II. SERVICES ELIGIBLE FOR REIMBURSEMENT

Category	County	CalOptima/Health Networks
Non-DOT TB Treatment	**Medi-Cal**: PDS will bill CalOptima for covered TB screening and treatment services for both CalOptima Direct and Health Network Members.	**Medi-Cal**: CalOptima will pay County for claims for covered TB screening and treatment services for both CalOptima Direct and Health Network Members. CalOptima shall not pay County for DOT professional services.
HIV and STD Services (17th Street Testing, Treatment and Care)	**Medi-Cal**: For CalOptima clients in the process of transitioning to a CalOptima provider, County will bill CalOptima for medical services provided to CalOptima Direct Members, and the appropriate Health Network for Health Network Members. **PACE**: County will bill CalOptima for HIV testing and counseling services, and STD Services provided to PACE Members.	**Medi-Cal and PACE**: CalOptima will pay claims submitted for Medi-Cal and PACE Covered Services provided at 17th Street Testing, Treatment and Care to CalOptima Direct Medi-Cal Members and to PACE Members, respectively. **Medi-Cal**: CalOptima's Health Networks are responsible for Claims for Covered Services provided at 17th Street Testing, Treatment and Care to their Members.
Adult Immunizations	**Medi-Cal**: County will bill CalOptima or the appropriate Health Network for Health Network Members for Medi-Cal covered adult immunizations provided to CalOptima Direct and Health Network Members over the age of 18. For Members 18 to 21 years of age, County will bill CalOptima on a CMS-1500, UB-04 claim form, or electronic equivalent. **PACE**: County will bill CalOptima for Medicare covered adult immunizations provided to CalOptima PACE Members.	**Medi-Cal**: CalOptima or the appropriate Health Network for Health Network Members will reimburse County for Medi-Cal covered adult immunizations provided to CalOptima Direct and Health Network Members over the age of 18. **PACE**: CalOptima will reimburse County for Medicare covered adult immunizations provided to CalOptima PACE Members.

Category	County	CalOptima/Health Networks
Pediatric Preventive Services	**Medi-Cal**: County Children's Clinic will bill CalOptima or the appropriate Health Network for Health Network Members for Pediatric Preventive Services on a CMS-1500, UB-04 claim form, or electronic equivalent. For vaccines supplied free through the Vaccine For Children (VFC) Program, County will bill CalOptima or the appropriate Health Network for Health Network Members for vaccine administration costs only. Sick care (i.e. non-CHDP/PPS services) will be provided to CalOptima Direct patients only. County Children's Clinic will bill CalOptima for covered medical services provided to CalOptima Direct Members.	**Medi-Cal**: CalOptima or the appropriate Health Network for Health Network Members will pay claims submitted for Pediatric Preventive Services (PPS) provided to CalOptima Members when claim is submitted on a CMS-1500, UB-04 claim form, or electronic equivalent. CalOptima or the appropriate Health Network for Health Network Members will reimburse providers for the administration fee only for vaccine supplied free through the Vaccine For Children (VFC) Program. CalOptima will pay County for covered non-PPS medical services provided to CalOptima Direct Members.
Services provided at Orangewood	**Medi-Cal**: County/JHS - Orangewood shall bill CalOptima or the appropriate Health Network for Health Network Members, using the CMS-1500, UB-04 claim form, or electronic equivalent for Pediatric Preventive Services (CHDP health assessments) provided to CalOptima Members. County/JHS -Orangewood shall bill Health Networks or CalOptima Direct for other medically necessary services provided on site at Orangewood.	**Medi-Cal**: CalOptima or the appropriate Health Network for Health Network Members, will pay for Pediatric Preventive Services (PPS) billed on a CMS-1500, UB-04 claim form, or electronic equivalent for CalOptima Members at Orangewood. CalOptima or the Member's Health Network shall pay claims for medically necessary services to County/JHS - Orangewood at CalOptima fee-for-services rates. CalOptima or the Member's Health Network shall reimburse providers to whom County/JHS – Orangewood has referred Orangewood residents for medically necessary services at CalOptima fee-for-services rates.

Category	County	CalOptima/Health Networks
Public Health Lab Services	**Medi-Cal**: County will bill CalOptima or the appropriate Health Network for Health Network Members for Medi-Cal covered lab services provided to CalOptima Members. County will bill CalOptima on a CMS-1500, UB-04 claim form, or electronic equivalent.	**Medi-Cal**: CalOptima or the appropriate Health Network for Health Network Members will reimburse County for Medi-Cal covered lab services provided to CalOptima Members.
WPC/HHP Crossover Services	**Medi-Cal**: County will bill CalOptima for the select HHP services listed below, for services provided on or before December 31, 2021, for CalOptima Direct Members via invoice. 1. Targeted Engagement Services 2. Housing Services County shall not bill CalOptima for HHP services provided to a Medi-Cal Member assigned to Health Network. If a Health Network refers one of their assigned Medi-Cal Members to County for HHP services, County will bill the appropriate Health Network for the HHP services. County's arranged reimbursement rates with Health Network shall apply.	**Medi-Cal**: CalOptima will pay County for invoices submitted for the select HHP services listed below provided to CalOptima Direct Members for dates of service on or before December 31, 2021. 1. Targeted Engagement Services 2. Housing Services
CalAIM Enhanced Care Management (ECM) Services	**Medi-Cal**: County will bill CalOptima for the select CalAIM Program services listed below, for CalOptima Members via invoice. 1. Enhanced Care Management Services for CalOptima Members in the SMI and/or SUD populations inclusive of other related population of focus criteria to be effective January 1, 2022 under CalOptima's CalAIM program such as homelessness and high utilizers.	**Medi-Cal**: CalOptima will pay County for invoices submitted for the select CalAIM Program services listed below provided to CalOptima Members. 1. Enhanced Care Management Services for CalOptima Members in the SMI and/or SUD populations inclusive of other related population of focus criteria to be effective January 1, 2022 under CalOptima's CalAIM program such as homelessness and high utilizers.

Category	County	CalOptima/Health Networks
CalAIM Community Supports Services	**Medi-Cal, Medicare Advantage (OneCare), and Cal MediConnect (OneCare Connect)***: County will bill CalOptima for the select CalAIM Program services listed below, for CalOptima Members. Effective 10/01/2022 1. Housing Deposits 2. Housing Transition Navigation Services 3. Housing Tenancy and Sustaining Services 4. Recuperative Care (Medical Respite) Effective 7/01/2022 5. Medically Tailored Meals 6. Day Habilitation Programs 7. Short-Term Post-Hospitalization Housing Effective as of the Effective Date of this Amendment.. 8. Community/Nursing Facility Transition to a Home 9. Nursing Facility Transition/Diversion *CalOptima's Cal MediConnect (OneCare Connect) program ended 12/31/2022.	**Medi-Cal, Medicare Advantage (OneCare), and Cal MediConnect (OneCare Connect)***: CalOptima will pay County for claims submitted for the select CalAIM Program services listed below provided to CalOptima Members. Effective 10/01/2022 1. Housing Deposits 2. Housing Transition Navigation Services 3. Housing Tenancy and Sustaining Services 4. Recuperative Care (Medical Respite) Effective 7/01/2022 5. Medically Tailored Meals 6. Day Habilitation Programs 7. Short-Term Post-Hospitalization Housing Effective as of the Effective Date of this Amendment. 8. Community/Nursing Facility Transition to a Home 9. Nursing Facility Transition/Diversion *CalOptima's Cal MediConnect (OneCare Connect) program ended 12/31/2022.

EXHIBIT E

Business Associate Agreement

This Business Associate Agreement is entered into by and between the Orange County Health Authority, a California local public agency, doing business as CalOptima Health ("**CalOptima**"), and County of Orange, a political subdivision of the State of California, through its division the Orange County Health Care Agency ("**Business Associate**"), effective January 1, 2024 ("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**. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in HIPAA, the HITECH Act, and regulations promulgated thereunder.

1.1. **Agreement** as used in this document means both this Business Associate Agreement and the Services Agreement to which this Business Associate Agreement applies, as specified in such Services Agreement.

1.2. **Breach** means, unless expressly excluded under 45 C.F.R. § 164.402, the acquisition, access, use, or disclosure of PHI in a manner not permitted under Subpart E of 45 C.F.R. Part 164 which compromises the security or privacy of the PHI and as more particularly defined under 45 C.F.R. § 164.402.

1.3. **Business associate** has the meaning given such term in 45 C.F.R. § 160.103.

1.4. **Confidential information** refers to information not otherwise defined as PHI in Section 1.15 below, but to which state and/or federal privacy and/or security protections apply.

1.5. **Data aggregation** has the meaning given such term in 45 C.F.R. § 164.501.

1.6. **Designated record set** has the meaning given such term in 45 C.F.R. § 164.501.

1.7. **Disclose** and **disclosure** mean the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

1.8. **Electronic health record** has the meaning given such term in 42 U.S.C. § 17921.

1.9. **Electronic media** means:

1.9.1. Electronic storage material on which data is or may be recorded electronically including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

1.9.2. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

1.10. **Electronic protected health information** ("ePHI") means individually identifiable health information that is transmitted by or maintained in electronic media.

1.11. **Health care operations** has the meaning given such term in 45 C.F.R. § 164.501.

1.12. **Individual** means the person who is the subject of PHI and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.13. **Individually identifiable health information** means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 C.F.R. § 160.103.

1.14. **Information system** means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

1.15. **Protected health information** ("PHI"), as used in this Agreement and unless otherwise stated, refers to and includes both PHI as defined at 45 C.F.R. § 160.103 and personal information ("PI") as defined in the Information Practices Act at California Civil Code § 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

1.16. **Required by law** means a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

1.17. **Secretary** means the Secretary of the U.S. Department of Health and Human Services or the Secretary's designee.

1.18. **Security incident** means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.19. **Services** has the same meaning as in the Services Agreement(s).

1.20. **Unsecured protected health information** ("unsecured PHI") means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in the guidance issued under 42 U.S.C. § 17932(h)(2).

1.21. **Use** and **uses** mean, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination or analysis of such information within the entity that maintains such information.

2. CalOptima 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 (collectively, "use or disclose PHI") in order to fulfill Business Associate's obligations under this Agreement.

4. **Permitted Uses and Disclosures of PHI by Business Associate.** Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of CalOptima, provided that such use or disclosure would not violate HIPAA, including the Privacy Regulations, 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.

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 of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code §§ 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, Welfare and Institutions Code § 5328, and California Health and Safety Code § 11845.5.

6.3 If Business Associate is a Qualified Service Organization ("QSO") as defined in 42 C.F.R. § 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 C.F.R. § 2.11.

7. **Additional Responsibilities of Business Associate**

7.1. **Nondisclosure**. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

7.2. **Safeguards and Security**

7.2.1. Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with Subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of Subpart C of 45 C.F.R. Part 164, in compliance with 45 C.F.R. § 164.316. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities.

7.2.2. Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to time. Examples of industry-recognized security frameworks include but are not limited to:

7.2.2.1. NIST SP 800-53 - National Institute of Standards and Technology Special Publication 800-53

7.2.2.2. FedRAMP - Federal Risk and Authorization Management Program

7.2.2.3. PCI - PCI Security Standards Council

7.2.2.4. ISO/ESC 27002 - International Organization for Standardization / International Electrotechnical Commission standard 27002

7.2.2.5. IRS PUB 1075 - Internal Revenue Service Publication 1075

7.2.2.6. HITRUST CSF - HITRUST Common Security Framework

7.2.3. Business Associate shall employ FIPS 140-2 compliant encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in

place and documented as such. Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information, including, but not limited to, encryption of all workstations, laptops, and removable media devices containing PHI and data transmissions of PHI.

7.2.4. Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

7.2.5. Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

7.2.6. Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 C.F.R. Part 164, Subpart C.

7.3. **Minimum Necessary**. With respect to any permitted use, disclosure, or request of PHI under this Agreement, Business Associate shall make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request respectively, as specified in 45 C.F.R. § 164.502(b).

7.4. **Business Associate's Agent**. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree through a written agreement to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such PHI and/or confidential information.

8. **Mitigation of Harmful Effects.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

9. **Access to PHI.** Except as otherwise provided in Section 9.1 below, Business Associate shall, to the extent CalOptima 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(c)(2)(ii).

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. If Business Associate maintains an electronic health record with PHI, and an individual requests a copy of such information in electronic format, Business Associate shall

make such information available in that format as required under the HITECH Act and 45 C.F.R. § 164.524(c)(2)(ii).

10. **Amendment of PHI.** Business Associate shall, to the extent CalOptima 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, necessary to respond to a proper request by the subject individual for an accounting of disclosures of PHI in accordance with HIPAA, the HITECH Act and implementing regulations. Unless directed by CalOptima 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 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. The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103. Any accounting provided by Business Associate under this Section shall include:

11.1. The date of the disclosure;

11.2. The name, and address if known, of the entity or person who received the PHI;

11.3. A brief description of the PHI disclosed; and

11.4. A brief statement of the purpose of the disclosure.

For each disclosure that could require an accounting under this Section, Business Associate shall document the information enumerated above, and shall securely maintain the information for six (6) years from the date of the disclosure (but beginning no earlier than April 14, 2003).

12. **Compliance with HITECH Act.** Business Associate shall comply with the requirements of Title XIII, Subtitle D, of the HITECH Act, which are applicable to business associates, and shall comply with the regulations promulgated thereunder.

13. **Compliance with Obligations of CalOptima 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 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, 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 or subcontractors 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 U.S. Department of Defense standards for data destruction DoD 5220.22-M (7 Pass) standard or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of CalOptima 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 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:

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 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 data because such notification would impede a criminal investigation or damage national security and whether such notice is in writing; and

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

17.4. **Complete Report.** Business Associate shall provide a complete written report of the investigation ("Final Report") to the CalOptima 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, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure and to reduce the harmful effects of the breach;

17.4.1.3. The potential impacts of the incident, such as potential misuse of data, identity theft, etc.; and

17.4.1.4. A corrective action plan describing how Business Associate will prevent reoccurrence of the incident in the future. Notwithstanding the foregoing, all corrective actions are subject to the approval of CalOptima and CalOptima's regulator(s), as applicable.

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, then CalOptima or, as required by CalOptima, Business Associate shall notify individuals accordingly. The notifications shall comply with applicable federal and state law. All such 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 subcontractors, 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 subcontractors or 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 subcontractors or 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 subcontractors or agents. Such fees and expenses may include, without limitation, attorneys' fees and costs and costs for computer security consultants, credit reporting agency services, postal or other delivery charges, notifications of breach to individuals, and required reporting of breach. Acceptance by CalOptima of any insurance certificates and endorsements required under the Service Agreement(s) does not relieve Business Associate from liability under this indemnification provision. This provision shall apply to any damages or claims for damages whether or not such insurance policies shall have been determined to apply.

20. **Audits, Inspection and Enforcement**

20.1. From time to time, CalOptima 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.** The term of this Agreement shall be effective as of the Effective Date and shall terminate in either (i) accordance with this Section 21 or (ii) when all of the PHI provided by CalOptima to Business Associate, or created or received by Business Associate on behalf of CalOptima, is destroyed or returned to CalOptima in accordance with Section 15. CalOptima may terminate this BAA, without cause, on five (5) days' prior written notice to Business Associate.

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**

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.

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.

In witness thereof, the parties have executed this Business Associate Agreement:

Business Associate:	**CalOptima:**
Debra Baetz	Veronica Carpenter
Print Name	Print Name
	Veronica Carpenter (Nov 17, 2023 12:48 PST)
Signature	Signature
Interim Director, Health Care Agency	Chief of Staff
Title	Title
	Nov 17, 2023
Date	Date

Approved as to form:
County Counsel
County of Orange, California

DocuSigned by:
By: Brittany McLean
9713A4061D4343D...
Date: 11/17/2023

Brittany McLean

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
30. Approve Use of New MOU Templates Mandated by the Department of Health Care Services

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

Recommended Actions
Authorize CalOptima Health Contracting staff to implement eight (8) standardized Department of Health Care Services (DHCS) Memorandum of Understanding (MOU) templates, effective January 1, 2024.

Background and Discussion
Managed care plans (MCP) are responsible for providing medically necessary covered services to members and coordinating member care, particularly for services carved out of the MCP contract with DHCS. CalOptima Health's contract with DHCS requires ongoing partnerships with certain third-party entities to be memorialized in an MOU, including entities such as Regional Centers, Caregiver Resource Centers, Social Services, and Continuum of Care Programs, to ensure care coordination and access to community-based resources in support of whole-person care (Third-Party Entity). The MOUs should ensure the MCP and Third-Party Entity coordinate services, including health related social service needs, when members are accessing services provided jointly by both systems.

Starting 2024, DHCS is providing standardized boilerplate MOU templates for use by MCPs and Third-Party Entities. Listed in the grid below are eight (8) templates that have been release by DHCS for use starting in January 2024, which will be implemented with the Orange County Health Care Agency, County of Orange Social Services Agency, Regional Center of Orange County, and other Third-Party Entities as required in DHCS All Plan Letter (APL) 23-029 (Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities).

The new, standardized MOUs will help clarify roles and responsibilities among parties, support local engagement, facilitate care coordination and the exchange of information necessary to enable care coordination and improve the referral processes between the parties. To comply with the requirements of DHCS APL 23-029, staff requests Board authorization to implement the MOU templates listed in the following grid:

MOUs Effective January 1, 2024		
County or Third-Party Entity	**Department**	**Program/Services**
Health Care Agency	County Behavioral Health Departments	Specialty Mental Health Services
Health Care Agency	County Behavioral Health Departments	Substance Use Disorder Services in Drug Medi-Cal (DMC) State Plan Counties

Back to Agenda

Health Care Agency	Local Health Departments	Including, without limitation, California Children's Services (CCS), Maternal, Child, and Adolescent Health (MCAH), and Tuberculosis Direct Observed Therapy
Health Care Agency	WIC Local Agencies or Non-Profit Entities	Women, Infant and Children
Regional Center Orange County	Regional Center	Intermediate Care Facility – Developmentally Disabled Services
Social Services Agency	Local Government Agency	In-Home Supportive Services (IHSS)
Social Services Agency	Local Government Agency	County Social Services programs and Child Welfare

MOUs Effective July 1, 2024 *(DHCS Template Forthcoming)*		
County or Third-Party Entity	**Department**	**Program/Services**
Health Care Agency	County Behavioral Health Departments	County-Based Targeted Case Management (TCM

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation
Approving the eight (8) new DHCS MOU templates will keep CalOptima Health in compliance with state regulations, and allow continued collaboration with local county and Third-Party Entities.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Attachment 1_DHCS All Plan Letter 23-029: Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities
2. Attachment 2_Specialty Mental Health Services MOU_OCHCA
3. Attachment 3_Substance Use Disorder Services in Drug Medi-Cal (DMC) State Plan County MOU_OCHCA
4. Attachment 4_Local Health Department MOU (CCS, MCAH, TB) OCHCA
5. Attachment 5_Women, Infant & Children_dhcs draft MOU_OCHCA
6. Attachment 6_Regional Center MOU_RCOC
7. Attachment 7_In Home Support Services MOU_SSA
8. Attachment 8_Social Services and Child Welfare MOU_SSA

Back to Agenda

Board Actions
N/A

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: October 11, 2023

ALL PLAN LETTER 23-029

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: MEMORANDUM OF UNDERSTANDING REQUIREMENTS FOR MEDI-CAL MANAGED CARE PLANS AND THIRD-PARTY ENTITIES

PURPOSE:
The purpose of this All Plan Letter (APL) is to clarify the intent of the Memorandum of Understanding (MOU) required to be entered into by the Medi-Cal managed care plans (MCPs) and Third Party Entities (defined below) under the Medi-Cal Managed Care Contract (MCP Contract) with the Department of Health Care Services (DHCS), and to specify the responsibilities of MCPs under those MOUs. In addition, this APL contains an MOU template with general provisions required to be included in all MOUs (Base Template) that the MCPs must execute pursuant to the MCP Contract and MOU templates tailored for certain programs, which contain the required general MOU provisions and program-specific provisions (Bespoke Templates).

Further, this APL addresses DHCS' expectations and oversight of MCP obligations under this APL and the MOUs, including MCP reporting requirements.

BACKGROUND AND INTENT:
The MCP Contract requires MCPs to build partnerships with the following Third Party Entities: local health departments; local educational and governmental agencies, such as county behavioral health departments for specialty mental health care and Substance Use Disorder (SUD) services; other local programs and services, including social services; child welfare departments; Continuum of Care programs; First 5 programs and providers; Regional Centers; Area Agencies on Aging; Caregiver Resource Centers; Women, Infants and Children Supplemental Nutrition Programs (WIC); Home and Community-Based Services (HCBS) waiver agencies and providers; and justice departments to ensure Member care is coordinated and Members have access to community-based resources in order to support whole-person care. This requirement can be found in the MCP Contract, Exhibit A, Attachment III, Section 5.6 (MOUs with Third Parties).

The MOUs are intended to be effective vehicles to clarify roles and responsibilities among parties, support local engagement, and facilitate care coordination and the exchange of information necessary to enable care coordination and improve the referral

processes between the parties. The MOUs are also intended to improve transparency and accountability by setting forth certain existing requirements for each party as it relates to service or care delivery and coordination so that the parties are aware of each other's obligations.

Each MOU is a binding, contractual agreement between the MCP and a Third-Party Entity (referred to in this APL as the "Other Party") and outlines the responsibilities and obligations of the MCP to coordinate and facilitate the provision of services to Members where Members are served by multiple parties. The purpose of the MOU is to:

- List the minimum MOU components required by the MCP Contract;
- Clarify roles and responsibilities for coordination of the delivery of care and services of all Members, particularly across MCP carved-out services, which may be provided by the Other Party;
- Establish negotiated and agreed upon processes for how the MCP and the Other Party will collaborate and coordinate on population health and/or other programs and initiatives;
- Memorialize what data will be shared between the MCP and the Other Party and how the data will be shared to support care coordination and enable monitoring;
- Provide public transparency into relationships and roles/responsibilities between the MCP and the Other Party; and
- Provide mechanisms for the parties to resolve disputes and ensure overall oversight and accountability under the MOU.

The MOU does not impose new requirements on the Other Party, but rather restates or cross-references existing requirements imposed on the Other Party by their respective oversight body, if any, in order to clarify the Other Party's roles and responsibilities under existing laws, regulations, and guidance ("existing requirements").

POLICY:
MCPs must make a good faith effort to execute MOUs with Other Parties by either January 1, 2024, July 1, 2024, or January 1, 2025, as outlined below:

MOUs Effective January 1, 2024	
Department	**Program/Services**
County Behavioral Health Departments	Specialty Mental Health Services

Back to Item

Back to Agenda

MOUs Effective January 1, 2024	
Department	**Program/Services**
County Behavioral Health Departments	SUD Services
County Behavioral Health Departments	SUD Services in Drug Medi-Cal (DMC) State Plan Counties
Local Health Departments	Including, without limitation, California Children's Services (CCS),[1] Maternal, Child, and Adolescent Health (MCAH), and Tuberculosis Direct Observed Therapy DRAFT
WIC Local Agencies or Non-Profit Entities	WIC
Regional Centers	Intermediate Care Facility – Developmentally Disabled Services
Local Government Agencies (LGA)	In-Home Supportive Services (IHSS)
LGA/County Social Services Departments	County Social Services programs and Child Welfare

MOUs Effective July 1, 2024	
Department	**Program**
LGA	County-Based Targeted Case Management (TCM)[1]

[1] The County TCM MOU will be effective July 1, 2024, to align with the program changes set forth in the Enhanced Care Management Policy Guide dated July of 2023, available at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf

Back to Item

Back to Agenda

MOUs Effective January 1, 2025
HCBS Waiver Agencies and Programs
LGA/California Department of Corrections and Rehabilitation, county jails, and youth correctional facilities
Continuum of Care
First 5 Programs
Area Agencies on Aging
California Caregiver Resource Centers
Local Education Agencies (LEAs)
Indian Health Services/Tribal Entities

PROVISIONS REQUIRED TO BE INCLUDED IN MOUs

MCPs are responsible for providing Medically Necessary Covered Services to Members and coordinating Member care, particularly for services carved out of the MCP Contract. The MOU between the MCP and the Other Party is intended to serve as the primary vehicle for documenting and developing processes and procedures to ensure the MCP and the Other Party coordinate services, including health related social service needs, when Members are accessing services from both systems. For example, for the CCS program, the MOU will outline the roles and responsibilities of the MCP as well as the local agency county health departments for coordinating care, exchanging information, and conducting administrative activities related to CCS-enrolled Members accessing and receiving care.

Each MOU with all Other Parties must include, at a minimum, all of the provisions required in **Attachment A, Base MOU Template** and as required in the MCP Contract, including the following:

- Services Covered by This MOU: Describes the services that the MCP and the Other Party must coordinate for Members who reside in the Other Party's jurisdiction or who receive the Other Party's services.
- Party Obligations: Describes each party's provision of services and oversight responsibilities (e.g., the parties must designate liaisons to coordinate with each other and ensure compliance with the MOU requirements, including the MCP ensuring compliance by its Subcontractors, Downstream Subcontractors, and Network Providers). The intent of this provision is to ensure each party is aware of what services the other is required to provide or arrange under existing

Back to Item

Back to Agenda

requirements. This provision is also intended to ensure that the parties know how and who to contact for each party to support the MOU implementation. This provision also requires the MCP to impose certain MOU requirements on its Subcontractors, Downstream Subcontractors, and Network Providers.

- Training and Education: Requires the MCP to provide education to Members and Network Providers about accessing Covered Services and the Other Party's services. Requires the MCP to train its employees who carry out responsibilities under the MOU and, as applicable, train Network Providers, Subcontractors and Downstream Subcontractors on the MOU requirements and services provided by the Other Party. This provision is intended to ensure the MCP provides its Subcontractors, Downstream Subcontractors, and Network Providers with information necessary for them to coordinate care with, and make referrals to, or receive referrals from, the Other Party.
- Referrals: Describes the requirement that the parties refer to each other as appropriate and describes each party's referral pathways to ensure both parties understand and are able to refer to or assist Members with obtaining services from each other. The intent of this provision is to encourage the parties to develop and document how parties can refer Members to one another and what information may need to accompany each referral.
- Care Coordination: Describes the policies and procedures for coordinating care between the parties, addressing barriers to care coordination, and ensuring the ongoing monitoring and improving of such care coordination. This provision is intended to encourage the parties to develop and document how the parties will coordinate care, monitor whether those processes are working, and improve the processes, as necessary.
- Quarterly Meetings: Requires the parties to meet at least quarterly to address care coordination, Quality Improvement (QI) activities, QI outcomes, systemic and case-specific concerns, and communicating with others within their organizations about such activities. Within 30 Working Days after each quarterly meeting, the MCP must post on its website the date and time the quarterly meeting occurred in order to demonstrate transparency that the meetings are taking place. The intent of this provision is to ensure that the parties have a set time to meet to assess whether the MOU is effective in supporting care coordination and whole-person care, as well as to address specific issues that may have arisen in the prior quarter. These meetings are not intended to be open to the public. These meetings may be conducted virtually.
- Quality Improvement: Requires that the parties have in place MOU-specific QI policies to ensure each party's ongoing oversight and improvement of the MOU requirements. These QI policies and activities are separate and apart from an MCP's other QI requirements. The intent of this provision is to encourage the parties to develop and document how they will assess whether the MOU is

Back to Item

Back to Agenda

improving care coordination and whole-person care and to develop metrics to evaluate whether the MOU is effective in achieving its goals.

- Data Sharing and Confidentiality: Describes the minimum data and information that the MCP must share with the Other Party to ensure the MOU requirements are met and describes the data and information the Other Party may share with the MCP to improve care coordination and referral processes. This provision is intended to encourage the parties to determine and document the minimum necessary information that must be shared to facilitate referrals and coordinate care, how to share that information, and whether Member consent is required. The data sharing requirements set forth in the MOUs are not intended to supersede any federal or state laws or regulations governing the ability of the MCP or Other Party to exchange information.
- Dispute Resolution: Describes the policies and procedures for resolving disputes between the parties and the process for bringing the disputes to DHCS (and other departments as appropriate) when the parties are unable to resolve disputes between themselves. The intent of this provision is to encourage the parties to develop and document a dispute resolution process to resolve conflicts with regard to each parties' responsibilities under the MOU.
- General: Describes additional general Contract requirements, such as the requirements that the MCP must publicly post the executed MOU, the MCP must annually review the MOU, and the MOU cannot be delegated, except as permitted under the MCP Contract.

Program-Specific MOU Requirements (Bespoke Templates)
MOUs are intended to acknowledge the unique relationships and specific needs that exist at the local level, as outlined in the MCP Contract. As such, the **Attachment B, Bespoke Templates** build on the Base Template requirements by including tailored provisions for the following programs:

1. Specialty Mental Health Services;
2. SUD Services;
3. SUD Services in DMC State Plan Counties;
4. Local Health Departments, including program-specific exhibits for CCS, MCAH, Tuberculosis Direct Observed Therapy, and Non-Contracted Services;
5. WIC;
6. Regional Centers;
7. IHSS;
8. County Social Services programs and Child Welfare; and
9. TCM.

Back to Item

Back to Agenda

MCPs cannot remove or alter the minimum requirements in the Base Template or Bespoke Templates. However, the MCP and the Other Party may agree to include additional provisions, including, without limitation, the optional provisions included in the templates, provided any additional provision does not conflict with the required minimum provisions. The templates include language that the parties may want to add to their MOUs to increase collaboration and communications. The proposed language is not exhaustive.

MOU COMPLIANCE AND OVERSIGHT REQUIREMENTS
The MCP Contract outlines specific processes that MCPs must have in place in order to maintain collaboration with the Other Party and have appropriate oversight of the MOU requirements.

Ultimately, the MCP compliance officer is responsible for MOU compliance, and ensuring compliance with the MOU must be part of the MCP's compliance program. The MCP compliance officer must ensure that deficiencies in MOU compliance are addressed in accordance with MCP's compliance program policies.

MCP Responsible Person and MCP-Other Party Liaison
The MCP must designate a responsible person(s) for overseeing the MCP's compliance with the relevant MOU(s) and the relevant provisions (MCP Responsible Person). This MCP Responsible Person must provide reports to the MCP compliance officer. For example, the MCP may consider designating staff within their contract management, provider relations, or community relations functional areas. The MCP must ensure the responsible person(s) is well-versed with the MOU(s) provisions, has developed relationships with the relevant Other Party, and is empowered to meet compliance with the MOU(s). MCPs must notify DHCS of a change in the responsible person/liaison as soon as practicable, but no later than five Working Days of the change.

As outlined in the Base Template, and incorporated in the Bespoke Templates, under "MCP Obligations: Oversight Responsibility," the MCP Responsible Person must:

1. Conduct regular meetings, on at least a quarterly basis, to address policy and practical concerns that may arise between MOU parties (See the Quarterly Meetings Section of the Base Template for an example of the required language);
2. Ensure an appropriate level of leadership (i.e., persons with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from the Other Party are invited to participate in the MOU engagements, as appropriate;

Back to Item

Back to Agenda

3. Report on the MCP's compliance with the MOU to the MCP's compliance officer no less frequently than quarterly;
4. Ensure there is sufficient staff at the MCP to support compliance with, and management of, the relevant MOU(s) and its provisions;
5. Ensure training and education regarding MOU provisions are conducted annually for the MCP's employees responsible for carrying out activities under the MOU, and as applicable, for Network Providers, Subcontractors, and Downstream Subcontractors;
6. Ensure that the MCP's Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of the MOUs (see the "Subcontractor and Network Providers" section below and the MOU templates for further details); and
7. Serve as, or designate a person at the MCP to serve as, the point of contact and liaison with the Other Party or Other Party programs (MCP-Other Party Liaison). This liaison is to serve as the subject matter expert for the Other Party to address day-to-day concerns for administering the MOU. For example, the MCP-CCS Liaison would serve as the contact for the CCS County administrator to address immediate concerns related to specialty care services for CCS Members in a particular county. The MCP must notify the Other Party of any changes to the MCP-Other Party Liaison in writing as soon as reasonably practical but no later than the date of change and must notify DHCS within five Working Days of the change.

Data Sharing and Confidentiality

MCPs must share the minimum necessary data and information to facilitate referrals and coordinate care under the MOU. MCPs must have policies and procedures for supporting the timely and frequent exchange of Member information and data, which may include behavioral health and physical health data; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining Member consent. MCPs must share information in compliance with applicable law, which may include the Health Insurance Portability and Accountability Act and its implementing regulations, as amended, Title 42 Code of Federal Regulations (CFR) Part 2, as well as other state and federal privacy laws.[2] As applicable and for the purposes of care management and coordination, MCPs should share information in compliance with the California Health and Human Services Agency Data Exchange Framework as referenced in APL 23-013

[2] The CFR is searchable at: https://www.ecfr.gov/

Back to Item

Back to Agenda

and any subsequent iterations on this topic, as well as DHCS' California Advancing and Innovating Medi-Cal Data Sharing Authorization Guidance.[3]

Dispute Resolution
MCPs must work collaboratively with the Other Party to establish dispute resolution processes and timeframes within the MOU. This includes how the MCP will work with the Other Party to resolve issues related to coverage or payment of services under conflicts regarding respective roles for care management for specific Members, or other concerns related to the administered services to Members. See the Base Template "Dispute Resolution" section for an example of the required language.

After a failure to resolve the dispute pursuant to the process and timeframe established in the MOU, the MCP must submit a written "Request for Resolution" to DHCS and the Other Party may submit the dispute to the relevant department with oversight of the Other Party (e.g., California Department of Social Services, California Department of Public Health, or California Department of Developmental Services). If the MCP submits the Request for Resolution, it must be signed by the MCP's Chief Executive Officer (CEO) or the CEO's designee. If the Request for Resolution is submitted by the Other Party, it should be signed by an authorized representative of the Other Party.

MCP's Request for Resolution to DHCS must include:

1. A summary of the disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to a Member;
2. A history of the attempts to resolve the issue(s) with the Other Party;
3. Justification for the desired remedy; and
4. Any additional documentation relevant to resolve the disputed issue(s), if applicable.

MCPs must submit the Request for Resolution to DHCS via secure email to MCPMOUS@dhcs.ca.gov.

DHCS, in collaboration with the sister department as appropriate, will communicate the final decision to the MCP and the Other Party, including any actions the MCP must take to implement the decision.

[3] APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

Back to Item

Back to Agenda

Subcontractors and Network Providers
MCPs must ensure that their Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of the MOUs.

If an MCP has a Subcontractor or Downstream Subcontractor arrangement delegating part or all of the responsibilities relating to effectuating the MOUs to a Knox-Keene licensed health care service plan(s), this Subcontractor or Downstream Subcontractor must be added as an express party to the MOU and named in the MOU as having the responsibilities set forth as applicable to this Subcontractor or Downstream Subcontractor. For example, if an MCP delegates risk for an assigned portion of its membership to a Subcontractor or Downstream Subcontractor, the signatories of the MOU must include the MCP, the Subcontractor or Downstream Subcontractor, and the Other Party.

Training
MCPs must provide training and orientation on the MOU requirements to their employees who carry out responsibilities under the MOU and, as applicable, to their Subcontractors, Downstream Subcontractors, and Network Providers. The training must include information on MOU requirements and the services that are provided or arranged for by each party and how those services can be accessed or coordinated for the Member. MCPs must provide this training within a specified time after the MOU is effective and at least annually thereafter.

Local Engagement
As noted, the MOU is intended to be a vehicle to support engagement with local partners. To that end, the MCP must ensure an appropriate local presence at its quarterly meetings by inviting the appropriate responsible person(s) and program executives from the Other Party. At each quarterly meeting, the MCP must ensure there is the opportunity to discuss and address care coordination and MOU-related issues with county executives.

Signatories
As noted above, if an MCP has a Subcontractor or Downstream Subcontractor arrangement delegating part or all of the responsibilities related to effectuating the MOU to a Knox-Keene licensed health care service plan(s), the signatories of the MOU must include the MCP, the Subcontractor or Downstream Subcontractor, and the Other Party. In addition, to minimize administrative burden on counties and Other Parties, DHCS encourages multi-party MOUs, which may include more than one MCP and/or Other Party signing an MOU. In addition, MCPs may work with the Other Party to consolidate signature pages for multiple types of MOUs, for example, if an MCP is

Back to Item

Back to Agenda

entering into an agreement for multiple county administered programs.

MONITORING AND REPORTING
Starting January 1, 2025, MCPs must submit to their DHCS Managed Care Operations Division (MCOD) Contract Manager an annual report that includes updates from the quarterly meetings with the Other Party and the results of their annual MOU review. The quarterly meetings are to discuss care coordination activities and the specific MOU-related issues. The report must include the following elements:

- A list of all attendees, including MCP Responsible Person(s), leadership, and county executives;
- All care coordination and referral concerns discussed;
- Strengths, barriers, and plans to improve effective collaboration between the MCP and the Other Party;
- All disputes and resulting outcomes;
- Strategies to address duplication of services; and
- Member engagement challenges and successes

To continuously evaluate the effectiveness of the MOU processes, MCPs must review their MOUs annually to determine if any amendments are needed, including incorporating any applicable contractual requirements and policy guidance to their MOUs. The annual report submission must include evidence of the annual review as well as copies of any MOUs amended or renewed as a result. The evidence of the annual review described in the annual report must include a summary of the review process and outcomes, and any resulting amendments to the MOU or policies and procedures.

If DHCS requests a review of any MOU and/or any requested policies and procedures related to the MOU, the MCP must submit the requested MOU documents to DHCS within ten Working Days of receipt of the request.

Quarterly Reporting
MCPs must demonstrate a good faith effort to meet the requirements of this APL. MCPs that are unable to execute their MOUs by the required execution date for MOUs for which DHCS has issued templates, must submit quarterly progress reports and documentation to DHCS demonstrating evidence of their good faith effort to execute the MOU.

DHCS Submissions and Reports
MCPs must submit all fully executed MOUs to their MCOD Contract Manager for file and use. In their submissions, MCPs must attest that they did not modify any of the

Back to Item

Back to Agenda

provisions of the Base Template or Bespoke Templates except to add provisions that do not conflict with or reduce either party's obligations under the Base Template or Bespoke Templates. If the MCP modifies any of the provisions of the Base Template or Bespoke Templates, the MCP must submit a redlined version of the MOU to DHCS for review and approval, prior to execution.

MCP Website Posting
MCPs must publish the MOU(s) and the annual report on their websites within 30 calendar days of MOU execution and report due date, respectively.

Subcontractor Compliance
MCPs are further responsible for ensuring that their Subcontractors, Downstream Subcontractors, and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.[4] These requirements must be communicated by each MCP to all Subcontractors, Downstream Subcontractors, and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[4] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

Back to Item

Back to Agenda

ATTACHMENT E:

MHP MEMORANDUM OF UNDERSTANDING TEMPLATE

COVER PAGE

Memorandum of Understanding

between [*Medi-Cal Managed Care Plan*] and [*Mental Health Plan*]

This Memorandum of Understanding ("MOU") is entered into by [*name of Managed Care Plan*] ("MCP**"**) and [*name of party*], [a *description of other party*] *("MHP"),* effective as of [*date*] ("Effective Date"). [*Where MCP has a Subcontractor or Downstream Subcontractor arrangement delegating part or all of the responsibilities related to effectuating this MOU to a Knox-Keene licensed health care service plan(s), this Subcontractor or Downstream Subcontractor must be added as an express party to this MOU and named in this MOU as having the responsibilities set forth herein that are applicable to this Subcontractor or Downstream Subcontractor.*] MHP, MCP, and MCP's relevant Subcontractors and/or Downstream Subcontractors may be referred to herein as a "Party" and collectively as "Parties."

WHEREAS, the Parties are required to enter into this MOU, a binding and enforceable contractual agreement under the Medi-Cal Managed Care Contract Exhibit A, Attachment III, All Plan Letters ("APL*")* 18-015, 22-005, 22-006, 22-028, and MHP is required to enter into this MOU pursuant to Cal. Code Regs. tit. 9 § 1810.370, MHP Contract, Exhibit A, Attachment 10, Behavioral Health Information Notice ("BHIN") 23-056 and any subsequently issued superseding BHINs, to ensure that Medi-Cal beneficiaries enrolled in MCP who are served by MHP ("Members") are able to access and/or receive mental health services in a coordinated manner from MCP and MHP;

WHEREAS, the Parties desire to ensure that Members receive MHP services in a coordinated manner and to provide a process to continuously evaluate the quality of the care coordination provided; and

WHEREAS, the Parties understand and agree that any Member information and data shared to facilitate referrals, coordinate care, or to meet any of the obligations set forth in this MOU must be shared in accordance with all applicable federal and state statutes and regulations, including, without limitation, 42 Code of Federal Regulations Part 2.

[Notation: This MOU template includes language, notated in italics and bracketed, that the Parties may want to add to this MOU to increase collaboration and communication. MCP and MHP may also agree to additional provisions provided that they do not conflict with the requirements of this MOU.]

In consideration of mutual agreements and promises hereinafter, the Parties agree as follows:

1. **Definitions.** Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the California Department of Health Care Services ("DHCS"), unless otherwise defined herein. The Medi-Cal Managed Care Contract is available on the DHCS webpage at www.dhcs.ca.gov.

a. “MCP Responsible Person” means the person designated by MCP to oversee MCP coordination and communication with MHP and ensure MCP’s compliance with this MOU as described in Section 4 of this MOU.

b. “MCP-MHP Liaison” means MCP’s designated point of contact responsible for acting as the liaison between MCP and MHP as described in Section 4 of this MOU. The MCP-MHP Liaison must ensure the appropriate communication and care coordination is ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.

c. “MHP Responsible Person” means the person designated by MHP to oversee coordination and communication with MCP and ensure MHP’s compliance with this MOU as described in Section 5 of this MOU.

d. “MHP Liaison” means MHP’s designated point of contact responsible for acting as the liaison between MCP and MHP as described in Section 5 of this MOU. The MHP Liaison should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the MHP Responsible Person and/or MHP compliance officer as appropriate.

e. “Network Provider” as it pertains to MCP, has the same meaning ascribed by the MCP’s Medi-Cal Managed Care Contract with the DHCS; and as it pertains to MHP, has the same meaning ascribed by the MHP Contract with the DHCS.

f. “Subcontractor” as it pertains to MCP, has the same meaning ascribed by the MCP’s Medi-Cal Managed Care Contract with the DHCS; and as it pertains to MHP, has the same meaning ascribed by the MHP Contract with the DHCS.

g. “Downstream Subcontractor” as it pertains to MCP, has the same meaning ascribed by the MCP’s Medi-Cal Managed Care Contract with the DHCS; and as it pertains to MHP, means a subcontractor of a MHP Subcontractor.

2. Term. This MOU is in effect as of the Effective Date and continues for a term of *[The Parties may agree to a term of three years or another term as agreed to by MCP and MHP]* or as amended in accordance with Section 14.f of this MOU.

3. Services Covered by This MOU. This MOU governs the coordination between MCP and MHP for Non-specialty Mental Health Services (“NSMHS”) covered by MCP and further described in APL 22-006, and Specialty Mental Health Services (“SMHS”) covered by MHP and further described in APL 22-003, APL 22-005, and BHIN 21-073, and any subsequently issued superseding APLs or BHINs, executed contract amendments, or other relevant guidance. The population eligible for NSMHS and SMHS set forth in APL 22-006 and BHIN 21-073 is the population served under this MOU.

4. MCP Obligations.

a. **Provision of Covered Services.** MCP is responsible for authorizing Medically Necessary Covered Services, including NSMHS, ensuring MCP’s Network Providers coordinate care for Members as provided in the applicable Medi-Cal Managed

Care Contract, and coordinating care from other providers of carve-out programs, services, and benefits.

b. **Oversight Responsibility.** The [*insert title*], the designated MCP Responsible Person listed in Exhibit A of this MOU, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

i. meet at least quarterly with MHP, as required by Section 9 of this MOU;

ii. report on MCP's compliance with the MOU to MCP's compliance officer no less frequently than quarterly. MCP's compliance officer is responsible for MOU compliance oversight reports as part of MCP's compliance program and must address any compliance deficiencies in accordance with MCP's compliance program policies;

iii. ensure there is a sufficient staff at MCP who support compliance with and management of this MOU;

iv. ensure the appropriate levels of MCP leadership (i.e., person with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from MHP are invited to participate in the MOU engagements, as appropriate;

v. ensure training and education regarding MOU provisions are conducted annually for MCP's employees responsible for carrying out activities under this MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network Providers; and

vi. serve, or may designate a person at MCP to serve, as the MCP-MHP Liaison, the point of contact and liaison with MHP. The MCP-MHP Liaison is listed in Exhibit A of this MOU. MCP must notify MHP of any changes to the MCP-MHP Liaison in writing as soon as reasonably practical but no later than the date of change and must notify DHCS within 5 Working Days of the change.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

5. MHP Obligations.

a. **Provision of Specialty Mental Health Services.** MHP is responsible for providing or arranging for the provision of SMHS.

b. **Oversight Responsibility.** The [*insert title*], the designated MHP Responsible Person, listed on Exhibit B of this MOU, is responsible for overseeing MHP's compliance with this MOU. The MHP Responsible Person serves, or may designate a person to serve, as the designated MHP Liaison, the point of contact and liaison with MCP. The MHP Liaison is listed on Exhibit B of this MOU. The MHP Liaison may be the same person as the MHP Responsible Person. MHP must notify MCP of changes to the MHP Liaison as soon as reasonably practical but no later than the date of change. The MHP Responsible Person must:

i. meet at least quarterly with MCP, as required by Section 9 of this MOU;

ii. report on MHP's compliance with the MOU to MHP's compliance officer no less frequently than quarterly. MHP's compliance officer is responsible for MOU compliance oversight and reports as part of MHP's compliance program and must address any compliance deficiencies in accordance with MHP's compliance program policies;

iii. ensure there is sufficient staff at MHP to support compliance with and management of this MOU;

iv. ensure the appropriate levels of MHP leadership (i.e., persons with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from MCP are invited to participate in the MOU engagements, as appropriate;

v. ensure training and education regarding MOU provisions are conducted annually to MHP's employees responsible for carrying out activities under this MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network providers; and

vi. be responsible for meeting MOU compliance requirements, as determined by policies and procedures established by MHP, and reporting to the MHP Responsible Person.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MHP must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

6. Training and Education.

a. To ensure compliance with this MOU, the Parties must provide training and orientation for their employees who for carry out activities under this MOU and, as applicable, Network Providers, Subcontractors, and Downstream Subcontractors who assist MCP with carrying out MCP's responsibilities under this MOU. The training must include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU. For persons or entities performing responsibilities as of the Effective Date, the Parties must provide this training within *[The Parties may agree to 30, 45, of 60 Working Days.]* of the Effective Date. Thereafter, the Parties must provide this training prior to any such person or entity performing responsibilities under this MOU and to all such persons or entities at least annually thereafter. The Parties must require its Subcontractors and Downstream Subcontractors to provide training on relevant MOU requirements and MHP services to their contracted providers.

b. In accordance with health education standards required by the Medi-Cal Managed Care Contract, the Parties must provide Members and Providers with educational materials related to accessing Covered Services, including for services provided by MHP.

c. The Parties each must provide the other Party, Members, and Network Providers with training and/or educational materials on how MCP Covered Services and MHP services may be accessed, including during nonbusiness hours.

[The Parties may agree to additional requirements such as:

- *The Parties must together develop training and education resources covering the services provided or arranged by the Parties, and each Party must share their training and educational materials with the other Party to ensure the information included in their respective training and education materials includes an accurate set of services provided or arranged for by each Party and is consistent with MCP and MHP policies and procedures, and with clinical practice standards.*
- *The Parties must develop and share outreach communication materials and initiatives to share resources about MCP and MHP with individuals who may be eligible for MCP's Covered Services and/or MHP services.]*

7. Screening, Assessment, and Referrals.

a. **Screening and Assessment.** The Parties must develop and establish policies and procedures that address how Members must be screened and assessed for mental health services, including administering the applicable Screening and Transition of Care Tools for Medi-Cal Mental Health Services as set forth in APL 22-028 and BHIN 22-065.

i. MCP and MHP must use the required screening tools for Members who are not currently receiving mental health services, except when a Member contacts the mental health provider directly to seek mental health services.

ii. MCP and MHP must use the required Transition of Care Tool to facilitate transitions of care for Members when their service needs change.

iii. The policies and procedures must incorporate agreed-upon and/or required timeframes; list specific responsible parties by title or department; and include any other elements required by DHCS for the mandated statewide Adult Screening Tool for adults aged 21 and older, Youth Screening Tool for youth under age 21, and Transition of Care Tool, for adults aged 21 and older and youth under age 21, as well as the following requirements:

1. The process by which MCP and MHP must conduct mental health screenings for Members who are not currently receiving mental health services when they contact MCP or MHP to seek mental health services. MCP and MHP must refer such Members to the appropriate delivery system using the Adult or Youth Screening Tool for Medi-Cal Mental Health Services based on their screening result.
2. The process by which MCP and MHP must ensure that Members receiving mental health services from one delivery system receive timely and coordinated care when their existing services are being transitioned to another delivery system or when services are being added to their existing mental health treatment from another delivery system in accordance with APL 22-028 and BHIN 22-065.

b. **Referrals.** The Parties must work collaboratively to develop and establish policies and procedures that ensure that Members are referred to the appropriate MHP services and MCP Covered Services**.**

i. The Parties must adopt a "no wrong door" referral process for Members and work collaboratively to ensure that Members may access services through multiple pathways and are not turned away based on which pathway they rely on, including, but not limited to, adhering to all applicable No Wrong Door for Mental Health Services Policy requirements described in APL 22-005 and BHIN 22-011. The Parties must refer Members using a patient-centered, shared decision-making process.

ii. The Parties must develop and implement policies and procedures addressing the process by which MCP and MHP coordinate referrals based on the completed Adult or Youth Screening Tool in accordance with APL 22-028 and BHIN 22-065, including:

1. The process by which MHP and MCP transition Members to the other delivery system.
2. The process by which Members who decline screening are assessed.
3. The process by which MCP:
    a. Accepts referrals from MHP for assessment, and the mechanisms of communicating such acceptance and that a timely assessment has been made available to the Member.
    b. Provides referrals to MHP for assessment, and the mechanisms of sharing the completed screening tool and confirming acceptance of referral and that a timely assessment has been made available to the Member by MHP.
    c. Provides a referral to an MHP Network Provider (if processes agreed upon with MHP), and the mechanisms of sharing the completed screening tool and confirming acceptance of the referral and that a timely assessment has been made available to the Member by MHP.
4. The process by which MHP:
    a. Accepts referrals from MCP for assessment, and the mechanisms for communicating such acceptance and that a timely assessment has been made available to the Member.
    b. Provides referrals to MCP for assessment, and the mechanisms of sharing the completed screening tool and confirming acceptance of the referral and that a timely assessment has been made available to the Member by MCP.
    c. Provides a referral to an MCP Network Mental Health Provider (if processes agreed upon with MCP), and the mechanisms of confirming the MCP Network Mental Health Provider accepted the referral and that a timely assessment has been made available to the Member by MCP.
    d. Provides a referral to MCP when the screening indicates that a Member under age 21 would benefit from a pediatrician/Primary Care Physician ("PCP") visit.

5. The process by which MCP and MHP coordinate referrals using the Transition of Care Tool in accordance with APL 22-028 and BHIN 22-065.

6. The process by which MCP (and/or its Network Providers):

a. Accepts referrals from MHP, and the mechanisms of communicating such acceptance, including that the Member has been connected with a Network Provider who accepts their care and that services have been made available to the Member.

b. Provides referrals to MHP and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the Member has been connected with a provider who accepts their care and that services have been made available to the Member.

c. Provides a referral to an MHP Network Provider (if processes have been agreed upon with MHP), and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the Member has been connected with a provider who accepts their care and that services have been made available to the Member.

d. MCP must coordinate with MHP to facilitate transitions between MCP and MHP delivery systems and across different providers, including guiding referrals for Members receiving NSMHS to transition to an SMHS provider and vice versa, and the new provider accepts the referral and provides care to the Member.

7. The process by which MHP (and/or its Network Providers):

a. Accepts referrals from MCP, and the mechanisms of communicating such acceptance, including that the Member has been connected with a Network Provider who accepts their care and that services have been made available to the Member.

b. Provides referrals to MCP, and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the Member has been connected with a Network Provider who accepts their care and that services have been made available to the Member.

c. Provides a referral to an MCP Network Provider (if processes have been agreed upon with MCP), and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the Member has been connected with a Network Provider who accepts their care and that services have been made available to the Member.

iii. MHP must refer Members to MCP for MCP's Covered Services, as well as any Community Supports services or care management programs for which Members may qualify, such as Enhanced Care Management ("ECM"), Complex Care Management ("CCM"), or Community Supports. However, if MHP is also an ECM Provider, MHP provides ECM services pursuant to a separate agreement between MCP and MHP for ECM services; this MOU does not govern MHP's provision of ECM.

iv. MCP must have a process for referring eligible Members for substance use disorder ("SUD") services to a Drug Medi-Cal-certified program or a Drug

Medi-Cal Organized Delivery System ("DMC-ODS") program in accordance with the Medi-Cal Managed Care Contract.

[The Parties may agree to additional requirements such as:

Closed Loop Referrals. *By January 1, 2025, the Parties must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Management Policy Guide,[1] APL 22-024, or any subsequent version of the APL, and as set forth by DHCS through APL, or other, similar guidance. The Parties must work collaboratively to develop and implement a process to ensure that MCP and MHP comply with the applicable provisions of closed loop referrals guidance within 90 Working Days of issuance of this guidance. The Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.]*

8. **Care Coordination and Collaboration.**
    a. **Care Coordination.**
        i. The Parties must adopt policies and procedures for coordinating Members' access to care and services that incorporate all the specific requirements set forth in this MOU and ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative.
        ii. The Parties must discuss and address individual care coordination issues or barriers to care coordination efforts at least quarterly.
        iii. The Parties must establish policies and procedures to maintain collaboration with each other and to identify strategies to monitor and assess the effectiveness of this MOU. The policies and procedures must ensure coordination of inpatient and outpatient medical and mental health care for all Members enrolled in MCP and receiving SMHS through MHP, and must comply with federal and State law, regulations, and guidance, including Cal. Welf. & Inst. Code Section 5328.
        iv. The Parties must establish and implement policies and procedures that align for coordinating Members' care that address:
            1. The specific point of contact from each Party, if someone other than each Party's Responsible Person, to act as the liaison between Parties and be responsible for initiating, providing, and maintaining ongoing care coordination for all Members under this MOU;
            2. A process for coordinating care for individuals who meet access criteria for and are concurrently receiving NSMHS and SMHS consistent with the No Wrong Door for Mental Health Services Policy described in APL 22-005 and BHIN 22-011 to ensure the care is clinically appropriate and non-duplicative and considers the Member's established therapeutic relationships;

[1] CalAIM Population Health Management Policy Guide available at https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf

3. A process for coordinating the delivery of medically necessary Covered Services with the Member's PCP, including, without limitation, transportation services, home health services, and other Medically Necessary Covered Services for eligible Members;

4. Permitting Members to concurrently receive NSMHS and SMHS when clinically appropriate, coordinated, and not duplicative consistent with the No Wrong Door for Mental Health Services Policy described in APL 22-005 and BHIN 22-011.

5. A process for ensuring that Members and Network Providers can coordinate coverage of Covered Services and carved-out services outlined by this MOU outside normal business hours, as well as providing or arranging for 24/7 emergency access to admission to psychiatric inpatient hospital.

v. **Transitional Care.**

1. The Parties must establish policies and procedures and develop a process describing how MCP and MHP will coordinate transitional care services for Members. A "transitional care service" is defined as the transfer of a Member from one setting or level of care to another, including, but not limited to, discharges from hospitals, institutions, and other acute care facilities and skilled nursing facilities to home or community-based settings,[2] or transitions from outpatient therapy to intensive outpatient therapy. For Members who are admitted to an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, including, but not limited to, Short-Term Residential Therapeutic Programs and Psychiatric Residential Treatment Facilities, where MHP is the primary payer, MHPs are primarily responsible for coordination of the Member upon discharge. In collaboration with MHP, MCP is responsible for ensuring transitional care coordination as required by Population Health Management,[3] including, but not limited to:

a. Tracking when Members are admitted, discharged, or transferred from facilities contracted by MHP (e.g., psychiatric inpatient hospitals, psychiatric health facilities, residential mental health facilities) in accordance with Section 11(a)(iii) of this MOU.

b. Approving prior authorizations and coordinating services where MCP is the primary payer (e.g., home services, long-term services and supports for dual-eligible Members);

c. Ensuring the completion of a discharge risk assessment and developing a discharge planning document;

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[2] Expectations for transitional care are defined in the PHM Policy Program Guide: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf

[3] Expectations for transitional care are defined in the PHM Policy Program Guide: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf; *see also* PHM Roadmap and Strategy: https://www.dhcs.ca.gov/CalAIM/Documents/Final-Population-Health-Management-Strategy-and-Roadmap.pdf

d. Assessing Members for any additional care management programs or services for which they may qualify, such as ECM, CCM, or Community Supports and enrolling the Member in the program as appropriate;

e. Notifying existing CCM Care Managers of any admission if the Member is already enrolled in ECM or CCM; and

f. Assigning or contracting with a care manager to coordinate with behavioral health or county care coordinators for each eligible Member to ensure physical health follow up needs are met as outlined by the Population Health Management Policy Guide.

2. The Parties must include a process for updating and overseeing the implementation of the discharge planning documents as required for Members transitioning to or from MCP or MHP services.

3. For inpatient mental health treatment provided by MHP or for inpatient hospital admissions or emergency department visits known to MCP, the process must include the specific method to notify each Party within 24 hours of admission and discharge and the method of notification used to arrange for and coordinate appropriate follow-up services.

4. The Parties must have policies and procedures for addressing changes in a Member's medical or mental health condition when transferring between inpatient psychiatric service and inpatient medical services, including direct transfers.

vi. **Clinical Consultation.**

1. The Parties must establish policies and procedures for MCP and MHP to provide clinical consultations to each other regarding a Member's mental illness, including consultation on diagnosis, treatment, and medications.

2. The Parties must establish policies and procedures for reviewing and updating a Member's problem list, as clinically indicated (e.g., following crisis intervention or hospitalization), including when the care plan or problem list must be updated, and coordinating with outpatient mental health Network Providers.

Enhanced Care Management.

2. Delivery of the ECM benefit for individuals who meet ECM Population of Focus definitions (including, but not limited to, the Individuals with Severe Mental Illness and Children Populations of Focus) must be consistent with DHCS guidance regarding ECM, including:

a. That MCP prioritize assigning a Member to an SMHS Provider as the ECM Provider if the Member receives SMHS from that Provider and that Provider is a contracted ECM Provider, unless the Member has expressed a different preference or MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions;

b. That the Parties implement a process for SMHS Providers to refer their patients to MCP for ECM if the patients meet Population of Focus criteria; and

c. That the Parties implement a process for avoiding duplication of services for individuals receiving ECM with SMHS Targeted Case Management ("TCM"), Intensive Care Coordination ("ICC"), and/or Full-Service Partnership ("FSP") services as set forth in the CalAIM ECM Policy Guide, as revised or superseded from time to time, and coordination activities.

vii. Enhanced Care Management.

1. Delivery of the ECM benefit for individuals who meet ECM Population of Focus definitions (including, but not limited to, the Individuals with Severe Mental Illness and Children Populations of Focus) must be consistent with DHCS guidance regarding ECM, including:

a. That MCP prioritize assigning a Member to an SMHS Provider as the ECM Provider if the Member receives SMHS from that Provider and that Provider is a contracted ECM Provider, unless the Member has expressed a different preference or MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions;

b. That the Parties implement a process for SMHS Providers to refer their patients to MCP for ECM if the patients meet Population of Focus criteria; and

c. That the Parties implement a process for avoiding duplication of services for individuals receiving ECM with SMHS Targeted Case Management ("TCM"), Intensive Care Coordination ("ICC"), and/or Full-Service Partnership ("FSP") services as set forth in the CalAIM ECM Policy Guide, as revised or superseded from time to time, and coordination activities.

viii. Community Supports.

1. Coordination must be established with applicable Community Supports providers under contract with MCP, including:

a. The identified point of contact, from each Party to act as the liaison to oversee initiating, providing, and maintaining ongoing coordination as mutually agreed upon in MCP and MHP protocols;

b. Identification of the Community Supports covered by MCP; and

c. A process specifying how MHP will make referrals for Members eligible for or receiving Community Supports.

ix. Eating Disorder Services.

1. MHP is responsible for the SMHS components of eating disorder treatment and MCP is responsible for the physical health components of eating disorder treatment and NSMHS, including, but not limited to, those in APL 22-003 and BHIN 22-009, and any subsequently issued superseding APLs or BHINs, and must develop a process to ensure such treatment is provided to eligible Members, specifically:

a. MHP must provide for medically necessary psychiatric inpatient hospitalization and outpatient SMHS.

b. MCP must also provide or arrange for NSMHS for Members requiring eating disorder services.

2. For partial hospitalization and residential eating disorder programs, MHP is responsible for medically necessary SMHS components, while MCP is responsible for the medically necessary physical health components.

a. MCP is responsible for the physical health components of eating disorder treatment, including emergency room services, and inpatient hospitalization for Members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization.

x. **Prescription Drugs.**

1. The Parties must establish policies and procedures to coordinate prescription drug, laboratory, radiological, and radioisotope service procedures. The joint policies and procedures must include:

a. MHP is obligated to provide the names and qualification of prescribing physicians to MCP.

b. MCP is obligated to provide MCP's procedures for obtaining authorization of prescribed rugs and laboratory services, including a list of available pharmacies and laboratories.

9. Quarterly Meetings.

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU but not less frequently than quarterly to address care coordination, Quality Improvement ("QI") activities, QI outcomes, systemic and case-specific concerns, and communication with others within their organizations about such activities. *[Parties may agree to meet more frequently.]* These meetings may be conducted virtually.

b. Within 30 Working Days after each quarterly meeting, the Parties must each post on its website the date and time the quarterly meeting occurred, and, as applicable, distribute to meeting participants a summary of any follow-up action items or changes to processes that are necessary to fulfill the Parties' obligations under the Medi-Cal Managed Care Contract, the MHP Contract, and this MOU.

c. The Parties must invite the other Party's Responsible Person and appropriate program executives to participate in quarterly meetings to ensure appropriate committee representation, including local presence, to discuss and address care coordination and MOU-related issues. The Parties' Subcontractors and Downstream Subcontractors should be permitted to participate in these meetings, as appropriate.

d. The Parties must report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS.

e. **Local Representation.** MCP must participate, as appropriate, in meetings or engagements to which MCP is invited by MHP, such as local county meetings, local

community forums, and MHP engagements, to collaborate with MHP in equity strategy and wellness and prevention activities.

10. Quality Improvement. The Parties must develop QI activities specifically for the oversight of the requirements of this MOU, including, without limitation, any applicable performance measures and QI initiatives, including those to prevent duplication of services, as well as reports that track referrals, Member engagement, and service utilization. Such QI activities must include processes to monitor the extent to which Members are able to access mental health services across SMHS and NSMHS, and Covered Service utilization. The Parties must document these QI activities in policies and procedures.

[The Parties may agree to additional requirements, such as a requirement that the Parties must implement policies and procedures establishing and addressing QI activities for coordinating the care and delivery of services for Members.]

11. Data Sharing and Confidentiality. The Parties must establish and implement policies and procedures to ensure that the minimum necessary Member information and data for accomplishing the goals of this MOU are exchanged timely and maintained securely and confidentially and in compliance with the requirements set forth below to the extent permitted under applicable state and federal law. The Parties will share protected health information ("PHI") for the purposes of medical and behavioral health care coordination pursuant to Cal. Code Regs. tit. 9, Section 1810.370(a)(3), and to the fullest extent permitted under the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA") and 42 Code Federal Regulations Part 2, and other State and federal privacy laws. For additional guidance, the Parties should refer to the CalAIM Data Sharing Authorization Guidance.[4]

a. **Data Exchange.** Except where prohibited by law or regulation, MCP and MHP must share the minimum necessary data and information to facilitate referrals and coordinate care under this MOU. The Parties must have policies and procedures for supporting the timely and frequent exchange of Member information and data, including behavioral health and physical health data; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining Member consent, when required. The minimum necessary information and data elements to be shared as agreed upon by the Parties, are set forth in Exhibit C of this MOU. To the extent permitted under applicable law, the Parties must share, at a minimum, Member demographic information, behavioral and physical health information, diagnoses, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the Member's health and/or welfare. The Parties must annually review and, if appropriate, update Exhibit C of this MOU to facilitate sharing of information and data. MHP and MCP must

[4] CalAIM Data Sharing Authorization Guidance VERSION 2.0 June 2023 available at: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance-Version-2-Draft-Public-Comment.pdf.

establish policies and procedures to implement the following with regard to information sharing:

i. A process for timely exchanging information about Members eligible for ECM, regardless of whether the Specialty Mental Health provider is serving as an ECM provider;

ii. A process for MHP to send regular, frequent batches of referrals to ECM and Community Supports to MCP in as close to real time as possible;

iii. A process for MHP to send admission, discharge, and transfer data to MCP when Members are admitted to, discharged from, or transferred from facilities contracted by MHP (e.g., psychiatric inpatient hospitals, psychiatric health facilities, residential mental health facilities), and for MCP to receive this data. This process may incorporate notification requirements as described in Section 8(a)(v)(3);

iv. A process to implement mechanisms to alert the other Party of behavioral health crises (e.g., MHP alerts MCP of Members' uses of mobile health, psych inpatient, and crisis stabilization and MCP alerts MHP of Members' visits to emergency departments and hospitals); and

v. A process for MCP to send admission, discharge, and transfer data to MHP when Members are admitted to, discharged from, or transferred from facilities contracted by MCP (e.g., emergency department, inpatient hospitals, nursing facilities), and for MHP to receive this data. This process may incorporate notification requirements as described in Section 8(a)(v)(3).

[The Parties may agree to additional requirements such as:

- *MCP and MHP must enter into the State's Data Exchange Framework Data Sharing Agreement ("DSA") for the safe sharing of information.*
- *If Member authorization is required, the Parties must agree to a standard consent form to obtain a Member's authorization to share and use information for the purposes of treatment, payment, and care coordination protected under 42 Code of Federal Regulations Part 2.]*

b. **Behavioral Health Quality Improvement Program**. If MHP is participating in the Behavioral Health Quality Improvement Program, then MCP and MHP are encouraged to execute a DSA. If MHP and MCP have not executed a DSA, MHP must sign a Participation Agreement to onboard with a Health Information Exchange that has signed the California Data Use and Reciprocal Support Agreement and joined the California Trusted Exchange Network.

c. **Interoperability.** MCP and MHP must make available to Members their electronic health information held by MCP pursuant to 42 Code of Federal Regulations Section 438.10 and in accordance with APL 22-026 or any subsequent version of the APL. MCP must make available an application programming interface that makes complete and accurate Network Provider directory information available through a

public-facing digital endpoint on MCP's and MHP's respective websites pursuant to 42 Code of Federal Regulations Sections 438.242(b) and 438.10(h).

[The Parties may agree to additional requirements such as:

Disaster and Emergency Preparedness. *The Parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the Parties' health care delivery system to ensure the continued coordination and delivery of MHP services and MCP's Covered Services for impacted Members.]*

12. Dispute Resolution.

a. The Parties must agree to dispute resolution procedures such that in the event of any dispute or difference of opinion regarding the Party responsible for service coverage arising out of or relating to this MOU, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. The Parties must document the agreed-upon dispute resolution procedures in policies and procedures. Pending resolution of any such dispute, MCP and MHP must continue without delay to carry out all responsibilities under this MOU unless the MOU is terminated. If the dispute cannot be resolved within 15 Working Days of initiating such negotiations, either Party may pursue its available legal and equitable remedies under California law. Disputes between MCP and DMC-ODS that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP and/or DMC-ODS to DHCS.

b. Disputes between MCP and MHP that cannot be resolved in a good faith attempt between the Parties must be forwarded to DHCS via a written "Request for Resolution" by either MHP or MCP within three business days after failure to resolve the dispute, consistent with the procedure defined in Cal. Code Regs. tit. 9, § 1850.505, "Resolutions of Disputes between MHPs and Medi-Cal Managed Care Plans" and APL 21-013. Any decision rendered by DHCS regarding a dispute between MCP and MHP concerning provision of Covered Services is not subject to the dispute procedures set forth in the Primary Operations Contract Exhibit E, Section 1.21 (Contractor's Dispute Resolution Requirements);

c. A dispute between MHP and MCP must not delay the provision of medically necessary SMHS, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries as required by Cal. Code Regs. tit. 9, § 1850.525;

d. Until the dispute is resolved, the following must apply:

i. The Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided; or

ii. When the dispute concerns MCP's contention that MHP is required to deliver SMHS to a Member either because the Member's condition would not be responsive to physical health care-based treatment or because MHP has incorrectly determined the Member's diagnosis to be a diagnosis not covered by MHP, MCP must manage the care of the Member under the terms of its contract with the State until the

dispute is resolved. MHP must identify and provide MCP with the name and telephone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to MCP provider responsible for the Member's care; or

iii. When the dispute concerns MHP's contention that MCP is required to deliver physical health care-based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose or treat the mental illness, MHP is responsible for providing or arranging and paying for those services until the dispute is resolved.

e. if decisions rendered by DHCS find MCP is financially liable for services, MCP must comply with the requirements in Cal. Code Regs. tit. 9, § 1850.530.

f. The Parties may agree to an expedited dispute resolution process if a Member has not received a disputed service(s) and the Parties determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, the Parties will have one Working Day after identification of a dispute to attempt to resolve the dispute at the plan level. All terms and requirements established in APL 21-013 and BHIN 21-034 apply to disputes between MCP and MHP where the Parties cannot agree on the appropriate place of care. Nothing in this MOU or provision must constitute a waiver of any of the government claim filing requirements set forth in Title I, Division 3.6, of the California Government Code or as otherwise set forth in local, state, and federal law.

g. MHP must designate a person or process to receive notice of actions, denials, or deferrals from MCP, and to provide any additional information requested in the deferral notice as necessary for a medical necessity determination.

h. MCP must monitor and track the number of disputes with MHP where the Parties cannot agree on an appropriate place of care and, upon request, must report all such disputes to DHCS.

i. Once MHP receives a deferral from MCP, MHP must respond by the close of the business day following the day the deferral notice is received, consistent with Cal. Welf. & Inst. Code § 14715.

j. Nothing in this MOU or provision constitutes a waiver of any of the government claim filing requirements set forth in Title I, Division 3.6, of the California Government Code or as otherwise set forth in local, State, or federal law.

13. Equal Treatment. Nothing in this MOU is intended to benefit or prioritize Members over persons served by MHP who are not Members. Pursuant to Title VI, 42 United States Code Section 2000d, et seq., MHP cannot provide any service, financial

aid, or other benefit, to an individual which is different, or is provided in a different manner, from that provided to others provided by MHP.

14. General.

a. **MOU Posting.** MCP and MHP must each post this executed MOU on its website.

b. **Documentation Requirements.** MCP and MHP must retain all documents demonstrating compliance with this MOU for at least 10 years as required by the Medi-Cal Managed Care Contract and the MHP Contract. If DHCS requests a review of any existing MOU, the Party that received the request must submit the requested MOU to DHCS within 10 Working Days of receipt of the request.

c. **Notice.** Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by in-person delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail, certified, return receipt requested, postage prepaid, are deemed given on the date of delivery indicated on the return receipt. The Parties may change their addresses for purposes of receiving notice hereunder by giving notice of such change to each other in the manner provided for herein.

d. **Delegation.** MCP and MHP may delegate its obligations under this MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor as permitted under the Medi-Cal Managed Care Contract, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a Party to this MOU. Further, the Parties may enter into Subcontractor Agreements or Downstream Subcontractor Agreements that relate directly or indirectly to the performance of the Parties' obligations under this MOU. Other than in these circumstances, the Parties cannot delegate the obligations and duties contained in this MOU.

e. **Annual Review.** MCP and MHP must conduct an annual review of this MOU to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. MCP and MHP must provide DHCS evidence of the annual review of this MOU as well as copies of any MOUs modified or renewed as a result.

f. **Amendment.** This MOU may only be amended or modified by the Parties through a writing executed by the Parties. However, this MOU is deemed automatically amended or modified to incorporate any provisions amended or modified in the Medi-Cal Managed Care Contract, the MHP Contract, and subsequently issued superseding

APLs, BHINs, or guidance, or as required by applicable law or any applicable guidance issued by a State or federal oversight entity.

g. **Governance.** This MOU is governed by and construed in accordance with the laws of the state of California.

h. **Independent Contractors.** No provision of this MOU is intended to create, nor is any provision deemed or construed to create any relationship between MHP and MCP other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this MOU. Neither MHP nor MCP, nor any of their respective contractors, employees, agents, or representatives, is construed to be the contractor, employee, agent, or representative of the other.

i. **Counterpart Execution.** This MOU may be executed in counterparts signed electronically, and sent via PDF, each of which is deemed an original, but all of which, when taken together, constitute one and the same instrument.

j. **Superseding MOU.** This MOU constitutes the final and entire agreement between the Parties and supersedes any and all prior oral or written agreements, negotiations, or understandings between the Parties that conflict with the provisions set forth in this MOU. It is expressly understood and agreed that any prior written or oral agreement between the Parties pertaining to the subject matter herein is hereby terminated by mutual agreement of the Parties.

(Remainder of this page intentionally left blank)

The Parties represent that they have authority to enter into this MOU on behalf of their respective entities and have executed this MOU as of the Effective Date.

MCP

Signature:
Name:
Title:
Notice Address:

MHP

Signature:
Name:
Title:
Notice Address:

[Subcontractor or Downstream Subcontractor]

Signature:
Name:
Title:
Notice Address:

[MCP, if multiple MCPs in County]

Signature:
Name:
Title:
Notice Address:

Exhibits A & B

[Placeholder for exhibits to contain MCP-MHP and MHP Liaisons as referenced in Sections 4.b and 5.b of this MOU]

Exhibit C

Data Elements

[The Parties may agree to additional data elements to incorporate and/or include a Data Sharing Agreement between the Parties.]

ATTACHMENT D:

DMC-ODS MEMORANDUM OF UNDERSTANDING TEMPLATE

COVER PAGE

Memorandum of Understanding

between [*Medi-Cal Managed Care Plan*] and [*DMC-ODS*]

This Memorandum of Understanding ("MOU") is entered into by and between [*name of Managed Care Plan*] ("MCP") and [*name of party*], a [*description of other party*] ("DMC-ODS"), effective as of [*date*] ("Effective Date"). [*Where MCP has a Subcontractor or Downstream Subcontractor arrangement delegating part or all of the responsibilities related to effectuating this MOU to a Knox-Keene licensed health care service plan(s), this Subcontractor or Downstream Subcontractor must be added as an express party to this MOU and named in this MOU as having the responsibilities set forth herein that are applicable to this Subcontractor or Downstream Subcontractor.*] DMC-ODS, MCP, and MCP's relevant Subcontractors and/or Downstream Subcontractors may be referred to herein as a "Party" and collectively as "Parties."

WHEREAS, the Parties are required to enter into this MOU, a binding and enforceable contractual agreement, under the Medi-Cal Managed Care Contract Exhibit A, Attachment III, All Plan Letter ("APL") 22-005 and subsequently issued superseding APLs, and DMC-ODS is required to enter into this MOU under the DMC-ODS Intergovernmental Agreement Exhibit A, Attachment I, Behavioral Health Information Notice ("BHIN") 23-001, 23-057 and any subsequently issued superseding BHINs, to ensure that Medi-Cal Members enrolled in MCP who are served by DMC-ODS ("Members") are able to access and/or receive substance use disorder ("SUD") services in a coordinated manner from MCP and DMC-ODS;

WHEREAS, the Parties desire to ensure that Members receive SUD services in a coordinated manner and provide a process to continuously evaluate the quality of the care coordination provided; and

WHEREAS, the Parties understand and agree that any Member information and data shared to facilitate referrals, coordinate care, or to meet any of the obligations set forth in this MOU must be shared in accordance with all applicable federal and state statutes and regulations, including, without limitation, 42 Code of Federal Regulations Part 2.

[Notation: This MOU template includes language, notated in italics and bracketed, that the Parties may want to add to this MOU to increase collaboration and communication. MCP and DMC-ODS may also agree to additional provisions provided that they do not conflict with the requirements of this MOU.]

In consideration of mutual agreements and promises hereinafter, the Parties agree as follows:

1. **Definitions.** Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the California Department of Health Care Services ("DHCS"), unless otherwise defined herein. The Medi-Cal Managed Care Contract is available on the DHCS webpage at www.dhcs.ca.gov.

a. “MCP Responsible Person” means the person designated by MCP to oversee MCP coordination and communication with DMC-ODS and ensure MCP’s compliance with this MOU as described in Section 4 of this MOU.

b. “MCP-DMC-ODS Liaison” means MCP’s designated point of contact responsible for acting as the liaison between MCP and DMC-ODS as described in Section 4 of this MOU. The MCP-DMC-ODS Liaison must ensure the appropriate communication and care coordination is ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.

c. “DMC-ODS Responsible Person” means the person designated by DMC-ODS to oversee coordination and communication with MCP and ensure DMC-ODS compliance with this MOU as described in Section 5 of this MOU.

d. “DMC-ODS Liaison” means DMC-ODS’s designated point of contact responsible for acting as the liaison between MCP and DMC-ODS as described in Section 5 of this MOU. The DMC-ODS Liaison should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the DMC-ODS Responsible Person and/or DMC-ODS compliance officer as appropriate.

e. “Network Provider”, as it pertains to MCP, has the same meaning ascribed by the MCP’s Medi-Cal Managed Care Contract with the DHCS; and as it pertains to DMC-ODS, has the same meaning ascribed by the DMC-ODS Intergovernmental Agreement with the DHCS.

f. “Subcontractor” as it pertains to MCP, has the same meaning ascribed by the MCP’s Medi-Cal Managed Care Contract with the DHCS; and as it pertains to DMC-ODS, has the same meaning ascribed by the DMC-ODS Intergovernmental Agreement with the DHCS.

g. “Downstream Subcontractor”, as it pertains to MCP, has the same meaning ascribed by the MCP’s Medi-Cal Managed Care Contract with the DHCS; and as it pertains to DMC-ODS, means a subcontractor of a DMC-ODS Subcontractor.

2. Term. This MOU is in effect as of the Effective Date and continues for a term of *[The Parties may agree to a term of three years or another term as agreed to by MCP and DMC-ODS]* or as amended in accordance with Section 14.f of this MOU.

3. Services Covered by This MOU. This MOU governs the coordination between DMC-ODS and MCP for the provision of SUD services as described in APL 22-006, and any subsequently issued superseding APLs, and Medi-Cal Managed Care Contract, BHIN 23-001, DMC-ODS Requirements for the Period of 2022-2026, and the DMC-ODS Intergovernmental Agreement, and any subsequently issued superseding APLs, BHINs, executed contract amendments, or other relevant guidance.

4. MCP Obligations.

a. **Provision of Covered Services**. MCP is responsible for authorizing Medically Necessary Covered Services and coordinating Member care provided by the MCP’s Network Providers and other providers of carve-out programs, services, and benefits.

b. **Oversight Responsibility.** The [*insert title*], the designated MCP Responsible Person, listed on Exhibit A of this MOU, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

i. Meet at least quarterly with DMC-ODS, as required by Section 9 of this MOU;

ii. Report on MCP's compliance with the MOU to MCP's compliance officer no less frequently than quarterly. MCP's compliance officer is responsible for MOU compliance oversight reports as part of MCP's compliance program and must address any compliance deficiencies in accordance with MCP's compliance program policies;

iii. Ensure there is sufficient staff at MCP to support compliance with and management of this MOU;

iv. Ensure the appropriate level of MCP leadership (i.e., persons with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from DMC-ODS are invited to participate in the MOU engagements, as appropriate;

v. Ensure training and education regarding MOU provisions are conducted annually for MCP's employees responsible for carrying out activities under this MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network Providers; and

vi. Serve, or may designate a person at MCP to serve, as the MCP-DMC-ODS Liaison, the point of contact and liaison with DMC-ODS. The MCP-DMC-ODS Liaison is listed in Exhibit A of this MOU. MCP must notify DMC-ODS of any changes to the MCP-DMC-ODS Liaison in writing as soon as reasonably practical, but no later than the date of change, and must notify DHCS within five Working Days of the change.

c. Compliance by Subcontractors, Downstream Subcontractors, and Network Providers. MCP must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

5. DMC-ODS Obligations.

a. **Provision of DMC-ODS Services**. DMC-ODS is responsible for providing or arranging covered SUD services.

b. **Oversight Responsibility.** The [*insert title*], the designated DMC-ODS Responsible Person, listed on Exhibit B of this MOU, is responsible for overseeing DMC-ODS's compliance with this MOU. The DMC-ODS Responsible Person serves, or may designate a person to serve, as the designated DMC-ODS Liaison, the point of contact and liaison with MCP. The DMC-ODS Liaison is listed on Exhibit B of this MOU. The DMC-ODS Liaison may be the same person as the DMC-ODS Responsible Person. DMC-ODS must notify MCP of changes to the DMC-ODS Liaison as soon as reasonably practical but no later than the date of change. The DMC-ODS Responsible Person must:

i. Meet at least quarterly with MCP, as required by Section 9 of this MOU;

ii. Report on DMC-ODS compliance with the MOU to DMC-ODS' compliance officer no less frequently than quarterly. The compliance officer is responsible for MOU compliance oversight and reports as part of DMC-ODS's compliance program and must address any compliance deficiencies in accordance with DMC-ODS's compliance program policies;

iii. Ensure there is sufficient staff at DMC-ODS to support compliance with and management of this MOU;

iv. Ensure the appropriate levels of DMC-ODS leadership (i.e., persons with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from MCP are invited to participate in the MOU engagements, as appropriate;

v. Ensure training and education regarding MOU provisions are conducted annually for DMC-ODS's employees responsible for carrying out activities under this MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network Providers; and

vi. Be responsible for meeting MOU compliance requirements, as determined by policies and procedures established by DMC-ODS, and reporting to the DMC-ODS Responsible Person.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** DMC-ODS must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

6. Training and Education.

a. To ensure compliance with this MOU, the Parties must provide training and orientation for their employees who carry out activities under this MOU and, as applicable, Network Providers, Subcontractors, and Downstream Subcontractors who assist MCP with carrying out MCP's responsibilities under this MOU. The training must include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU. For persons or entities performing these responsibilities as of the Effective Date, the Parties must provide this training within *[The Parties may agree to 30, 45, or 60 Working Days.]* of the Effective Date. Thereafter, the Parties must provide this training prior to any such person or entity performing responsibilities under this MOU and all such persons or entities at least annually thereafter. MCP must require its Subcontractors and Downstream Subcontractors to provide training on relevant MOU requirements and DMC-ODS services to their contracted providers.

b. In accordance with health education standards required by the Medi-Cal Managed Care Contract, the Parties must provide Members and Network Providers with educational materials related to accessing Covered Services, including for services provided by DMC-ODS.

c. The Parties each must provide the other Party, Members, and Network Providers with training and/or educational materials on how MCP Covered Services and DMC-ODS services may be accessed, including during nonbusiness hours.

[The Parties may agree to additional requirements, such as:

- *The Parties must together develop training and education resources covering the services provided or arranged by the Parties, and each Party must share their training and educational materials with the other Party to ensure the information included in their respective training and education materials includes an accurate set of services provided or arranged for by each Party and is consistent with MCP and DMC-ODS policies and procedures, and with clinical practice standards.*
- *The Parties must develop and share outreach communication materials and initiatives to share resources about MCP and DMC-ODS with individuals who may be eligible for MCP's Covered Services and/or DMC-ODS services.]*

7. **Screening, Assessment, and Referrals.**

a. **Screening and Assessment.**

i. The Parties must work collaboratively to develop and establish policies and procedures that address how Members must be screened and assessed for MCP Covered Services and DMC-ODS services.

ii. MCP must develop and establish policies and procedures for providing Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment ("SABIRT") to Members aged eleven (11) and older in accordance with APL 21-014. MCP policies and procedures must include, but not be limited to:

1. A process for ensuring Members receive comprehensive substance use, physical, and mental health screening services, including the use of American Society of Addiction Medicine (ASAM) Level 0.5 SABIRT guidelines;
2. A process for providing or arranging the provision of medications for Addiction Treatment (also known as Medication-Assisted Treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings;

b. **Referral Process.** The Parties must work collaboratively to develop policies and procedures that ensure Members are referred to the appropriate MCP Covered Services and DMC-ODS services.

i. The Parties must facilitate referrals to DMC-ODS for Members who may potentially meet the criteria to access DMC-ODS services and ensure DMC-ODS has procedures for accepting referrals from MCP.

ii. MCP must refer Members using a patient-centered, shared decision-making process.

iii. MCP must develop and implement an organizational approach to the delivery of services and referral pathways to DMC-ODS services.

iv. DMC-ODS must refer Members to MCP for Covered Services, as well as any Community Supports services or care management programs for which they may qualify, such as Enhanced Care Management ("ECM") or Complex Case Management ("CCM"). If DMC-ODS is an ECM Provider, DMC-ODS provides ECM services pursuant to that separate agreement between MCP and DMC-ODS for ECM services; this MOU does not govern DMC-ODS's provision of ECM.

v. The Parties must work collaboratively to ensure that Members may access services through multiple pathways. The Parties must ensure Members receive

SUD services when Members have co-occurring SMHS and/or NSMHS and SUD needs.

vi. MCP must have a process by which MCP accepts referrals from DMC-ODS staff, providers, or a self-referred Member for assessment, makes a determination of medical necessity for the Member to receive DMC-ODS Covered Services, and provides referrals within the DMC-ODS provider network; and

vii. DMC-ODS must have a process by which DMC-ODS accepts referrals from MCP staff, providers, or a self-referred Member for assessment, and a mechanism for communicating such acceptance to MCP, the provider, or the self-referred Member, respectively.

[The Parties may agree to additional requirements, such as:

Closed Loop Referrals. *By January 1, 2025, the Parties must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Management Policy Guide[1], APL 22-024, or any subsequent version of the APL, and as set forth by DHCS through an APL or other, similar guidance. The Parties must work collaboratively to develop and implement a process to ensure that MCP and DMC-ODS comply with the applicable provisions of closed loop referrals guidance within 90 Working Days of issuance of this guidance. The Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.]*

8. **Care Coordination and Collaboration.**

a. **Care Coordination.**

i. The Parties must adopt policies and procedures for coordinating Members' access to care and services that incorporate all the requirements set forth in this MOU.

ii. The Parties must discuss and address individual care coordination issues or barriers to care coordination efforts at least quarterly.

iii. MCP must have policies and procedures in place to maintain cross-system collaboration with DMC-ODS and to identify strategies to monitor and assess the effectiveness of this MOU.

iv. The Parties must implement policies and procedures that align for coordinating Members' care that address:

1. The requirement for DMC-ODS to refer Members to MCP to be assessed for care coordination and other similar programs and other services for which they may qualify provided by MCP including, but not limited to, ECM, CCM, or Community Supports;

2. The specific point of contact from each Party, if someone other than each Party's Responsible Person, to act as the liaison between Parties and be responsible for initiating, providing, and maintaining ongoing care coordination for all Members under this MOU;

[1] CalAIM Population Health Management Policy Guide, available at https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.

3. A process for how MCP and DMC-ODS will engage in collaborative treatment planning to ensure care is clinically appropriate and non-duplicative and considers the Member's established therapeutic relationships;

4. A process for coordinating the delivery of Medically Necessary Covered Services with the Member's Primary Care Provider, including without limitation transportation services, home health services, and other Medically Necessary Covered Services for eligible Members;

5. A process for how MCP and DMC-ODS will help to ensure the Member is engaged and participates in their care program and a process for ensuring the Members, caregivers, and providers are engaged in the development of the Member's care;

6. A process for reviewing and updating a Member's problem list, as clinically indicated. The process must describe circumstances for updating problem lists and coordinating with outpatient SUD providers;

7. A process for how the Parties will engage in collaborative treatment planning and ensure communication among providers, including procedures for exchanges of medical information; and

8. Processes to ensure that Members and providers can coordinate coverage of Covered Services and carved-out services outlined by this MOU outside of normal business hours, as well as providing or arranging for 24/7 emergency access to Covered Services and carved-out services.

v. Transitional Care.

1. The Parties must establish policies and procedures and develop a process describing how MCP and DMC-ODS will coordinate transitional care services for Members. A "transitional care service" is defined as the transfer of a Member from one setting or level of care to another, including, but not limited to, discharges from hospitals, institutions, and other acute care facilities and skilled nursing facilities to home- or community-based settings,[2] level of care transitions that occur within the facility, or transitions from outpatient therapy to intensive outpatient therapy and vice versa.

2. For Members who are admitted for residential SUD treatment, including, but not limited to, Short-Term Residential Therapeutic Programs and Psychiatric Residential Treatment Facilities where DMC-ODS is the primary payer, DMC-ODS is primarily responsible for coordination of the Member upon discharge. In collaboration with DMC-ODS, MCP is responsible for ensuring transitional care coordination as required by Population Health Management,[3] including, but not limited to:

a. Tracking when Members are admitted, discharged, or transferred from facilities contracted by DMC-ODS in accordance with Section 11(a)(iii) of this MOU;

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[2] Expectations for transitional care are defined in the PHM Policy Program Guide: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf

[3] Expectations for transitional care are defined in the PHM Policy Program Guide: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf; *see also* PHM Roadmap and Strategy: https://www.dhcs.ca.gov/CalAIM/Documents/Final-Population-Health-Management-Strategy-and-Roadmap.pdf

b. Approving prior authorizations and coordinating services where MCP is the primary payer (e.g., home services, long-term services, and supports for dual-eligible Members);

c. Ensuring the completion of a discharge risk assessment and developing a discharge planning document;

d. Assessing Members for any additional care management programs or services for which they may qualify, such as ECM, CCM, or Community Supports, and enrolling the Member in the program as appropriate;

e. Notifying existing CCM Care Managers of any admission if the Member is already enrolled in ECM or CCM; and

f. Assigning or contracting with a care manager to coordinate with county care coordinators to ensure physical health follow-up needs are met for each eligible Member as outlined by the Population Health Management Policy Guide.[4]

3. The Parties must include in their policies and procedures a process for updating and overseeing the implementation of the discharge planning documents as required for Members transitioning to or from MCP or DMC-ODS services;

4. For inpatient residential SUD treatment provided by DMC-ODS or for inpatient hospital admissions or emergency department visits known to MCP, the process must include the specific method to notify each Party within 24 hours of admission and discharge and the method of notification used to arrange for and coordinate appropriate follow-up services.

vi. **Clinical Consultation**. The Parties must establish policies and procedures to ensure that Members have access to clinical consultation, including consultation on medications, as well as clinical navigation support for patients and caregivers.

vii. Enhanced Care Management.

1. Delivery of the ECM benefit for individuals who meet ECM Population of Focus definitions (including, but not limited to, the Individuals with Severe Mental Illness and Children Populations of Focus) must be consistent with DHCS guidance regarding ECM, including:

a. That MCP prioritize assigning a Member to a DMC-ODS Provider as the ECM Provider if the Member receives DMC-ODS services from that Provider and that Provider is a contracted ECM Provider, unless the Member has expressed a different preference or MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions; and

b. That the Parties implement a process for DMC-ODS Providers to refer their patients to MCP for ECM if the patients meet Population of Focus criteria.

2. The Parties must implement a process for avoiding duplication of services for individuals receiving ECM with DMC-ODS care coordination. Members receiving DMC-ODS care coordination can also be eligible for and receive ECM.

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[4] CalAIM Population Health Management Policy Guide available at https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.

3. MCP must have written processes for ensuring the non-duplication of services for Members receiving ECM and DMC-ODS care coordination.

viii. **Community Supports.** Coordination must be established with applicable Community Supports providers under contract with MCP, including:

1. The identified point of contact from each Party to act as the liaison to oversee initiating, providing, and maintaining ongoing coordination as mutually agreed upon in MCP and DMC-ODS protocols;

2. Identification of the Community Supports covered by MCP; and

3. A process specifying how DMC-ODS will make referrals for Members eligible for or receiving Community Supports.

ix. **Prescription Drugs.** The Parties must develop a process for coordination between MCP and DMC-ODS for prescription drug and laboratory, radiological, and radioisotope service procedures, including a process for referring eligible Members for SUD services to a Drug Medi-Cal-certified program or a DMC-ODS program in accordance with the Medi-Cal Managed Care Contract.

9. Quarterly Meetings.

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU but not less frequently than quarterly, in order to address care coordination, Quality Improvement ("QI") activities, QI outcomes, systemic and case-specific concerns, and communicating with others within their organizations about such activities. *[Parties may agree to meet more frequently.]* These meetings may be conducted virtually.

b. Within 30 Working Days after each quarterly meeting, the Parties must each post on its website the date and time the quarterly meeting occurred, and, as applicable, distribute to meeting participants a summary of any follow-up action items or changes to processes that are necessary to fulfill the Parties' obligations under the Medi-Cal Managed Care Contract, the DMC-ODS Intergovernmental Agreement, and this MOU.

c. The Parties each must invite the other Party's Responsible Person and appropriate program executives to participate in quarterly meetings to ensure appropriate committee representation, including a local presence, to discuss and address care coordination and MOU-related issues. The Parties' Subcontractors and Downstream Subcontractors should be permitted to participate in these meetings, as appropriate.

d. The Parties must report to DHCS updates from quarterly meetings in a manner and at a frequency specified by DHCS.

e. **Local Representation.** MCP must participate, as appropriate, at meetings or engagements to which MCP is invited by DMC-ODS, such as local county meetings, local community forums, and DMC-ODS engagements, to collaborate with DMC-ODS in equity strategy and wellness and prevention activities.

10. Quality Improvement. The Parties must develop QI activities specifically for the oversight of the requirements of this MOU, including, without limitation, any applicable performance measures and QI initiatives, including those to prevent duplication of

services, as well as reports that track referrals, Member engagement, and service utilization. The Parties must document these QI activities in policies and procedures.

[The Parties may agree to additional requirements, such as a requirement that the Parties must implement policies and procedures establishing and addressing QI activities for coordinating the care and delivery of services for Members.]

11. Data Sharing and Confidentiality. The Parties must establish and implement policies and procedures to ensure that the minimum necessary Member information and data to accomplish the goals of this MOU are exchanged timely and maintained securely and confidentially and in compliance with the requirements set forth below to the extent permitted under applicable state and federal law. The Parties will share protected health information ("PHI") for the purposes of medical and behavioral health care coordination pursuant to Welfare and Institutions § 14184.102(j), and to the fullest extent permitted under the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA"), 42 Code Federal Regulations Part 2, and other State and federal privacy laws. For additional guidance, the Parties should refer to the CalAIM Data Sharing Authorization Guidance.[5]

a. **Data Exchange.** Except where prohibited by law or regulation, MCP and DMC-ODS must share the minimum necessary data and information to facilitate referrals and coordinate care under this MOU. The Parties must have policies and procedures for supporting the timely and frequent exchange of Member information and data, including behavioral health and physical health data; maintaining the confidentiality of exchanged information and data; and obtaining Member consent, when required. The minimum necessary information and data elements to be shared as agreed-upon by the Parties are set forth in Exhibit C of this MOU. To the extent permitted under applicable law, the Parties must share, at a minimum, Member demographic information, behavioral and physical health information, diagnoses, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the Member's health and/or welfare. The Parties must annually review and, if appropriate, update Exhibit C of this MOU to facilitate sharing of information and data. DMC-ODS and MCP must establish policies and procedures to implement the following with regard to information sharing:

i. A process for timely exchanging information about Members eligible for ECM, regardless of whether the DMC-ODS Provider is serving as an ECM Provider;

ii. A process for DMC-ODS to send regular frequent batches of referrals to ECM and Community Supports to MCP in as close to real time as possible;

iii. A process for DMC-ODS to send admission, discharge, and transfer data to MCP when Members are admitted to, discharged from, or transferred from facilities contracted by DMC-ODS (e.g., residential SUD treatment facilities, residential SUD withdrawal management facilities), and for MCP to receive this data.

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[5] CalAIM Data Sharing Authorization Guidance VERSION 2.0 June 2023 available at: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance-Version-2-Draft-Public-Comment.pdf

This process may incorporate notification requirements as described in Section 8(a)(v)(3);

iv. A process to implement mechanisms to alert the other Party of behavioral health crises (e.g., DMC-ODS alerts MCP of uses of SUD crisis intervention); and

v. A process for MCP to send admission, discharge, and transfer data to DMC-ODS when Members are admitted to, discharged from, or transferred from facilities contracted by MCP (e.g., emergency department, inpatient hospitals, nursing facilities), and for DMC-ODS to receive this data. This process may incorporate notification requirements as described in Section 8(a)(v)(3).

[The Parties may agree to additional requirements such as:

- *MCP and DMC-ODS must enter into the State's Data Exchange Framework Data Sharing Agreement ("DSA") for the safe sharing of information.*
- *If Member authorization is required, the Parties must agree to a standard consent form to obtain a Member's authorization to share and use information for the purposes of treatment, payment, and care coordination protected under 42 Code of Federal Regulations Part 2.]*

b. **Behavioral Health Quality Improvement Program**. If DMC-ODS is participating in the Behavioral Health Quality Improvement Program, then MCP and DMC-ODS are encouraged to execute a DSA. If DMC-ODS and MCP have not executed a DSA, DMC-ODS must sign a Participation Agreement to onboard with a Health Information Exchange that has signed the California Data Use and Reciprocal Support Agreement and joined the California Trusted Exchange Network.

c. **Interoperability.** MCP and DMC-ODS must exchange data in compliance with the payer-to-payer data exchange requirements pursuant to 45 Code of Federal Regulations Part 170. MCP must make available to Members their electronic health information held by the Parties and make available an application program interface that makes complete and accurate Network Provider directory information available through a public-facing digital endpoint on MCP's and DMC-ODS's respective websites pursuant to 42 Code of Federal Regulations Section 438.242(b) and 42 Code of Federal Regulations Section 438.10(h). The Parties must comply with DHCS interoperability requirements set forth in APL 22-026 and BHIN 22-068, or any subsequent version of the APL and BHIN, as applicable.

[The Parties may agree to additional requirements such as:

Disaster and Emergency Preparedness. *The Parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the Parties' health care delivery system to ensure the continued coordination and delivery of DMC-ODS services and MCP's Covered Services for impacted Members.]*

12. Dispute Resolution.

a. The Parties must agree to dispute resolution procedures such that in the event of any dispute or difference of opinion regarding the Party responsible for service coverage arising out of or relating to this MOU, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. The Parties must document the agreed-upon dispute resolution procedures in policies and procedures. Pending resolution of any such dispute, MCP and DMC-ODS must continue without delay to carry out all responsibilities under this MOU unless the MOU is terminated. If the dispute cannot be resolved within 15 Working Days of initiating such negotiations or such other period as may be mutually agreed to by the Parties in writing, either Party may pursue its available legal and equitable remedies under California law. Disputes between MCP and DMC-ODS that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP and/or DMC-ODS to DHCS.

b. Unless otherwise determined by the Parties, the DMC-ODS Liaison must be the designated individual responsible for receiving notice of actions, denials, or deferrals from MCP, and for providing any additional information requested in the deferral notice as necessary for a medical necessity determination.

c. MCP must monitor and track the number of disputes with DMC-ODS where the Parties cannot agree on an appropriate place of care and, upon request, must report all such disputes to DHCS.

d. Until the dispute is resolved, the following provisions must apply:

i. The Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided; or

ii. When the dispute concerns MCP's contention that DMC-ODS is required to deliver SUD services to a Member and DMC-ODS has incorrectly determined the Member's diagnosis to be a diagnosis not covered by DMC-ODS, MCP must manage the care of the Member under the terms of its contract with the State, including providing or arranging and paying for those services until the dispute is resolved.

iii. When the dispute concerns DMC-ODS's contention that MCP is required to deliver physical health care-based treatment, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose, DMC-ODS is responsible for providing or arranging and paying for those services until the dispute is resolved.

e. Nothing in this MOU or provision constitutes a waiver of any of the government claim filing requirements set forth in Title I, Division 3.6, of the California Government Code or as otherwise set forth in local, State, or federal law.

13. Equal Treatment. Nothing in this MOU is intended to benefit or prioritize Members over persons served by DMC-ODS who are not Members. Pursuant to Title VI, 42 United States Code Section 2000d, et seq., DMC-ODS cannot provide any service, financial aid, or other benefit, to an individual that is different, or is provided in a different manner, from that provided to others provided by DMC-ODS.

14. General.

a. **MOU Posting.** MCP and DMC-ODS must each post this executed MOU on its website.

b. **Documentation Requirements.** MCP and DMC-ODS must retain all documents demonstrating compliance with this MOU for at least 10 years as required by the Medi-Cal Managed Care Contract and DMC-ODS Intergovernmental Agreement. If DHCS requests a review of any existing MOU, the Party that received the request must submit the requested MOU to DHCS within 10 Working Days of receipt of the request.

c. **Notice.** Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by in-person delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail, certified, return receipt requested, postage prepaid, are deemed given on the date of delivery indicated on the return receipt. The Parties may change their addresses for purposes of receiving notice hereunder by giving notice of such change to each other in the manner provided for herein.

d. **Delegation.** MCP and DMC-ODS may delegate its obligations under this MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor as permitted under the Medi-Cal Managed Care Contract, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a Party to this MOU. Further, the Parties may enter into Subcontractor Agreements or Downstream Subcontractor Agreements that relate directly or indirectly to the performance of the Parties' obligations under this MOU. Other than in these circumstances, the Parties cannot delegate the obligations and duties contained in this MOU.

e. **Annual Review.** MCP and DMC-ODS must conduct an annual review of this MOU to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. MCP and DMC-ODS must provide DHCS evidence of the annual review of this MOU as well as copies of any MOUs modified or renewed as a result.

f. **Amendment.** This MOU may only be amended or modified by the Parties through a writing executed by the Parties. However, this MOU is deemed automatically amended or modified to incorporate any provisions amended or modified in the Medi-Cal Managed Care Contract, DMC-OS Intergovernmental Agreement, any subsequently issued superseding APL, BHINs, or guidance, or as required by applicable law or any applicable guidance issued by a State or federal oversight entity.

g. **Governance.** This MOU is governed by and construed in accordance with the laws of the state of California.

h. **Independent Contractors.** No provision of this MOU is intended to create, nor is any provision deemed or construed to create, any relationship between DMC-ODS and MCP other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this MOU. Neither DMC-ODS nor MCP, nor any of their respective contractors, employees, agents, or

representatives, is construed to be the contractor, employee, agent, or representative of the other.

i. **Counterpart Execution.** This MOU may be executed in counterparts signed electronically and sent via PDF, each of which is deemed an original, but all of which, when taken together, constitute one and the same instrument.

j. **Superseding MOU.** This MOU constitutes the final and entire agreement between the Parties and supersedes any and all prior oral or written agreements, negotiations, or understandings between the Parties that conflict with the provisions set forth in this MOU. It is expressly understood and agreed that any prior written or oral agreement between the Parties pertaining to the subject matter herein is hereby terminated by mutual agreement of the Parties.

(Remainder of this page intentionally left blank)

The Parties represent that they have authority to enter into this MOU on behalf of their respective entities and have executed this MOU as of the Effective Date.

MCP	**DMC-ODS**
Signature: **Name:** **Title:** **Notice Address:**	**Signature:** **Name:** **Title:** **Notice Address:**

[Subcontractor]

Signature:
Name:
Title:
Notice Address:

[MCP, if multiple MCPs in County]

Signature:
Name:
Title:
Notice Address:

Exhibits A and B

[Placeholder for exhibits to contain MCP-DMC-ODS and DMC-ODS Liaisons as referenced in Sections 4.b. and 5.b of this MOU]

Exhibit C

Data Elements

[The Parties may agree to additional data elements to incorporate and/or include a Data Sharing Agreement between the Parties.]

ATTACHMENT F: LOCAL HEALTH DEPARTMENT MEMORANDUM OF UNDERSTANDING TEMPLATE

COVER PAGE

Back to Item

Back to Agenda

Memorandum of Understanding

between [*Medi-Cal Managed Care Plan*] and [*Local Health Department*]

This Memorandum of Understanding ("MOU") is entered into by [*name of Managed Care Plan*] ("MCP**"**) and [*name of Local Health Department*], a local health department ("LHD"), effective as of [*date*] ("Effective Date"). [*Where MCP has a Subcontractor or Downstream Subcontractor arrangement delegating part or all of the responsibilities related to effectuating this MOU to a Knox-Keene licensed health care service plan(s), this Subcontractor or Downstream Subcontractor must be added as an express party to this MOU and named in this MOU as having the responsibilities set forth herein that are applicable to this Subcontractor or Downstream Subcontractor.*] MCP, and MCP's relevant Subcontractor and/or Downstream Subcontractor, and LHD may be referred to herein as a "Party" and collectively as "Parties."

WHEREAS, MCP is required under the Medi-Cal Managed Care Contract Exhibit A, Attachment III, to enter into this MOU, a binding and enforceable contractual agreement, to ensure that Medi-Cal beneficiaries enrolled, or eligible to enroll, in MCP ("Members") are able to access and/or receive services in a coordinated manner from MCP and LHD;

WHEREAS, the Parties desire to ensure that Members receive services available through LHD direct service programs in a coordinated manner and to provide a process to continuously evaluate the quality of care coordination provided; and

WHEREAS, the Parties understand and agree that to the extent any data that is protected health information ("PHI") or personally identifiable information ("PII") exchanged in furtherance of this agreement originates from the California Department of Public Health ("CDPH") owned databases, LHD must comply with all applicable federal and State statutes and regulations and any underlying CDPH/LHD agreement terms and conditions that impose restrictions on access to, use of, and disclosure of that data.

[Notation: This MOU template includes language, notated in italics and bracketed, that the Parties may want to add to this MOU to increase collaboration and communication. MCP and LHD may also agree to additional provisions provided that they do not conflict with the requirements of this MOU.]

In consideration of the mutual agreements and promises hereinafter, the Parties agree as follows:

1. **Definitions.** Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the Department of Health Care Services ("DHCS"), unless otherwise defined herein. The Medi-Cal Managed Care Contract is available on the DHCS webpage at www.dhcs.ca.gov.

    a. "MCP Responsible Person" means the person designated by MCP to oversee MCP coordination and communication with the LHD Responsible Person,

facilitate quarterly meetings in accordance with Section 9 of and ensure MCP's compliance with this MOU as described in Section 4 of this MOU. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in MCP practices.

b. "MCP-LHD Liaison" means MCP's designated point of contact(s) responsible for acting as the liaison between MCP and LHD Program Liaison(s) as described in Section 4 of this MOU. The MCP-LHD Liaison(s) must ensure that the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 10 of this MOU, and must provide updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.

c. "LHD Responsible Person" means the person designated by LHD to oversee coordination and communication with MCP, facilitate quarterly meetings in accordance with Section 10 of this MOU, and ensure LHD's compliance with this MOU as described in Section 5 of this MOU. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in LHD practices.

d. "LHD Program Liaison" means LHD's designated point of contact(s) responsible for acting as the liaison between MCP and LHD as described in Section 5 of this MOU. The LHD Program Liaison(s) should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and should provide updates to the LHD Responsible Person as appropriate.

2. Term. This MOU is in effect as of the Effective Date and continues for a term of *[The Parties may agree to a term of three years or another term as agreed to by MCP and LHD.]* or as amended in accordance with Section 17.f of this MOU.

3. Services Covered by This MOU. This MOU governs the coordination between LHD and MCP for the delivery of care and services for Members who reside in LHD's jurisdiction and may be eligible for services provided, made available, or arranged for by LHD. The Parties are subject to additional requirements for specific LHD programs and services that LHD provides, which are listed in the applicable program-specific exhibits ("Program Exhibits"), each labeled with the specific program or service.

4. MCP Obligations.

a. **Provision of Covered Services.** MCP is responsible for authorizing Medically Necessary Covered Services and coordinating care for Members provided by MCP's Network Providers and other providers of carve-out programs, services and benefits, such as dental benefits.

b. **Oversight Responsibility.** The [insert title], the designated MCP Responsible Person, listed in Exhibit A of this MOU, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

i. Meet at least quarterly with the LHD Responsible Person and LHD Program Liaisons, as required by Section 10 of this MOU;

ii. Report no less frequently than quarterly on MCP's compliance with the MOU to MCP's compliance officer who is responsible for MOU compliance oversight reports as part of MCP's compliance program and must address any compliance deficiencies in accordance with MCP's compliance program policies;

iii. Ensure there is sufficient staff at MCP who support compliance with and management of this MOU;

iv. Ensure the appropriate level of MCP leadership (i.e., persons with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from LHD are invited to participate in the MOU engagements, as appropriate;

v. Ensure training and education regarding MOU provisions are conducted annually for MCP's employees responsible for carrying out activities under this MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network Providers; and

vi. Serve, or may designate a person at MCP to serve, as the MCP-LHD Liaison, the point of contact and liaison with LHD or LHD programs. The MCP-LHD Liaison is listed in Exhibit A of this MOU. MCP must notify LHD of any changes to the MCP-LHD Liaison in writing as soon as reasonably practical but no later than the date of change and must notify DHCS within five Working Days of the change.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

5. LHD Obligations.

a. **Provision of Services.** LHD is responsible for services provided or made available by LHD.

b. **Oversight Responsibility.** The [insert title], the designated LHD Responsible Person, listed in Exhibit B of this MOU, is responsible for overseeing LHD's compliance with this MOU. It is recommended that this person be in a leadership capacity with decision-making authority on behalf of LHD. LHD must designate at least one person to serve as the designated LHD Program Liaison, the point of contact and liaison with MCP, for the programs relevant to this MOU. It is recommended that this person be in a leadership capacity at the program level. The LHD Program Liaison(s) is listed in Exhibit B of this MOU. LHD may designate a liaison(s) by program or service line. LHD must notify MCP of changes to the LHD Program Liaison(s) as soon as reasonably practical but no later than the date of change, except when such prior notification is not possible, in which case, notice should be provided within five Working Days of the change.

[The Parties may agree to additional requirements such as:

- *The LHD Responsible Person must ensure there is sufficient staff at LHD who support compliance with and management of this MOU.*
- *LHD must develop and implement MOU compliance policies and procedures for LHD programs, including oversight reports and mechanisms to address barriers to care coordination.*
- *The LHD Responsible Person must ensure that training and education regarding MOU provisions are conducted annually for LHD employees, Subcontractors, Downstream Subcontractors, and Network Providers as applicable.*
- *The LHD Program Liaison(s) must meet MOU compliance requirements, as determined by policies and procedures established by LHD, and must report to the LHD Responsible Person.]*

6. Training and Education.

a. To ensure compliance with this MOU, MCP must provide training and orientation for its employees who carry out responsibilities under this MOU and, as applicable, for MCP's Network Providers, Subcontractors, and Downstream Subcontractors who assist MCP with carrying out MCP's responsibilities under this MOU. The training must include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU. For persons or entities performing these responsibilities as of the Effective Date, MCP must provide this training within *[The Parties may agree to 30, 45, or 60 Working Days.]* of the Effective Date. Thereafter, MCP must provide this training prior to any such person or entity performing responsibilities under this MOU and to all such persons or entities at least annually thereafter. MCP must require its Subcontractors and Downstream Subcontractors to provide training on relevant MOU requirements and LHD programs and services to its Network Providers. *[The Parties may agree to make this requirement mutual.]*

b. In accordance with health education standards required by the Medi-Cal Managed Care Contract, MCP must provide educational materials to Members and Network Providers related to accessing Covered Services, including for services provided by LHD.

c. MCP must provide LHD, Members, and Network Providers with training and/or educational materials on how MCP's Covered Services and carved-out services may be accessed, including during nonbusiness hours.

[The Parties may agree to additional requirements such as:

- *If MCP or LHD develops training and education resources covering the services provided or arranged by the Parties, then each Party must share its training and education resources with the other Party to ensure the information included in their respective training and education resources sets forth an accurate set of*

services provided or arranged for by each Party and is consistent with MCP and LHD policies and procedures, and with clinical practice standards.

- *The Parties must make information that describes MCP Covered Services and/or LHD services or programs under this MOU available to Members, LHD clients, and/or other individuals who may be eligible for these resources.*
- *MCP training materials shared with LHD must include billing and claims requirements for LHD reimbursement for non-contracted LHD services pursuant to Section 13.*
- *MCP must share LHD provider training and/or educational opportunities that MCP is aware of with Network Providers and practitioners.*
- *LHD must provide to the LHD Program Liaison(s) and LHD program providers training and educational materials on MCP's Covered Services, including non-emergency medical transportation ("NEMT") and non-medical transportation ("NMT"), to support LHD program providers in assisting Members with accessing MCP's Covered Services.]*

7. Referrals.

a. **Referral Process**. The Parties must work collaboratively to develop policies and procedures that ensure Members are referred to the appropriate LHD program.

i. The Parties must facilitate referrals to the relevant LHD program for Members who may potentially meet the criteria of the LHD program and must ensure the LHD program has procedures for accepting referrals from MCP or responding to referrals where LHD programs cannot accept additional Members. Where applicable, such decisions should be made through a patient-centered, shared decision-making process. LHD should facilitate MCP referrals to LHD services or programs by assisting MCP in identifying the appropriate LHD program and/or should provide referral assistance when it is required.

ii. MCP must refer Members to LHD for direct service programs as appropriate including, without limitation, those set forth in Section 13.

iii. LHD should refer Members to MCP for any Community Supports services or additional care management programs for which they may qualify, such as Enhanced Care Management ("ECM") or Complex Case Management ("CCM"). However, if LHD is an ECM Provider pursuant to a separate agreement between MCP and LHD for ECM services, this MOU does not govern LHD's provision of ECM services.

iv. LHD should refer Members to MCP for Covered Services.

[The Parties may agree to additional requirements such as:

***Closed Loop Referrals.** By January 1, 2025, the Parties must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the*

CalAIM Population Health Management Policy Guide,[1] DHCS All-Plan Letter ("APL") 22-024 or any subsequent version of the APL, and as set forth by DHCS through an APL or other similar guidance. The Parties must work collaboratively to develop and implement a process to ensure that MCP and LHD comply with the applicable provisions of closed loop referrals guidance within 90 Working Days of issuance. The Parties must establish a system that tracks cross-system referrals and meets all requirements set forth by DHCS through an APL or other, similar guidance.]

8. **Care Coordination and Collaboration.**
    a. **Care Coordination.**
        i. The Parties must adopt policies and procedures for coordinating Members' access to care and services that incorporate all the specific requirements set forth in this MOU, including those in the Program Exhibits.
        ii. The Parties must discuss and address individual care coordination issues or barriers to care coordination efforts at least quarterly.
        iii. MCP must have policies and procedures in place to maintain collaboration with LHD and to identify strategies to monitor and assess the effectiveness of this MOU.

9. **Blood Lead Screening/Follow-up Testing and Lead Case Management.**
    a. **Blood Lead Screening and Follow-up Testing.**
        i. MCP must cover and ensure the provision of blood lead screenings and Medically Necessary follow up testing as indicated for Members at ages one (1) and two (2) in accordance with Cal. Code Regs. tit. 17 Sections 37000 – 37100, the Medi-Cal Managed Care Contract, and APL 20-016, or any superseding APL.
        ii. MCP must coordinate with its Network Providers to determine whether eligible Members have received blood lead screening and/or any Medically Necessary follow-up blood lead testing. If eligible Members have not received blood lead screening or indicated follow-up testing, MCP must arrange for and ensure each eligible Member receives blood lead screening and any indicated follow-up blood lead testing.
        iii. MCP must identify, at least quarterly, all Members under six years of age with no record of receiving a required blood lead screening and/or Medically Necessary follow-up blood lead tests in accordance with CDPH requirements[2] and must notify the Network Provider or other responsible provider of the requirement to screen and/or test Members in accordance with requirements set forth in the Medi-Cal Managed Care Contract.

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[1] CalAIM Population Health Management Policy Guide available at: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf

[2] For more information see CDPH Childhood Lead Poisoning Prevention Branch, *Standard of Care on Screening for Childhood Lead Poisoning*, available at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/screen_regs_3.aspx

iv. MCP must ensure that its Network Providers, including laboratories analyzing for blood lead, report instances of elevated blood lead levels as required by Cal. Health & Safety Code Section 124130.

v. To the extent LHD, in the administration of a program or service is made aware that the child enrolled in MCP has not had a blood lead screening and to the extent that LHD resources allow, LHD will notify MCP of the need for the child to be screened.

vi. If the Member refuses the blood lead screening test, MCP must comply with the requirements set forth in the Medi-Cal Managed Care Contract to ensure a statement of voluntary refusal by the Member (if an emancipated minor) or the parent(s) or guardian(s) of the Member is documented in the Member's Medical Record.

b. **Case Management for Elevated Blood Lead Levels**

i. Where case management for elevated blood lead levels is provided by the Childhood Lead Poisoning Prevention Branch ("CLPPB") and administered by Care Management Section staff at CDPH, MCP must coordinate directly with the CLPPB to address barriers to care coordination, case management, or other matters related to services for children with elevated blood lead levels.

ii. Where case management for elevated blood lead levels is provided by LHD as a contracted entity with the CDPH CLPPB, and to the extent LHD resources allow, MCP must coordinate with the LHD Program Liaison, as necessary and applicable, to address barriers to care coordination, case management, or other matters related to services for children with elevated blood lead levels.

10. Quarterly Meetings.

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU, but not less frequently than quarterly in order to address care coordination, Quality Improvement ("QI") activities, QI outcomes, systemic and case-specific concerns, and communication with others within their organizations about such activities. *[The Parties may agree to meet more frequently.]* These meetings may be conducted virtually.

i. Within 30 Working Days after each quarterly meeting, MCP must post on its website the date and time the quarterly meeting occurred and, as applicable, distribute to meeting participants a summary of any follow-up action items or changes to processes that are necessary to fulfill MCP's obligations under the Medi-Cal Managed Care Contract and this MOU.

ii. MCP must invite the LHD Responsible Person, LHD Program Liaison(s), and LHD executives, to participate in MCP quarterly meetings to ensure appropriate committee representation, including a local presence, and to discuss and address care coordination and MOU-related issues. Subcontractors and Downstream Subcontractors, as well as other LHD program staff should be permitted to participate in these meetings, as appropriate.

iii. MCP must report to DHCS updates from quarterly meetings in a manner and at a frequency specified by DHCS.

b. **Local Representation.** MCP, represented by the MCP-LHD Liaison, must participate, as appropriate, at meetings or engagements to which MCP is invited by LHD, such as local county meetings, local community forums, and LHD engagements, to collaborate with LHD in equity strategy and wellness and prevention activities.

11. Quality Improvement. The Parties must develop QI activities specifically for the oversight of the requirements of this MOU, including, without limitation any applicable performance measures and QI initiatives, including those to prevent duplication of services, as well as reports that track referrals, Member engagement, and service utilization. MCP must document these QI activities in policies and procedures.

[The Parties may agree to additional requirements, such as a requirement that the Parties must adopt joint policies and procedures establishing and addressing QI activities for coordinating the care and delivery of services for Members.]

12. Population Needs Assessment ("PNA"). MCP will meet the PNA requirements by demonstrating meaningful participation in LHD's Community Health Assessments and Community Health Improvement Plans processes in the service area(s) where MCP operates.[3] MCP must coordinate with LHD to develop a process to implement DHCS guidance regarding the PNA requirements once issued. MCP must work collaboratively with LHD to develop and implement a process to ensure that MCP and LHD comply with the applicable provisions of the PNA guidance within 90 days of issuance.

13. Non-Contracted LHD Services. If LHD does not have a separate Network Provider Agreement with MCP and provides any of the following services as an out-of-network provider:

a. sexually transmitted infection ("STI") screening, assessment, and/or treatment;
b. family planning services;
c. immunizations; and
d. HIV testing and counseling

MCP must reimburse LHD for these services at no less than the Medi-Cal Fee-For-Service ("FFS") rate as required by the Medi-Cal Managed Care Contract and as described in Exhibit C of this MOU.

14. Data Sharing and Confidentiality. The Parties must implement policies and procedures to ensure that the minimum necessary Member information and data for accomplishing the goals of this MOU are exchanged timely, maintained securely and

[3] CalAIM: Population Health Management Policy Guide (updated August 2023), available at: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide-August-Update081723.pdf

confidentially, and in compliance with the requirements set forth below. The Parties must share information in compliance with applicable law, which may include the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA"), 42 Code of Federal Regulations Part 2, and other State and federal privacy laws.

a. **Data Exchange.** MCP must, and LHD is encouraged to, share the minimum necessary data and information to facilitate referrals and coordinate care under this MOU. The Parties must have policies and procedures for supporting the timely and frequent exchange of Member information and data, which may include Member demographic, behavioral, dental and physical health information, diagnoses, progress notes, assessments, medications prescribed, laboratory results, and known changes in condition that may adversely impact the Member's health and/or welfare and that are relevant to the services provided or arranged for by LHD; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining Member consent. The minimum necessary information and data elements to be shared as agreed upon by the Parties are set forth in Exhibit G of this MOU. The Parties must annually review and, if appropriate, update Exhibit G to facilitate sharing of information and data.

i. MCP must, and LHD is encouraged to, share information necessary to facilitate referrals as described in Section 7 and further set forth in the Program Exhibits. The data elements to be shared must be agreed upon jointly by the Parties, reviewed annually, and set forth in this MOU.

ii. Upon request, MCP must provide the immunization status of the Members to LHD pursuant to the Medi-Cal Managed Care Contract and as may be described in Exhibit G.

b. **Interoperability.** MCP must make available to Members their electronic health information held by MCP pursuant to 42 Code of Federal Regulation Section 438.10 and in accordance with APL 22-026. MCP must make available an application program interface that makes complete and accurate Network Provider directory information available through a public-facing digital endpoint on MCP's website pursuant to 42 Code of Federal Regulation Sections 438.242(b) and 438.10(h).

[The Parties may agree to additional requirements such as:

***Disaster and Emergency Preparedness.** The Parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the Parties' health care delivery system to ensure the continued coordination and delivery of LHD programs and services and MCP's Covered Services for impacted Members.]*

15. Dispute Resolution.

a. The Parties must agree to dispute resolution procedures such that in the event of any dispute, difference of opinion regarding the Party responsible for service

coverage arising out of or relating to this MOU, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. MCP must, and LHD should, document the agreed-upon dispute resolution procedures in policies and procedures. Pending resolution of any such dispute, MCP and LHD must continue without delay to carry out all their responsibilities under this MOU, including providing Members with access to services under this MOU, unless this MOU is terminated. If the dispute cannot be resolved within [*suggested:* 15 Working Days] of initiating such dispute or such other period as may be mutually agreed to by the Parties in writing, either Party may pursue its available legal and equitable remedies under California law.

b. Disputes between MCP and LHD that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP to DHCS and may be forwarded by LHD to DHCS. Until the dispute is resolved, the Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided.

c. Nothing in this MOU or provision constitutes a waiver of any of the government claim filing requirements set forth in Title I, Division 3.6, of the California Government Code or as otherwise set forth in local, State, or federal law.

16. **Equal Treatment**. Nothing in this MOU is intended to benefit or prioritize Members over persons served by LHD who are not Members. Pursuant to Title VI, 42 United States Code Section 2000d, et seq., LHD cannot provide any service, financial aid, or other benefit to an individual that is different, or is provided in a different manner, from that provided to others by LHD.

17. **General.**

a. **MOU Posting.** MCP must post this executed MOU on its website.

b. **Documentation Requirements.** MCP must retain all documents demonstrating compliance with this MOU for at least 10 years as required by the Medi-Cal Managed Care Contract. If DHCS requests a review of any existing MOU, MCP must submit the requested MOU to DHCS within 10 Working Days of receipt of the request.

c. **Notice.** Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by in-person delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail, certified, return receipt requested, postage prepaid, are deemed given on the date of delivery indicated on the return receipt. The Parties may change their addresses for

purposes of receiving notice hereunder by giving notice of such change to each other in the manner provided for herein.

d. **Delegation.** MCP may delegate its obligations under this MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor as permitted under the Medi-Cal Managed Care Contract, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a Party to this MOU. Further, the Parties may enter into Subcontractor Agreements or Downstream Subcontractor Agreements that relate directly or indirectly to the performance of MCP's obligations under this MOU. Other than in these circumstances, MCP cannot delegate the obligations and duties contained in this MOU.

e. **Annual Review.** MCP must conduct an annual review of this MOU to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. MCP must provide DHCS evidence of the annual review of this MOU as well as copies of any MOU modified or renewed as a result.

f. **Amendment.** This MOU may only be amended or modified by the Parties through a writing executed by the Parties. However, this MOU is deemed automatically amended or modified to incorporate any provisions amended or modified in the Medi-Cal Managed Care Contract, or as required by applicable law or any applicable guidance issued by a State or federal oversight entity.

g. **Governance.** This MOU is governed by and construed in accordance with the laws of the State of California.

h. **Independent Contractors.** No provision of this MOU is intended to create, nor is any provision deemed or construed to create any relationship between LHD and MCP other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this MOU. Neither LHD nor MCP, nor any of their respective contractors, employees, agents, or representatives, is construed to be the contractor, employee, agent, or representative of the other.

i. **Counterpart Execution.** This MOU may be executed in counterparts, signed electronically and sent via PDF, each of which is deemed an original, but all of which, when taken together, constitute one and the same instrument.

j. **Superseding MOU.** This MOU constitutes the final and entire agreement between the Parties and supersedes any and all prior oral or written agreements, negotiations, or understandings between the Parties that conflict with the provisions set forth in this MOU. It is expressly understood and agreed that any prior written or oral agreement between the Parties pertaining to the subject matter herein is hereby terminated by mutual agreement of the Parties.

(Remainder of this page intentionally left blank)

The Parties represent that they have authority to enter into this MOU on behalf of their respective entities and have executed this MOU as of the Effective Date.

MCP CEO or Responsible Person

Signature:
Name:
Title:
Notice Address:

LHD Director or Responsible Person

Signature:
Name:
Title:
Notice Address:

[Subcontractor or Downstream Subcontractor]

Signature:
Name:
Title:
Notice Address:

[MCP, if multiple MCPs in County]

Signature:
Name:
Title:
Notice Address:

Exhibits A and B.

[Placeholder for Exhibits to contain MCP and LHD Program Liaisons as referenced in Sections 4.b and 5.b of this MOU]

Programs (e.g., California Children's Services)	Designated MCP Liaison	Designated LHD Program Liaison(s)

[Notation: The Parties should each list their designated Responsible Person(s) and liaison(s) by name and contact information in this Exhibit. For example, if LHD has different persons designated to act as the liaison for CCS and Blood Lead Screening, each should be listed in this Exhibit by name, contact information, and designated role.]

Exhibit C. Non-Contracted LHD Services.

This Exhibit C governs LHD's provision of any of the services listed below only to the extent that such services are provided by LHD as a non-contracted Provider of MCP Covered Services. If LHD has a Network Provider Agreement with MCP pursuant to which any of these services are covered, such Network Provider Agreement governs.

a. Immunizations. MCP is responsible for providing all immunizations to Members recommended by the Centers for Disease Control and Prevention ("CDC") Advisory Committee on Immunization Practices ("ACIP") and Bright Futures/American Academy of Pediatrics ("AAP") pursuant to the Medi-Cal Managed Care Contract and must allow Members to access immunizations through LHD regardless of whether LHD is in MCP's provider network, and MCP must not require prior authorization for immunizations from LHD.

i. MCP must reimburse LHD for immunization services provided under this MOU at no less than the Medi-Cal FFS rate.

ii. MCP must reimburse LHD for the administration fee for immunizations given to Members who are not already immunized as of the date of immunization, in accordance with the terms set forth in APL 18-004.

b. Sexually Transmitted Infections ("STI") Services, Family Planning, and HIV Testing and Counseling. MCP must ensure Members have access to STI testing and treatment, family planning, and HIV testing and counseling services, including access through LHD pursuant to 42 United States Code Sections 1396a(a)(23) and 1396n(b) and 42 Code of Federal Regulations Section 431.51.

i. MCP must not require prior authorization or referral for Members to access STI, family planning or HIV testing services.

ii. MCP must reimburse LHD for STI services under this MOU at a rate no less than the Medi-Cal FFS rate for the diagnosis and treatment of an STI episode, as defined in Policy Letter No. 96-09.

iii. MCP must reimburse LHD for family planning services at a rate no less than the appropriate Medi-Cal FFS rate for services listed in Medi-Cal Managed Care Contract (Specific Requirements for Access to Program and Covered Services), provided to Members of childbearing age to temporarily or permanently prevent or delay pregnancy.

iv. If LHD provides HIV testing and counseling services to Members, MCP, in accordance with the Medi-Cal Managed Care Contract and federal law, including, but not limited to, 42 U.S.C. §§ 1396a(a)(23) and 1396n(b) and 42 Code of Federal Regulations Section 431.51, must reimburse LHD at a rate no less than the Medi-Cal FFS rate for such services as defined in PL § 96-09.

c. Reimbursement. MCP must reimburse the aforementioned STI testing and treatment, family planning, and HIV testing and counseling services only if LHD submits to MCP the appropriate billing information and either treatment records or documentation of a Member's refusal to release medical records to MCP.

Exhibit D. Tuberculosis ("TB") Screening, Diagnosis, Treatment, and Care Coordination.

1. **Parties' Obligations.**

a. MCP must ensure access to care for latent tuberculosis infection ("LTBI") and active TB disease and coordination with LHD TB Control Programs for Members with active tuberculosis disease, as specified below.

b. MCP must arrange for and coordinate outpatient diagnostic and treatment services to all Members with suspected or active TB disease to minimize delays in initiating isolation and treatment of infectious patients. These outpatient services include physical examination, drug therapy, laboratory testing, and radiology.

c. MCP must consult with LHD to assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-TB drug therapy, in accordance with the Medi-Cal Managed Care Contract.

2. **Care Coordination.**

a. **LTBI Testing and Treatment.**

i. **TB Risk Assessment.** MCP must provide screening through Network Providers for LTBI in all Members with risk factors for TB infection as recommended by the U.S. Preventive Services Task Force ("USPSTF") and the AAP.[4] The CDPH TB Risk Assessment Tools[5] should be used to identify adult and pediatric patients at risk for TB.

ii. **TB Testing.** MCP should encourage Network Providers to offer TB testing to Members who are identified with risk factors for TB infection and should recommend the Interferon Gamma Release Assay ("IGRA") blood test for Members when screening for LTBI in order to comply with current standards outlined by the CDC, CDPH, the California TB Controllers Association,[6] and/or the American Thoracic Society ("ATS")[7] for conducting TB screening.

iii. **Other Diagnostic Testing and Treatment.** MCP must arrange for and coordinate outpatient diagnostic and treatment services to all Members with LTBI. These outpatient services include physical examination, drug therapy, laboratory testing, and radiology.

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[4] AAP, Red Book Report of the Committee on Infectious Diseases, 32nd Ed., available at: https://publications.aap.org/redbook/book/347/chapter/5748923/Introduction

[5] CDPH, TB Risk Assessment Tools, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Risk-Assessment.aspx

[6] California Tuberculosis Controllers Association ("CTCA"), Latent Tuberculosis Infection Guidance for Preventing Tuberculosis in California, available at: https://ctca.org/guidelines/guidelines-latent-tuberculosis-infection-guideline/

[7] ATS/Infectious Diseases Society of America/CDC Clinical Practice Guidelines: Diagnosis of Tuberculosis in Adults and Children, available at: https://www.thoracic.org/statements/resources/tb-opi/diagnosis-of-tuberculosis-in-adults-and-children.PDF

iv. **LTBI Treatment.** MCP should instruct Network Providers to ensure Members have access to LTBI treatment in accordance with the updated 2023 USPSTF Recommendation[8] and CDC LTBI Treatment Guidelines[9], which recommend treating individuals diagnosed with LTBI.

b. **Reporting of Known or Suspected Active TB Cases.**

i. MCP must require Network Providers to report to LHD by electronic transmission, phone, fax, and/or the Confidential Morbidity Report[10] known or suspected cases of active TB disease for any Member residing within *[LHD/covered service area]* within one day of identification in accordance with Cal. Code Regs. tit. 17 Section 2500.

ii. MCP must obtain LHD's Health Officer (or designee's) approval in the jurisdiction where the hospital is located, prior to hospital discharge or transfer of any patients with known or suspected active TB disease.[11]

c. **Active TB Disease Testing and Treatment.**

i. MCP is encouraged to ensure Members are referred to specialists with TB experience (e.g., infectious disease specialist, pulmonologist) or to LHD's TB clinic, when needed or applicable.

ii. **Treatment Monitoring**. MCP must provide Medically Necessary Covered Services to Members with TB, such as treatment monitoring, physical examinations, radiology, laboratory, and management of drug adverse events, including but not limited to the following:

1. Requiring Network Providers to obtain at least monthly sputum smears and cultures for acid-fast bacillus until there is a documented conversion to negative culture and referring patients unable to spontaneously produce sputum specimens to sputum induction or BAL, as needed.
2. Promptly submitting initial and updated treatment plans to LHD at least every three months until treatment is completed.
3. Reporting to LHD when the patient does not respond to treatment or misses an appointment.
4. Promptly reporting drug susceptibility results to LHD and ensuring access to rapid molecular identification and drug resistance testing during diagnosis and treatment as recommended by LHD.

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[8] US Preventive Services Task Force, Screening for Latent Tuberculosis Infection in Adults (May 2, 2023): https://jamanetwork.com/journals/jama/fullarticle/2804319?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jama.2023.3954

[9] CTCA, Latent Tuberculosis Infection Guidance for Preventing Tuberculosis in California, available at: https://ctca.org/guidelines/guidelines-latent-tuberculosis-infection-guideline/.

[10] CDPH, TB Confidential Morbidity Report, available at: https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph110b.pdf.

[11] Cal. Health & Safety Code Sections 121365 and 121367 grant local health officers with the authority to issue any orders deemed necessary to protect the public health which may include authorizing the removal to, detention in, or admission into, a health facility or other treatment facility.

iii. Treatment.

1. LHD and MCP must coordinate the provision of medication prescriptions for each Member to fill at an MCP-approved pharmacy.

2. LHD should coordinate the provision of TB treatment and related services, including for the provision of a treatment plan, with the Member's primary care physician ("PCP") or other assigned clinical services provider.

3. LHD and MCP will coordinate the inpatient admission of Members being treated by LHD for TB.

iv. Case Management.

1. LHD is encouraged to refer Members to MCP for ECM and Community Supports when LHD assesses the Member and identifies a need. MCP is encouraged to require its Network Providers to refer all Members with suspected or active TB disease, to the LHD Health Officer (or designee) for Directly Observed Therapy ("DOT") evaluation and services.

2. MCP must continue to provide all Medically Necessary Covered Services to Members with TB receiving DOT.

3. MCP must assess Members with the following conditions or characteristics for potential noncompliance and for consideration for DOT: substance users, persons with mental illness; the elderly, child, and adolescent Members; persons with unmet housing needs; persons with complex medical needs (e.g., end-stage renal disease, diabetes mellitus); and persons with language and/or cultural barriers. If a Member's Network Provider believes that a Member with one or more of these risk factors is at risk for noncompliance, MCP must refer the Member to LHD for DOT.

4. LHD is responsible for assigning a TB case manager to notify the Member's PCP of suspected and active TB cases, and the TB case manager must be the primary LHD contact for coordination of care with the PCP or a TB specialist, whomever is managing the Member's treatment.

5. MCP should provide LHD with the contact information for the MCP-LHD Liaison to assist with coordination between the Network Provider and LHD for each diagnosed TB patient, as necessary.

6. LHD is responsible for assigning a TB case manager to notify the designated Network Provider of suspected and active cases, and the TB case manager must be the primary LHD contact for coordination of care with Network Providers.

d. **Case and Contact Investigations.**

i. As required by Cal. Health & Safety Code Sections 121362 and 121363, MCP must ensure that Network Providers share with LHD any testing, evaluation, and treatment information related to LHD's contact and/or outbreak investigations. The Parties must cooperate in conducting contact and outbreak investigations.

ii. LHD is responsible for conducting contact investigation activities for all persons with suspected or confirmed active TB in accordance with Cal. Health &

Safety Code Sections 121363 and 121365 and CDPH/CTCA contact investigations guidelines,[12] including:

1. Identifying and ensuring recommended testing, examination, and other follow-up investigation activities for contacts with suspected or confirmed active cases;
2. Communicating with MCP's Network Providers about guidance for examination of contacts and chemoprophylaxis; and
3. Working with Network Providers to ensure completion of TB evaluation and treatment.

iii. MCP is responsible for ensuring its Network Providers cooperate with LHD in the conduct of contact investigations,[13] including:

1. Providing medical records as requested and specified within the time frame requested;
2. Ensuring that its case management staff will be available to facilitate or coordinate investigation activities on behalf of MCP and its Network Providers, including requiring its Network Providers to provide appropriate examination of Members identified by LHD as contacts within seven days;
3. Ensuring Member access to LTBI testing and treatment and following LTBI Treatment Guidelines published by the CDC.[14]
4. Requiring that its Network Providers to provide the examination results to LHD within one day for positive TB results, including:

(a) Results of IGRA or tuberculin tests conducted by Network Providers;

(b) Radiographic imaging or other diagnostic testing, if performed; and

(c) Assessment and diagnostic/treatment plans, following evaluation by the Network Provider.

3. **Quality Assurance and Quality Improvement.** MCP must consult regularly with LHD to develop outcome and process measures for care coordination as required by this Exhibit D for the purpose of measurable and reasonable quality assurance and improvement.

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[12] CDPH/CTCA Guidelines for the Assessment of Tuberculosis Patient Infectiousness and Placement into High and Lower Risk Settings, available at: https://ctca.org/wp-content/uploads/2018/11/ctcaciguidelines117_2.pdf; CDPH TB Control Branch, Resources for Local Health Departments, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Resources-for-LHDs.aspx

[13] Cal. Health & Safety Code Section 121350-121460 (standards for tuberculosis control).

[14] CDC, Latent Tuberculosis Infection Resources, available at: https://www.cdc.gov/tb/publications/ltbi/ltbiresources.htm

Exhibit E. Maternal Child and Adolescent Health.

This Exhibit E governs the coordination between LHD Maternal, Child and Adolescent Health Programs ("MCAH Programs") and MCP for the delivery of care and services to Members who reside in LHD's service area and may be eligible for one or more MCAH Program to the extent such programs are offered by LHD. These MCAH programs include, but are not limited to, the Black Infant Health Program, the Adolescent Family Life Program, the California Home Visiting Program, and/or the Children and Youth with Special Health Care Needs Program.

1. **Parties' Obligations.**

a. Per service coverage requirements under Medi-Cal for Kids and Teens, previously known as Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT"),[15] MCP must ensure the provision of all screening, preventive, and Medically Necessary diagnostic and treatment services for Members under 21 years of age.

b. The MCP Responsible Person serves, or may designate a person at MCP to serve, as the day-to-day liaison with LHD specifically for MCAH Programs (e.g., the MCP-MCAH Liaison); the MCP-MCAH Liaison is listed in Exhibit A (the designated person may be the same as the MCP-LHD Liaison). MCP must notify LHD of any changes to the MCP-MCAH Liaison in accordance with Section 4 of this MOU.

c. To the extent that programs are offered by LHD and to the extent LHD resources allow, LHD must administer MCAH Programs, funded by CDPH, in accordance with CDPH guidance set forth in the Local MCAH Programs Policies and Procedures manual[16] and other guidance documents.

d. The LHD Responsible Person may also designate a person to serve as the day-to-day liaison with MCP specifically for one or more MCAH Programs (e.g., LHD Program Liaison(s)); the LHD Program Liaison(s) is listed in Exhibit B. LHD must notify MCP of changes to the LHD Program Liaison in accordance with Section 5 of this MOU.

2. **Referrals to, and Eligibility for and Enrollment in, MCAH Programs.**

a. MCP must coordinate, as necessary, with the Network Provider, Member, and MCAH Program to ensure that the MCAH Program receives any necessary information or documentation to assist the MCAH Program with performing an eligibility assessment or enrolling a Member in an MCAH Program.

b. MCP must collaborate with LHD to update referral processes and policies designed to address barriers and concerns related to referrals to and from MCAH Programs.

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[15] Additional guidance available in APL 23-005: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf

[16] CDPH, Local MCAH Programs Policies and Procedures (updated May 2023), available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/LocalMCAH/CDPH%20Document%20Library/MCAH-Policies-and-Procedures.pdf

c. LHD is responsible for providing MCP with information regarding how MCP and its Network Providers can refer to an MCAH Program, including, as applicable, referral forms, links, fax numbers, email addresses, and other means of making and sending referrals to MCAH Programs. LHD is responsible for working with MCP, as necessary, to revise referral processes and to address barriers and concerns related to referrals to MCAH Programs.[17]

d. LHD is responsible for the timely enrollment of, and follow-up with, Members eligible for MCAH Programs in accordance with MCAH Programs' enrollment practices and procedures and to the extent LHD resources allow. LHD must assess Member's eligibility for MCAH Programs *[and/or enrolling Members, as applicable in MCAH Programs]* within [*insert #*] Working Days of receiving a referral. *[LHD should provide a definitive time period. If the definitive time period differs per MCAH Program, LHD should include the time period for each program.]*

e. LHD is responsible for coordinating with MCAH Programs to conduct the necessary screening and assessments to determine Members' eligibility for and the availability of one or more MCAH Programs and coordinate with MCP and/or its Network Providers as necessary to enroll Members.[18]

f. LHD MCAH Programs are not entitlement programs and may deny or delay enrollment if programs are at capacity.

3. Care Coordination and Collaboration.

a. MCP and LHD must coordinate to ensure Members receiving services through MCAH Programs have access to prevention and wellness information and services. LHD is encouraged to assist Members with accessing prevention and wellness services covered by MCP, by sharing resources and information to with Members about services for which they are eligible, to address needs identified by MCAH Programs' assessments.

b. MCP must screen Members for eligibility for care management programs such as CCM and ECM, and must, as needed, provide care management services for Members enrolled in MCAH Programs, including for comprehensive perinatal services, high-risk pregnancies, and children with special health care needs. MCP must engage LHD, as needed, for care management and care coordination.

c. MCP should collaborate with MCAH Programs on perinatal provider technical support and communication regarding perinatal issues and service delivery and to monitor the quality of care coordination.

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[17] CDPH, Local MCAH Programs Policies and Procedures, available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/LocalMCAH/CDPH%20Document%20Library/MCAH-Policies-and-Procedures.pdf

[18] CDPH, Local MCAH Programs Policies and Procedures, available at https://www.cdph.ca.gov/Programs/CFH/DMCAH/LocalMCAH/CDPH%20Document%20Library/MCAH-Policies-and-Procedures.pdf

4. **Coordination of Medi-Cal for Kids and Teens (formerly EPSDT) Services**.[19]

i. Where MCP and LHD have overlapping responsibilities to provide services to Members under 21 years of age, MCPs must do the following:

1. Assess the Member's need for Medically Necessary EPSDT services, including mental, behavioral, social, and/or developmental services, utilizing the AAP Periodicity Table[20] and the CDC's ACIP child vaccination schedule[21], the required needs assessment tools.

2. Determine what types of services (if any) are being provided by MCAH Programs, or other third-party programs or services.

3. Coordinate the provision of services with the MCAH Programs to ensure that MCP and LHD are not providing duplicative services and that the Member is receiving all Medically Necessary EPSDT services within 60 calendar days following the preventive screening or other visit identifying a need for treatment regardless of whether the services are Covered Services under the Medi-Cal Managed Care Contract.

5. **Quarterly Meetings.**

a. MCP must invite the LHD Responsible Person and LHD Program Liaison(s) for MCAH Programs to participate in MCP quarterly meetings as needed to ensure appropriate committee representation, including a local presence, and in order to discuss and address care coordination and MOU-related issues. Other MCAH Program representatives may be permitted to participate in quarterly meetings.

b. MCP must participate, as appropriate, in meetings or engagements to which MCP is invited by LHD, such as local county meetings, local community forums, and county engagements, to collaborate with LHD for MCAH Programs on equity strategy and prevention activities.

[The Parties may agree to additional requirements, such as that MCP and LHD may collaborate to collect feedback from Members in MCAH Programs on topics of interest to Parties through surveys, focus groups, or other agreed-upon methods, and in accordance with this MOU.]

6. **Quality Improvement.** MCP and LHD must ensure issues related to MCAH Program coordination and collaboration are included when addressing barriers to carrying out the obligations under this MOU.

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[19] Additional guidance available in APL 23-005: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf

[20] AAP Periodicity Table available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

[21] CDC ACIP Child Vaccination Schedule available at: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html

7. Data Information and Exchange.

[The Parties may agree to additional requirements such as:

- *MCP and LHD must exchange data and Member enrollment information in MCAH Programs and Member information related to prevention, wellness, and home visiting activities, or services designed to minimize health disparities, to ensure Members are receiving all Medically Necessary services.*
- *LHD will seek authorization from MCAH Program participants eligible to enroll in MCP services or programs such as ECM or Community Supports so LHD can provide MCP with participants' information regarding their needs for MCP Covered Services.]*

Exhibit F. California Children's Services.

This Exhibit F governs LHD's provision of the California Children's Services ("CCS") Program only to the extent that such services are provided by LHD. MCP and LHD will collaborate to coordinate care, conduct administrative activities, and exchange information required for the effective and seamless delivery of services to MCP's Members enrolled, or eligible to enroll, in the CCS Program. This Exhibit F does not apply to an LHD or MCP that operates the Whole Child Model ("WCM").

This Exhibit delineates the roles and responsibilities of MCP and LHD for coordinating care and ensuring the non-duplication of services for Members eligible for or enrolled in the CCS Program.

[This Exhibit includes in brackets provisions to be included for Dependent Counties – those with total populations under 200,000 persons that may administer the CCS Program independently or jointly with DHCS pursuant to Cal. Health & Safety Code Section 123850(a) – that set forth additional roles and responsibilities in such counties.]

1. **Party Obligations.**
    a. **MCP Obligations.**
        i. MCP must ensure all Medically Necessary Covered Services related to the CCS condition are provided until a determination of CCS Program eligibility is made. MCP must continue to provide all Medically Necessary Covered Services to the Member if the CCS Program determines the referred Member is not eligible for the CCS Program and for services not provided through the CCS Program.
        ii. MCP must provide all Medically Necessary Covered Services not authorized by the CCS Program for CCS-enrolled Members, including, without limitation, Medi-Cal for Kids and Teens (previously known as EPSDT) services, pediatric preventive services, and immunizations unless determined to be medically contraindicated in accordance with the Medi-Cal Managed Care Contract and APL 23-005.
        iii. It is MCP's responsibility to provide case management (arranging PDN hours) in accordance with APL 20-012 and any superseding APL or other, similar guidance.
        iv. MCP must provide to the CCS Program, in a timely manner, all medical utilization and other clinical data necessary for the CCS Program to complete annual medical determinations and redeterminations, as well as other medical determinations, as needed, for CCS-eligible Members.
    b. **LHD Obligations.**
        i. LHD must ensure that its CCS Program authorizes and provides medical case management services for the medical conditions outlined and authorized

in Cal. Code Regs. tit. 22 Sections 41410-41518.9 for Members who have CCS-covered conditions (referred to as "CCS-Eligible Condition(s)").[22]

ii. LHD is responsible for making all CCS Program medical, financial, and residential eligibility determinations for potential CCS-eligible Members, including responding to and tracking appeals relating to CCS Program eligibility determinations and annual redeterminations.

[**Replace 1.b.ii with the following for Dependent Counties:** DHCS is responsible for CCS Program medical eligibility determinations and redeterminations, and LHD's CCS Program is responsible for financial and residential eligibility determinations and redeterminations for potential CCS-eligible Members. Such medical eligibility determinations and redeterminations include eligibility determinations for (i) Medical Therapy Program ("MTP") services; (ii) High-Risk Infant Follow-up ("HRIF") Program services; and (iii) organ transplants and related services. DHCS may utilize the information shared by MCP to conduct medical determinations and redeterminations to determine the Member's eligibility for the CCS Program. To the extent that DHCS is responsible for conducting the eligibility determinations on behalf of the CCS Program in the dependent county, if DHCS determines a Member is eligible for CCS Program services, it will notify the CCS Program of such eligibility at which point LHD must ensure the CCS Program coordinates the Member's care and case management with MCP.]

2. Training and Education.

a. The training and education that MCP is required to provide under Section 6 of this MOU must include information about LHD's CCS Program, how to refer Members to the CCS Program, and how to assist Members with accessing CCS Program services.

b. The training MCP is required to provide under Section 6 of this MOU must include:

i. Instructions on how to complete the appropriate baseline health assessments and diagnostic evaluations, which provide sufficient clinical detail to establish or raise a reasonable suspicion that a Member has a CCS-Eligible Condition;

ii. Instructions on how to refer Members with a suspected CCS-Eligible Condition on the same day the evaluation is completed, using methods accepted by LHD (the initial referral must be followed by the submission of supporting medical documentation sufficient to allow for CCS Program eligibility determination by LHD);

iii. A statement that the CCS Program reimburses only CCS-paneled providers and CCS-approved hospitals;

[22] Covered conditions and regulations applicable to the CCS Program are described by CCS Numbered Letters ("NL") located on the CCS website, available at: https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

iv. A statement that the Network Provider must continue to provide all Medically Necessary Covered Services to the Member until the Member's CCS Program eligibility is confirmed;

v. Information on how to refer Members in LHD's CCS Program to community resources; and

vi. Information on how the PCP can assist with accessing CCS Program authorized services and can coordinate such services with other services Members may receive.

3. **Referrals and Eligibility Determinations.**

a. MCP Referrals. MCP is responsible for assisting Network Providers with identifying potentially CCS-eligible Members for whom there is diagnostic evidence that such Members have a CCS-Eligible Condition in accordance with Cal. Code Regs. tit. 22 Section 41515.1 and referring such Members to LHD to determine whether the Members are eligible for the CCS Program.

[**Add the following for Dependent Counties:** To the extent applicable in the dependent county, upon referring Members who may be CCS-eligible to the CCS Program, MCP must also submit Members' medical utilization information, clinical data, and any other necessary information, in the manner specified by DHCS, to CCSDirectedReview@dhcs.ca.gov to ensure DHCS has the requisite information to conduct the Member's medical eligibility determination.]

i. MCP must include with its Member referrals documentation of the Member's medical and residential information to enable LHD to make an eligibility determination for the CCS Program.

ii. MCP must refer, or assist Network Providers with referring, to LHD's CCS Program for CCS initial eligibility determinations a Member who:

1. Has a medical diagnosis, records, or history suggesting potential CCS-Eligible Condition(s) as outlined in the CCS medical eligibility regulations;
2. Presents at a hospital emergency room, a provider office, or another health care facility for a non-CCS condition, and for whom the medical evaluation identifies a potential CCS-Eligible Condition(s);
3. Is an infant with a potential CCS-Eligible Condition at the time of discharge from the neonatal intensive care unit (such Member must be assessed for eligibility and, if eligible, referred to the CCS Program's HRIF program); or
4. Has diagnostic evidence that the Member has a condition eligible for Medical Therapy Program services from the CCS Program's Medical Therapy Unit; or
5. May have a newly identified potential CCS-Eligible Condition(s) as determined by a Network Provider.[23]

[23] Additional information about the MTP is available at https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-Whole-Child-Model-Revised.pdf

iii. In accordance with Chapter 1, Section 1.B of the California Children's Services Program Administrative Case Management Manual[24], LHD must ensure that within five calendar days from the receipt of a referral from MCP the CCS Program staff review the information provided and take one of the following actions:

1. Accept the referral as complete as defined in the CCS Program Administrative Case Management Manual Case Management Manual; or
2. Reject the referral as incomplete and forward a transmittal notice to MCP as required by the CCS Program Administrative Case Management Manual Case Management Manual.

b. LHD Eligibility Determination.

i. LHD must determine Members' medical, financial, and residential eligibility, initially and on an annual basis in accordance with Cal. Code Regs. tit. 22 Section 41515.1, for CCS-Eligible Conditions based on evaluation of documentation provided by MCP or by a CCS paneled provider.

[**Replace 3.b.i with the following for Dependent Counties**: LHD is responsible for conducting Members' financial and residential eligibility determinations. DHCS must determine Members' medical eligibility, initially and on an annual basis, for CCS-Eligible Condition(s) based on evaluation of documentation provided by MCP or by a CCS paneled provider. DHCS must notify LHD of Members who meet the medical eligibility criteria and must assist LHD with ensuring such Members are enrolled in its CCS Program.]

ii. LHD must assist its CCS Program with obtaining, and may request from MCP, any additional information required (e.g., medical reports) to determine CCS Program eligibility.

iii. LHD must ensure its CCS Program informs the Member and their family (or designated legal caregiver) of the CCS eligibility determination.

iv. LHD must create and send the Notice of Action ("NOA") to a Member who is determined to be ineligible for or is denied CCS Program services. Each NOA must notify the Member of their ineligibility in accordance with Cal. Code Regs. tit. 22 Sections 42131 and 42132 and must refer the Member back to MCP, which remains responsible for providing the Medically Necessary Covered Services to correct or ameliorate Members' physical conditions and/or mental illnesses. ***[Remove for Dependent Counties and add as a new section:*** *DHCS is responsible for creating a NOA for a Member who is denied services or is determined to be medically ineligible, and LHD is responsible for sending such NOA to a Member evaluated for its CCS Program.]*

[24] CCS Program Administrative Case Management Manual: Chapter One, available at https://www.dhcs.ca.gov/services/ccs/Documents/CCSAdminCaseManManual.pdf

v. If LHD receives a Member referral through an Inter-County Transfer, the CCS Program must complete applicable activities as set forth in the DHCS CCS Inter-county Transfer NL.

c. Enhanced Care Management Referrals.

i. The CCS Program should work with MCP to create a referral pathway for ECM for ECM-eligible Members.

ii. MCP must identify eligible Members for ECM through analysis of CCS Program enrollment and additional data available to MCPs, including utilizing Social Drivers of Health ("SDOH")-related ICD-10 Z-codes and identifying SDOH and high measures on adverse childhood experiences screenings.

iii. In cases where a Member is enrolled in the CCS Program and such CCS Program provider becomes a contracted ECM Provider, MCP must assign that Member to that CCS Program for ECM unless the Member or their parent, designated legal caregiver, or Authorized Representative prefers otherwise.

iv. If LHD's CCS Program is an ECM Provider, LHD's CCS Program must provide ECM services pursuant to that separate agreement between MCP and the CCS Program; this MOU does not govern the CCS Program's provision of ECM services.

4. Care Coordination and Collaboration.

a. Care Coordination.

i. MCP must coordinate with the CCS Program to ensure that Members enrolled in the CCS Program or eligible for CCS Program services receive all Medically Necessary Covered Services required for CCS-Eligible Condition(s) through the CCS Program and receive all Medically Necessary Covered Services that are not related to the CCS-Eligible Condition(s) through MCP.

ii. Until the Member's CCS eligibility is confirmed by the CCS Program **[or for Dependent Counties: DHCS]** and the CCS Program begins providing the Medically Necessary Covered Services for the CCS-Eligible Condition(s), MCP must continue to provide all Medically Necessary Covered Services for the CCS-Eligible Condition(s).

iii. Once the Member is enrolled in the CCS Program, the CCS Program is responsible for the Member's case management and care coordination for the CCS-Eligible Condition(s).

iv. MCP must develop and implement policies and procedures for coordination activities, joint case management, and communication requirements between the Member's PCP, specialty providers, hospitals, CCS providers, and CCS case manager(s).

v. MCP and LHD must have policies and procedures for coordination with LHD's CCS MTP to ensure appropriate access to MTP services and other services provided for the coordination of CCS Program services.

b. CCS HRIF Program. The CCS Program **[or for Dependent Counties: DHCS]** must coordinate and authorize HRIF services for eligible Members and must ensure access to, or arrange for the provision of, HRIF case management services.

c. PDN Case Management Responsibilities. MCP and LHD must coordinate the provision of case management services for Members who are receiving PDN services to ensure that Members receive case management services and that the Parties do not duplicate the services as set forth in APL 20-012, CCS NL 04-0520, and any superseding APL or other, similar guidance.[25]

i. If the CCS Program approves PDN services for CCS-eligible Members under the age of 21, the CCS Program is primarily responsible for providing case management to arrange for all approved PDN service hours to treat the CCS-Eligible Condition. When arranging for the CCS-eligible Members to receive authorized PDN services, the CCS Program must document all efforts to locate and collaborate with PDN service providers and MCP.

ii. If MCP approves PDN services for an eligible Member under the age of 21, MCP is primarily responsible for providing case management to arrange for the PDN service hours.

iii. MCP must, in collaboration with the CCS Program, continue to provide case management to Members receiving PDN authorized by the CCS Program, including, at the Member's request or the request of the Member's Authorized Representative, arranging for all approved PDN services.

d. Transportation Services.

i. CCS Maintenance and Transportation services related to CCS-Eligible Conditions are provided and covered by the CCS Program, as determined by the CCS Program and as resources allow, in accordance with Cal. Health & Safety Code Section 123840(j). MCP must communicate regularly with the CCS Program to ensure Members' needs are continuously met and must arrange for transportation for Members' Medi-Cal for Kids and Teens services when the Members' needs are not met in accordance with APL 22-008.

ii. Emergency Medical Transportation related to the CCS-Eligible Condition is the responsibility of the CCS Program.

iii. MCP must provide NEMT for all Medically Necessary Covered Services and pharmacy services, which may include services provided through the CCS Program, as outlined in the Medi-Cal Managed Care Contract and APL 22-008. MCP must refer and coordinate NEMT for services not covered under the Medi-Cal Managed Care Contract.

iv. **[For Independent Counties only]** MCP and the CCS Program must establish policies and procedures for determining whether NEMT is provided pursuant to a CCS-Eligible Condition(s) and when such services must be paid for by the CCS Program or MCP.

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[25] Additional information for PDN services is available in APL 20-012 at https://www.dhcs.ca.gov/services/Documents/APL-20-012.pdf.

v. If a Member requests NMT, MCP must authorize the NMT if necessary for the Member to obtain Medically Necessary Covered Services.

e. Emergency Services.

i. The CCS Program must coordinate with MCP for Members who need to be transferred to emergency services as set forth in NL10-0806 or any superseding NL, including:

1. Ensuring the CCS Program coordinates with the appropriate MCP-LHD Liaison confirm the suitable provision of emergency services related to trauma;
2. Requiring the CCS Program to notify the MCP-LHD Liaison as soon as possible of the need to transfer a CCS-eligible Member to the appropriate hospital; and
3. In the event families receive bills for services, contacting the provider to request they become a CCS-paneled provider and thus bill the CCS Program rather than the Member.

ii. The CCS Program must notify the MCP-LHD Liaison and DHCS if these efforts do not resolve the problem.

f. Continuity of Care for Transitioning Members.

i. MCP must maintain policies and procedures for identifying CCS-Eligible Members who are aging out of the CCS Program.

ii. MCP must follow the Continuity of Care requirements stated in APL 22-032 or any superseding APL.

iii. MCP must develop a care coordination plan to assist a Member with transitioning out of the CCS Program within 12 months prior to the Member's aging out, including:

1. Identifying the Member's CCS-Eligible Condition(s);
2. Planning for the needs of the Member to transition from the CCS Program;
3. Developing a communication plan with the Member in advance of the transition;
4. Identifying and coordinating primary care and specialty care providers appropriate for the Member's CCS-Eligible Condition(s); and
5. Continuing to assess the Member through the first 12 months after the Member's 21st birthday.

g. Major Organ Transplants.

i. To ensure the appropriate referral and care coordination for CCS-eligible or enrolled Members requiring a Major Organ Transplant ("MOT"), MCP and LHD must comply with guidance set forth in Blood, Tissue, and Solid Organ Transplants NL and APL 21-015 or any superseding NL and APL or other, similar guidance, and MCP must comply with the requirements set forth in the Medi-Cal Managed Care Contract.

ii. MCP will not be required to pay for costs associated with transplants that qualify as a CCS-Eligible Condition if MCP does not participate in the WCM program.

iii. MCP must refer CCS-eligible Members to a CCS-approved Special Care Center for an evaluation within 72 hours of the Member's PCP or specialist identifying the CCS-eligible Member as a potential candidate for a MOT.

iv. If the Member is not eligible for the CCS Program, MCP must authorize a MOT if Medically Necessary.

h. Quarterly Meetings.

i. MCP must invite LHD Responsible Person and the LHD Program Liaison(s) for the CCS Program to attend the quarterly meetings with LHD, to discuss any needed improvements and address barriers to care coordination or referral processes. Other LHD CCS Program representatives may be permitted to participate in quarterly meetings.

ii. The CCS Program must designate a medical director or other designee to actively participate in MCP's quarterly meetings with LHD. The CCS Program medical director or designee must attend meetings and provide feedback and recommendations on clinical issues relating to CCS conditions and treatment authorization guidelines and must serve as a clinical advisor on other clinical issues relating to CCS conditions.

5. Data Information and Exchange.

a. MCP must timely provide the following information to the CCS Program: the necessary documentation, medical records, case notes, medical utilization information, clinical data, and reports to enable the CCS Program to conduct the Member's initial residential and medical eligibility determination for the CCS Program and to provide services to the Member for treatment of their CCS-Eligible Condition.

b. Each of the Parties must notify the other Party upon learning that a Member has lost Medi-Cal eligibility.

Exhibit G.

[The Parties may agree to additional data elements, such as:

a. *MCP and LHD must share the following data elements:*
    i. *Member demographic information;*
    ii. *Behavioral, dental, and physical health information;*
    iii. *Diagnoses, progress notes, and assessments;*
    iv. *Medications prescribed;*
    v. *Laboratory results; and*
    vi. *Known changes in condition that may adversely impact the Member's health and/or welfare and that are relevant to the services.]*

ATTACHMENT B: WIC MEMORANDUM OF UNDERSTANDING TEMPLATE

COVER PAGE

Memorandum of Understanding

between [*Medi-Cal Managed Care Plan*] and [*Agency*] Relating to WIC Services

This Memorandum of Understanding ("MOU") is entered into by [*name of Managed Care Plan*] ("MCP") and [*name of local agency or non-profit entity*], ("Agency"), effective as of [*date*] ("Effective Date"). [*Where MCP has a Subcontractor or Downstream Subcontractor arrangement delegating part or all of the responsibilities related to effectuating this MOU to a Knox-Keene licensed health care service plan(s), this Subcontractor or Downstream Subcontractor must be added as an express party to this MOU and named in this MOU as having the responsibilities set forth herein that are applicable to this Subcontractor or Downstream Subcontractor.*] Agency, MCP, and MCP's relevant Subcontractors and/or Downstream Subcontractors are referred to herein as a "Party" and collectively as "Parties."

WHEREAS, MCP is required under the Medi-Cal Managed Care Contract, Exhibit A, Attachment III, to enter into this MOU, a binding and enforceable contractual agreement, to ensure that Medi-Cal beneficiaries enrolled, or eligible to enroll, in MCP ("Members") are able to access and/or receive services, including Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services, as well as other services that may not be covered by MCP, in a coordinated manner from MCP and Agency; and

WHEREAS, the Parties desire to ensure that Members receive services for which they may be eligible in a coordinated manner and to provide a process to continuously evaluate the quality of care coordination provided; and

WHEREAS, the Parties desire to work together to promote and support local, regional, and statewide efforts to provide food assistance, nutrition education and breastfeeding counseling, and access to health and social services to pregnant individuals, new parents and guardians, persons up to their first birthday (one year of age) ("Infants"), and persons over one year of age and up to their fifth birthday (five years of age) ("Children"); and

WHEREAS, the Parties understand and agree that to the extent that any data exchanged in furtherance of this MOU is protected health information ("PHI") or Personally Identifiable Information ("PII") derived from California Department of Public Health's ("CDPH") management information system for the Special Supplemental Nutrition Program for Women, Infants, and Children ("WIC" or "WIC Program") or otherwise collected, created, maintained, stored, transmitted, or used by Agency pursuant to its local agency agreement with CDPH, Agency must comply with all applicable federal and state statutes and regulations governing confidential information for the WIC Program and any underlying CDPH/WIC agreement terms and conditions that impose restrictions on the access, use, and disclosure of WIC data.

[Notation: This MOU template includes language, notated in italics and bracketed, that the Parties may want to add to this MOU to increase collaboration and communication.

MCP and Agency may also agree to additional provisions, provided that they do not conflict with the requirements of this MOU.]

In consideration of the mutual agreements and promises hereinafter, the Parties agree as follows:

1. Definitions. Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the California Department of Health Care Services ("DHCS"), unless otherwise defined herein. The Medi-Cal Managed Care Contract is available on the DHCS webpage at www.dhcs.ca.gov.

a. "MCP Responsible Person" means the person designated by MCP to oversee MCP coordination and communication with Agency and ensure MCP's compliance with this MOU as described in Section 4 of this MOU.

b. "MCP-Agency Liaison" means MCP's designated point of contact responsible for acting as the liaison between MCP and Agency as described in Section 4 of this MOU. The MCP-Agency Liaison must ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.

c. "Agency Responsible Person" means the person designated by Agency to oversee coordination and communication with MCP and ensure Agency's compliance with this MOU as described in Section 5 of this MOU.

d. "Agency Liaison" means Agency's designated point of contact responsible for acting as the liaison between MCP and Agency as described in Section 5 of this MOU. The Agency Liaison should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the Agency Responsible Person as appropriate.

2. Term. This MOU is in effect as of the Effective Date and continues for a term of *[The Parties may agree to a term of three years or another term as agreed to by MCP and Agency]* or as amended in accordance with Section 14.f of this MOU.

3. Services Covered by This MOU.

a. The WIC Program is authorized by Section 17 of the Child Nutrition Act of 1966, 42 United States Code Section 1786, and administered by CDPH. Agency is a local health department or non-profit organization that, pursuant to a local agency agreement with CDPH, certifies applicant eligibility for the WIC Program and provides WIC Program benefits to participants in Agency's service area.

b. Pursuant to the separate local agency agreement with CDPH, Agency provides WIC Program services to eligible persons in accordance with federal and State statutes and regulations governing the WIC Program ("WIC Services"). (42 United States Code Section § 1786; 7 Code of Federal Regulations Section 246; Health & Saf. Code § 123275 et seq.; Cal. Code Regs., tit. 22, Section 40601 et seq.) WIC Services

include supplemental nutrition assistance, nutrition education, and referrals to or information regarding other health-related or public assistance programs. (See 7 Code of Federal Regulations Sections 246.1, 246.7(b), 246.10, 246.11.)

c. Nothing in this MOU is intended to supersede, or conflict with, Agency's agreement with CDPH or CDPH's oversight authority over Agency's provision of WIC Services and the requirements applicable thereto. Should any conflict arise, the terms of Agency's agreement with CDPH will control.

d. This MOU governs to the coordination between Agency and MCP relating to the provision and delivery of Covered Services and WIC Services to Members.

e. As set forth in federal law, "WIC Participants" are pregnant women, women up to one year postpartum who are breastfeeding their Infants ("Breastfeeding Women"), women up to six months after termination of pregnancy ("Postpartum Women"), Infants, and Children who are receiving supplemental foods or food instruments or cash-value vouchers under the WIC Program, and the breastfed Infants of participant Breastfeeding Women. (7 Code of Federal Regulations Section 246.2 [defining participants as well as Pregnant Women, Postpartum Women, Breastfeeding Women, Infants, and Children for purposes of WIC Program participation].)

f. As set forth in federal law, "WIC Applicants" are pregnant women, Breastfeeding Women, Postpartum Women, Infants, and Children who are applying to receive WIC benefits, as well as the breastfed Infants of applicant Breastfeeding Women. (7 Code of Federal Regulations Section 246.2 [defining applicants].)

g. Agency provides referrals to or information regarding other health related or public assistance programs to both WIC Applicants and WIC Participants. All other WIC Services are available exclusively to Members who are WIC Participants and the parents and guardians of Infant or Child participants in the case of nutrition education. The provision of WIC Services by Agency to Members must be limited to Members who are WIC Applicants, WIC Participants, or the parents or guardians thereof, as applicable, and rendered in accordance with the statutes and regulations governing the WIC Program (see, e.g., 42 United States Code Section 1786(d); 7 Code of Federal Regulations Sections 246.2, 246.7), as well as the terms of Agency's local agency agreement with CDPH.

4. MCP Obligations.

a. **Provision of Covered Services.** MCP is responsible for authorizing Medically Necessary Covered Services and coordinating care for Members provided by MCP's Network Providers and other providers of carve-out programs, services, and benefits.

b. **Oversight Responsibility.** The [*insert title*], the designated MCP Responsible Person listed in Exhibit A of this MOU, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

i. Meet at least quarterly with Agency, as required by Section 9 of this MOU;

ii. Report on MCP's compliance with the MOU to MCP's compliance officer no less frequently than quarterly. MCP's compliance officer is responsible for MOU compliance oversight reports as part of MCP's compliance program and must address any compliance deficiencies in accordance with MCP's compliance program policies;

iii. Ensure there is sufficient staff at MCP to support compliance with and management of this MOU;

iv. Ensure the appropriate levels of MCP leadership (i.e., persons with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from Agency are invited to participate in the MOU engagements, as appropriate;

v. Ensure training and education regarding MOU provisions are conducted annually for MCP's employees responsible for carrying out activities under this MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network Providers; and

vi. Serve, or may designate a person at MCP to serve, as the MCP-Agency Liaison, the point of contact and liaison with Agency. The MCP-Agency Liaison is listed in Exhibit A of this MOU. MCP must notify Agency of any changes to the MCP-Agency Liaison in writing as soon as reasonably practical but no later than the date of change and must notify DHCS and CDPH within five Working Days of the change.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

5. Agency Obligations.

a. **Oversight Responsibility.** The [*insert title*], the designated Agency Responsible Person, listed in Exhibit B of this MOU, is responsible for overseeing Agency's compliance with this MOU. The Agency Responsible Person serves, or may designate a person to serve, as the designated Agency Liaison, the point of contact and liaison with MCP. The Agency Liaison is listed in Exhibit B of this MOU. Agency may designate a liaison by program or service line. Agency must notify MCP of changes to the Agency Liaison as soon as reasonably practical but no later than the date of change.

[The Parties may agree to additional requirements such as:

- *The Agency Responsible Person must ensure there is sufficient staff at Agency who support compliance with and management of this MOU.*
- *Agency must develop and implement MOU compliance policies and procedures, including oversight reports and mechanisms to address barriers to care coordination.*

- *The Agency Responsible Person must ensure training and education regarding MOU provisions are conducted annually for its employees who carry out responsibilities under this MOU, and, as applicable, for subcontractors and providers.*
- *The Agency Liaison must meet MOU compliance requirements, as determined by policies and procedures established by Agency, and must report to the Agency Responsible Person.]*

6. Training and Education.

a. To ensure compliance with this MOU, MCP must provide training and orientation for its employees who carry out responsibilities under this MOU and, as applicable, for MCP's Network Providers, Subcontractors, and Downstream Subcontractors who assist MCP with carrying out MCP's responsibilities under this MOU. The training must include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU. For persons or entities performing these responsibilities as of the Effective Date, MCP must provide this training within *[The Parties may agree to 30, 45, or 60 Working Days.]* of the Effective Date. Thereafter, MCP must provide this training prior to any such person or entity performing responsibilities under this MOU and to all such persons or entities at least annually thereafter. MCP must require its Subcontractors and Downstream Subcontractors to provide training on relevant MOU requirements and WIC Services to its Network Providers. [*The Parties may agree to make this requirement mutual.*]

b. In accordance with health education standards required by the Medi-Cal Managed Care Contract, MCP must provide Members and Network Providers with educational materials related to accessing Covered Services and WIC Services provided by Agency, including:

i. Information about WIC Services, including who is eligible for WIC Services; how WIC Services can be accessed; the WIC Program referral processes, including referral forms, links, fax numbers, email addresses, and other means of making and sending WIC Program referrals; and care coordination approaches; and

ii. Information on nutrition and lactation topics, food insecurity screening, and cultural awareness.

c. MCP must provide Agency, Members, and Network Providers with training and/or educational materials on how MCP's Covered Services and any carved-out services may be accessed, including during nonbusiness hours, and information on relevant MCP's Covered Services and benefits such as doula services, Community Health Worker services, dyadic services, and related referral processes for such services.[1]

[The Parties may agree to additional requirements such as:

[1] Additional guidance available at All-Plan Letter ("APL") 22-016, APL 22-031, and APL 22-029.

- *Provided Agency obtains the appropriate approvals required by its local agency agreement with CDPH prior to using or developing materials for the WIC Program, the Parties must together develop training and education resources covering the services provided or arranged for by the Parties.*
- *The Parties must share their training and educational materials with the each other to ensure the information in their respective training and educational materials includes an accurate set of services provided or arranged for by each Party and is consistent with MCP and Agency policies and procedures, and with clinical practice standards.*
- *Provided Agency obtains the appropriate approvals required by its local agency agreement with CDPH prior to using or developing materials for the WIC Program, the Parties must develop and share outreach communication materials and develop initiatives to share resources about MCP and Agency with individuals who may be eligible for MCP's Covered Services and/or WIC Services.*
- *MCP must include Agency outreach communications to inform Members about WIC on its website and in its Member education materials, Member handbook, and other appropriate materials, including placing the WIC website link [www.myfamily.wic.ca.gov and/or local WIC link] on its website.*
- *Agency must provide the Agency Liaison and Agency staff and providers with training and educational materials on MCP's Covered Services to support Agency in assisting Members with accessing MCP's Covered Services*.
- *[As applicable] Agency must ensure the WIC Regional Breastfeeding Liaison, as defined by the CDPH Regional Breastfeeding Liaison Program, is available to provide WIC orientation and breastfeeding training to MCP's Network Providers and support staff, including providing information on breastfeeding policy across the continuum of care, such as the 9 Steps to Breastfeeding Friendly Community Health Centers and Outpatient Care Settings, workplace lactation accommodation, and hospital breastfeeding policy regulations.*
- *MCP must coordinate with the WIC Regional Breastfeeding Liaison to communicate and schedule Network Provider training on WIC orientation and breastfeeding.]*

7. Referrals.

a. **Referral Process.** The Parties must work collaboratively to develop policies and procedures that ensure WIC-eligible Members are referred to the appropriate WIC Services and MCP's Covered Services. Referrals made pursuant to this MOU and any policies and procedures related thereto must comply with Section 13 of this MOU.

i. The Parties must facilitate referrals to Agency for Members who may meet the eligibility criteria for WIC Services, and ensure Agency has procedures for accepting referrals from MCP or responding to referrals where Agency cannot accept additional Members.

ii. MCP must refer Members using a patient-centered, shared decision-making process.

iii. MCP must refer and document the referral of Members to Agency who are pregnant women, Breastfeeding Women, Postpartum Women, or the legal guardians for Members who are Infants or Children, including referrals made as part of the initial evaluation of newly pregnant individuals, pursuant to 42 Code of Federal Regulations Section 431.635(c) and any relevant DHCS guidance. MCP must have policies and procedures to identify and refer, and to ensure its Network Providers identify and refer, those MCP Members who may be eligible for WIC Services to Agency.

1. As part of the referral, or as soon as possible thereafter, MCP must assist the Network Provider, Member, and Agency with coordination to ensure that Agency receives a copy of the Member's current hemoglobin and hematocrit laboratory values as soon as possible. If the Member has not yet had these laboratory tests, MCP must coordinate with the Network Provider and Member to assist the Member with obtaining such laboratory tests as soon as possible.

2. MCP must ensure its Network Providers share with Agency relevant information from patient visits, including, without limitation, height and weight measurements, hemoglobin/hematocrit values, blood lead values for Infants and Children, and health conditions when referring their patients to Agency and/or when requested by Agency for care coordination.

iv. MCP must collaborate with Agency to update referral processes and policies designed to address barriers and concerns related to referrals and delays in service delivery.

v. Agency should refer Members to MCP for MCP's Covered Services, including any Community Supports services or care management programs for which Members may qualify, such as Enhanced Care Management ("ECM") or Complex Case Management ("CCM"). However, if Agency is also an ECM Provider pursuant to a separate agreement between MCP and Agency for ECM services, this MOU does not govern Agency's provision of ECM services.

vi. Upon notification from MCP that a Member may be eligible for WIC Services, and in accordance with its normal practices and procedures governing WIC application and certification, Agency must conduct the applicable screening and assessments to determine whether the Member is eligible for WIC Services.

vii. Agency must provide MCP with information about WIC referral process(es), including referral forms, links, fax numbers, email addresses, and other means of making and sending referrals to Agency. Agency must work with MCP, as necessary, to revise referral processes and address barriers and concerns related to referrals.

viii. Agency is responsible for the timely enrollment of, and follow-up with, Members eligible for WIC Services in accordance with the processing standards set forth in 7 Code of Federal Regulations Section 246.7(f) and California Code of Regulations, Title 22, Section 40675.

[The Parties may add requirements such as the requirement that Agency must provide MCP with website link(s) or list(s) of current Agency office addresses and telephone numbers at the time of execution of this MOU and within a reasonable time after and no later than [insert #] Working Days of any changes.]

[The Parties may agree to additional requirements such as:

Closed Loop Referrals. *To the extent that the following does not (a) require modifications to the WIC Program's management information system by CDPH or its contractors, (b) require Agency to store confidential WIC Participant or WIC Applicant information as defined in 7 Code of Federal Regulations Section 246.26(d)(1)(i) in any database or management information system other than the one in use by CDPH, or (c) otherwise conflict with current or future statutes, regulations, or guidance for the WIC Program, by January 1, 2025, the Parties must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Management Policy Guide,[2] DHCS All Plan Letter ("APL") 22-024, or any subsequent version of the APL, and as set forth by DHCS through an APL or other, similar guidance. The Parties must work collaboratively to develop and implement a process to ensure that MCP and Agency comply with the applicable provisions of closed loop referrals guidance within 90 Working Days of issuance of this guidance. The Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.]*

8. **Care Coordination and Collaboration.**

a. **Care Coordination.**

i. The Parties must adopt policies and procedures for coordinating Members' access to care and services that incorporate all the requirements set forth in this MOU.

ii. The Parties must discuss and address individual care coordination issues or barriers to care coordination efforts at least quarterly.

iii. MCP must have policies and procedures in place to maintain collaboration with Agency and to identify strategies to monitor and assess the effectiveness of this MOU.

b. **Population Health Management.** MCP must coordinate with Agency to ensure Member access to EPSDT benefits and perinatal services. MCP must undertake such activities in accordance with the Medi-Cal Managed Care Contract, DHCS Population Health Management Program, and policy guidance,[3] with a focus on high-risk populations such as Infants and Children with special needs and perinatal African Americans, Alaska Natives, and Pacific Islanders.

[2] CalAIM Population Health Management Policy Guide, available at https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.
[3] Ibid.

c. **Maternity and Pediatric Care Coordination.** The Parties must work collaboratively to implement processes to coordinate WIC Participant care between Agency and Network Providers in primary care; in obstetrics-gynecology; in pediatric care settings, with Network Providers and hospitals where WIC Participants deliver; and for WIC Participants transitioning from inpatient deliveries to outpatient postpartum and pediatric care settings. Agency is prohibited from charging costs associated with performing these activities to the WIC Program except to the extent that the costs are permissible under applicable federal authorities and the terms and conditions of Agency's local agreement with CDPH.

i. MCP must provide care management services for Members who are WIC Participants, as needed, including for high-risk pregnancies and Infants and Children with special needs, and engage Agency, as needed, in care management and care coordination.

ii. MCP must ensure that its Network Providers arrange for the lactation services, or any relevant services outlined in applicable DHCS policy letters, and all lactation support requirements outlined in the Medi-Cal Managed Care Contract and Policy Letter 98-010, which includes breastfeeding promotion and counseling services as well as the provision of breast pumps and donor human milk for fragile Infants.

iii. Agency must advise MCP on the availability of breastfeeding Peer Counselors who are available to support WIC Participants. If Agency does not have available breastfeeding Peer Counselors for Members who are WIC Participants, MCP must arrange for a breastfeeding Peer Counselor to be provided by another provider or community support service.

iv. MCP must identify and refer Members who require therapeutic formulas to Medi-Cal Rx for these products. If such formulas are denied by Medi-Cal Rx, MCP must refer these Members to Agency and promptly provide Agency with a copy of the Medi-Cal Rx denial notification.

[The Parties may agree to additional requirements such as:

- *The Parties may coordinate to assemble a skilled workforce of peer counselors, registered dietitians, lactation educators, and lactation consultants to provide clinical nutrition and lactation services for Members in a timely manner.*
- *With prior written approval from CDPH, MCP and Agency may collaborate to collect feedback from WIC Participants on topics of interest to the Parties through surveys, focus groups, or other agreed-upon methods, and in accordance with Section 9 of this MOU. Such activities must comply with Section 11 of this MOU.]*

9. Quarterly Meetings.

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU, but not less frequently than quarterly, in order to address care coordination, Quality Improvement ("QI") activities, QI outcomes, systemic and case-specific concerns, and communication with others within their organizations about such

activities. *[The Parties may agree to meet more frequently.]* These meetings may be conducted virtually.

i. Within 30 Working Days after each quarterly meeting, MCP must post on its website the date and time the quarterly meeting occurred and, as applicable, distribute to meeting participants a summary of any follow-up action items or changes to processes that are necessary to fulfill MCP's obligations under the Medi-Cal Managed Care Contract and this MOU.

ii. MCP must invite the Agency Responsible Person and Agency executives to participate in MCP quarterly meetings to ensure appropriate committee representation, including a local presence, and to discuss and address care coordination and MOU-related issues. Subcontractors and Downstream Subcontractors should be permitted to participate in these meetings, as appropriate.

iii. MCP must report to DHCS updates from quarterly meetings in a manner and at a frequency specified by DHCS.

b. **Local Representation.** MCP must participate, as appropriate, in meetings or engagements to which MCP is invited by Agency, such as local county meetings, local community forums, and Agency engagements, to collaborate with Agency in equity strategy and wellness and prevention activities.

10. Quality Improvement. The Parties must develop QI activities specifically for the oversight of the requirements of this MOU, including, without limitation, any applicable performance measures and QI initiatives, including those to prevent duplication of services, as well as reports that track referrals, Member engagement, and service utilization. MCP must document these QI activities in its policies and procedures.

[The Parties may agree to additional requirements, such as a requirement that the Parties must adopt joint policies and procedures establishing and addressing QI activities for coordinating the care and delivery of services for Members. Such activities may relate to coordinating preventive care linkages; making WIC referrals; screening for food insecurity; and disseminating information and/or resources related to preventive care service access, breastfeeding exclusivity and duration, child obesity, gestational diabetes, entry into care, and other relevant topics.]

11. Data Sharing and Confidentiality. The Parties must implement policies and procedures to ensure that the minimum necessary Member information and data for accomplishing the goals of this MOU are exchanged timely and maintained securely and confidentially and in compliance with the requirements set forth below. The Parties must share information in compliance with applicable law, which may include the Health Insurance Portability and Accountability Act and its implementing regulations, as amended, 42 Code of Federal Regulations Part 2, and other State and federal privacy laws, including but not limited to federal law governing the access, use, and disclosure of WIC Program information. Under federal law, confidential WIC Applicant and WIC Participant information is any information about a WIC Applicant or WIC Participant, whether it is obtained from the WIC Applicant, WIC Participant, another source, or

generated as a result of WIC application, certification, or participation, that individually identifies a WIC Applicant or WIC Participant and/or family member(s). WIC Applicant or WIC Participant information is confidential, regardless of the original source and exclusive of previously applicable confidentiality provided in accordance with other federal, State or local law. (7 Code of Federal Regulations Section 246.26(d)(1)(i).) Agency's sharing of confidential WIC Participant and WIC Applicant information with MCP must comply with 7 Code of Federal Regulations Section 246.26.

a. **Data Exchange.** MCP must share the minimum necessary data and information to facilitate referrals and coordinate care under this MOU. Agency is encouraged to share the minimum necessary information and data to facilitate referrals and coordinate care under this MOU. Agency must secure appropriate written consent from WIC Participants and WIC Applicants on a form approved by CDPH before exchanging confidential WIC Participant and WIC Applicant information with MCP and such sharing must comply with the requirements set forth in 7 Code of Federal Regulations Section 246.26(d)(4). The Parties must have policies and procedures for supporting the timely and frequent exchange of Member information and data, which may include behavioral health and physical health data; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining Member consent. The minimum necessary information and data elements to be shared as agreed upon by the Parties as set forth in Exhibit C of this MOU. The Parties must annually review and, if appropriate, update Exhibit C of this MOU to facilitate sharing of information and data.

b. The Parties must enact policies and procedures to implement the following with regard to information sharing:

i. The Parties must collaborate to implement data linkages to streamline the referral process from MCP or its Network Providers to Agency to reduce the administrative burden on Agency and to increase the number of Members enrolled in WIC.

ii. The data exchange process must consider how to facilitate the provision of the following information from MCP or its Network Providers: proof of pregnancy, height and weight of Infants at birth, pregnant individual's pre-pregnancy height and weight, immunization history, wellness check information, social drivers of health information as agreed upon by the Parties, and any additional information agreed upon by the Parties.

iii. To the extent individual authorization is required, the Parties must obtain authorization to share and use information for the purposes contemplated in this MOU in a manner that complies with applicable laws and requirements.

c. **Interoperability.** MCP must make available to Members their electronic health information held by MCP pursuant to 42 Code of Federal Regulations Section 438.10 and in accordance with APL 22-026 or any subsequent version of the APL. MCP must make available an application programming interface that makes complete and accurate Network Provider directory information available through a public-facing digital

endpoint on MCP's website pursuant to 42 Code of Federal Regulations Sections 438.242(b) and 438.10(h).

[The Parties may agree to additional requirements such as:

Disaster and Emergency Preparedness. *The Parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the Parties' ability to provide services to ensure the continued coordination and delivery of WIC Services and MCP's Covered Services for impacted Members.]*

12. Dispute Resolution.

a. The Parties must agree to dispute resolution procedures such that in the event of any dispute or difference of opinion regarding the Party responsible for service coverage arising out of or relating to this MOU, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. MCP must, and Agency should, document the agreed-upon dispute resolution procedures in policies and procedures. Pending resolution of any such dispute, the Parties must continue without delay to carry out all their responsibilities under this MOU, including providing Members with access to services under this MOU, unless this MOU is terminated.

b. Disputes between MCP and Agency that cannot be resolved in a good faith attempt between the Parties within [*suggested: 15 Working Days*] of initiating such dispute must be forwarded by MCP to DHCS and may be reported by Agency to CDPH. Until the dispute is resolved, the Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided.

c. Nothing in this MOU or provision constitutes a waiver of any of the government claim filing requirements set forth in Title I, Division 3.6, of the California Government Code or as otherwise set forth in local, State, or federal law.

13. Equal Treatment.

a. Pursuant to 7 Code of Federal Regulations Section 246.3(b) and Title VI, 42 United States Code Section 2000d, et seq., Agency cannot provide any service, financial aid, or other benefit to an individual that is different, or is provided in a different manner, from that provided to others under the WIC Program. Nothing in this MOU is intended to benefit or prioritize Members over WIC Participants who are not Members.

b. Agency is prohibited from directing or recommending that an individual choose or refrain from choosing a specific Medi-Cal managed care plan, and MCP is prohibited from directing or recommending that an individual choose or refrain from choosing a specific agency that provides WIC Services.

c. Agency is prohibited from making decisions intended to benefit or disadvantage a specific Medi-Cal managed care plan, and MCP is prohibited from making decisions intended to benefit or disadvantage a specific agency that provides WIC Services.

14. General.

a. **MOU Posting.** MCP must post this executed MOU on its website.

b. **Documentation Requirements.** MCP must retain all documents demonstrating compliance with this MOU for at least 10 years as required by the Medi-Cal Managed Care Contract. If DHCS requests a review of any existing MOU, MCP must submit the requested MOU to DHCS within 10 Working Days of receipt of the request.

c. **Notice.** Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by in-person delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail, certified, return receipt requested, postage prepaid, are deemed given on the date of delivery indicated on the return receipt. The Parties may change their addresses for purposes of receiving notice hereunder by giving notice of such change to each other in the manner provided for herein.

d. **Delegation.** MCP may delegate its obligations under this MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor as permitted under the Medi-Cal Managed Care Contract, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a Party to this MOU. Further, MCP may enter into Subcontractor Agreements or Downstream Subcontractor Agreements that relate directly or indirectly to the performance of MCP's obligations under this MOU. Agency may delegate its obligations under this MOU only to the extent permitted by applicable law and the local agency agreement with CDPH. Other than in these circumstances, the Parties cannot delegate the obligations and duties contained in this MOU.

e. **Annual Review.** MCP must conduct an annual review of this MOU to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. MCP must provide DHCS evidence of the annual review of this MOU as well as copies of any MOU modified or renewed as a result.

f. **Amendment.** This MOU may only be amended or modified by the Parties through a writing executed by the Parties. However, this MOU is deemed automatically amended or modified to incorporate any provisions amended or modified in the Medi-Cal Managed Care Contract, amended or modified in Agency's local agency agreement with CDPH, or as required by applicable law or any applicable guidance issued by a State or federal oversight entity.

g. **Governance.** This MOU is governed by and construed in accordance with the laws of the State of California.

h. **Independent Contractors.** No provision of this MOU is intended to create, nor is any provision deemed or construed to create, any relationship between Agency and MCP other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this MOU. Neither Agency nor MCP, nor any of their respective contractors, employees, agents, or representatives, is construed to be the contractor, employee, agent, or representative of the other.

i. **Counterpart Execution.** This MOU may be executed in counterparts, signed electronically and sent via PDF, each of which is deemed an original, but all of which, when taken together, constitute one and the same instrument.

j. **Superseding MOU.** This MOU constitutes the final and entire agreement between the Parties and supersedes any and all prior oral or written agreements, negotiations, or understandings between the Parties that conflict with the provisions set forth in this MOU. It is expressly understood and agreed that any prior written or oral agreement between the Parties pertaining to the subject matter herein is hereby terminated by mutual agreement of the Parties.

(Remainder of this page intentionally left blank)

The Parties represent that they have authority to enter into this MOU on behalf of their respective entities and have executed this MOU as of the Effective Date.

MCP	**Agency**
Signature: **Name:** **Title:** **Notice Address:**	**Signature:** **Name:** **Title:** **Notice Address:**

[Subcontractor or Downstream Subcontractor]

Signature:
Name:
Title:
Notice Address:

[MCP, if multiple MCPs in County]

Signature:
Name:
Title:
Notice Address:

Exhibits A and B.

[Placeholder for exhibits to contain MCP-WIC and WIC Liaisons as referenced in Sections 4.b and 5.b of this MOU]

Exhibit C

Data Elements

[The Parties may agree to additional data elements such as:

a. *MCP and Agency must share the following data elements:*
    i. *Member demographic information;*
    ii. *Behavioral and physical health information;*
    iii. *Diagnoses, progress notes, and assessments;*
    iv. *Medications prescribed;*
    v. *Laboratory results; and*
    vi. *Known changes in condition that may adversely impact the Member's health and/or welfare and that are relevant to the services.]*

ATTACHMENT H:

REGIONAL CENTER MEMORANDUM OF UNDERSTANDING TEMPLATE

COVER PAGE

Back to Item

Back to Agenda

Memorandum of Understanding

between [*Medi-Cal Managed Care Plan*] and [*County Regional Center*]

This Memorandum of Understanding ("MOU") is entered into by [*name of Managed Care Plan*] ("MCP") and [*name of Regional Center*] ("Regional Center"), effective as of [*date*] ("Effective Date"). [*Where MCP has a Subcontractor or Downstream Subcontractor arrangement delegating part or all of the responsibilities related to effectuating this MOU to a Knox-Keene licensed health care service plan(s), this Subcontractor or Downstream Subcontractor must be added as an express party to this MOU and named in this MOU as having the responsibilities set forth herein that are applicable to this Subcontractor or Downstream Subcontractor.*] Regional Center, MCP, and MCP's relevant Subcontractors and/or Downstream Subcontractors are referred to herein as a "Party" and collectively as "Parties."

WHEREAS, MCP is required under the Medi-Cal Managed Care Contract, Exhibit A, Attachment III, to enter into this MOU, a binding and enforceable contractual agreement, to ensure that Medi-Cal beneficiaries enrolled, or eligible to enroll, in MCP ("Members") are able to access and/or receive services in a coordinated manner from MCP and Regional Center; and

WHEREAS, the Parties desire to ensure that Members receive Regional Center services in a coordinated, non-duplicative manner and to provide a process to continuously evaluate the quality of care coordination provided.

[Notation: This MOU template includes language, notated in italics and bracketed, that the Parties may want to add to this MOU to increase collaboration and communication. MCP and Regional Center may also agree to additional provisions, provided that they do not conflict with the requirements of this MOU.]

In consideration of the mutual agreements and promises hereinafter, the Parties agree as follows:

1. **Definitions.** Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the California Department of Health Care Services ("DHCS"), unless otherwise defined herein. The Medi-Cal Managed Care Contract is available on the DHCS webpage at www.dhcs.ca.gov.

   a. "MCP Responsible Person" means the person designated by MCP to oversee MCP coordination and communication with Regional Center and ensure MCP's compliance with this MOU as described in Section 4 of this MOU.

   b. "MCP-Regional Center Liaison" means MCP's designated point of contact responsible for acting as the liaison between MCP and Regional Center as described in Section 4 of this MOU. The MCP-Regional Center Liaison must ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.

c. "Regional Center Responsible Person" means the person designated by Regional Center to oversee coordination and communication with MCP and ensure Regional Center's compliance with this MOU as described in Section 5 of this MOU.

d. "Regional Center Liaison" means Regional Center's designated point of contact responsible for acting as the liaison between MCP and Regional Center as described in Section 5 of this MOU. The Regional Center Liaison should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the Regional Center Responsible Person as appropriate.

2. Term. This MOU is in effect as of the Effective Date and continues for a term of *[The Parties may agree to a term of three years or another term as agreed to by MCP and Regional Center.]* or as amended in accordance with Section 14.f of this MOU.

3. Services Covered by This MOU. This MOU governs the coordination of services between Regional Center and MCP for Members who are or may be served by Regional Center.

4. MCP Obligations.

a. **Provision of Covered Services.** MCP is responsible for coordinating care for Members provided by MCP's Network Providers and other providers of carve-out programs, services, and benefits as well as authorizing Medically Necessary Covered Services as outlined in DHCS All-Plan Letter ("APL") 23-010 or any subsequent version of the APL. MCP must comply with all requirements set forth in APL 23-023 or any subsequent version of the APL.

b. **Oversight Responsibility.** The [*insert title*], the designated MCP Responsible Person listed in Exhibit A of this MOU, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

i. Meet at least quarterly with Regional Center, as required by Section 9 of this MOU;

ii. Report on MCP's compliance with the MOU to MCP's compliance officer no less frequently than quarterly. MCP's compliance officer is responsible for MOU compliance oversight reports as part of MCP's compliance program and must address any compliance deficiencies in accordance with MCP's compliance program policies;

iii. Ensure there is sufficient staff at MCP to support compliance with and management of this MOU;

iv. Ensure the appropriate levels of MCP leadership (i.e., persons with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from Regional Center are invited to participate in the MOU engagements, as appropriate;

v. Ensure training and education regarding MOU provisions are conducted annually for MCP's employees responsible for carrying out activities under

this MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network Providers; and

vi. Serve, or may designate a person at MCP to serve, as the MCP-Regional Center Liaison, the point of contact and liaison with Regional Center. The MCP-Regional Center Liaison is listed in Exhibit A of this MOU. MCP must notify Regional Center of any changes to the MCP-Regional Center Liaison in writing as soon as reasonably practical but no later than the date of change and must notify DHCS within five Working Days of the change. The MCP-Regional Center Liaison functions may be assigned to the MCP-Long Term Services and Supports ("LTSS") liaison as long as the MCP-LTSS Liaison meets the training requirements and have the expertise to work with Regional Center, in accordance with APL 23-004 or any subsequent version of the APL and Section 6 of this MOU.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

5. Regional Center Obligations.

a. **Provision of Services.** Regional Center is responsible for services provided or made available by Regional Center. Regional Center must:

i. Determine eligibility for and authorize services arranged for or provided by Regional Center that are not covered by MCP;

ii. Provide case management and care coordination services for the provision of, or related to, Regional Center services;

iii. Develop, purchase, and coordinate the necessary services in each Member's Individualized Program Plan ("IPP") in accordance with the requirements set forth in the Lanterman Developmental Disabilities Services Act;

iv. Comply with requirements set forth in the CalAIM Regional Center Directive or any subsequent Regional Center Directives; and

v. Provide case management and care coordination services to eligible Members and assist those Members in maintaining their connection to and communication with MCP and/or MCP's Network Providers as needed.

b. **Oversight Responsibility.** The [*insert title*], the designated Regional Center Responsible Person listed in Exhibit B of this MOU, is responsible for overseeing Regional Center's compliance with this MOU. The Regional Center Responsible Person serves, or may designate a person to serve, as the designated Regional Center Liaison, the point of contact and liaison with MCP. The Regional Center Liaison may also be a Regional Center care coordinator. The Regional Center Liaison is listed in Exhibit B of this MOU. Regional Center must notify MCP of changes to the Regional Center Liaison as soon as reasonably practical but no later than the date of change.

[The Parties may agree to additional requirements such as:

- *The Regional Center Responsible Person must ensure there is sufficient staff at Regional Center who support compliance with and management of this MOU.*
- *Regional Center must develop and implement MOU compliance policies and procedures for Regional Center services and programs, including oversight reports and mechanisms to address barriers to care coordination.*
- *The Regional Center Responsible Person must ensure training and education regarding MOU provisions are conducted annually for Regional Center's employees, Subcontractors, Downstream Subcontractors, and Network Providers, as applicable.*
- *The Regional Center Liaison must meet MOU compliance requirements, as determined by policies and procedures established by Regional Center, and must report to the Regional Center Responsible Person.]*

6. Training and Education.

a. To ensure compliance with this MOU, MCP must provide training and orientation for its employees who carry out responsibilities under this MOU and, as applicable, for MCP's Network Providers, Subcontractors, and Downstream Subcontractors who assist MCP with carrying out MCP's responsibilities under this MOU. The training must include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU, including those set forth in APL 23-023 or any subsequent version of the APL. For persons or entities performing these responsibilities as of the Effective Date, MCP must provide this training within *[The Parties may agree to 30, 45, or 60 Working Days.]* of the Effective Date. Thereafter, MCP must provide this training prior to any such person or entity performing responsibilities under this MOU and to all such persons or entities at least annually thereafter. MCP must require its Subcontractors and Downstream Subcontractors to provide training on relevant MOU requirements and Regional Center programs and services to its Network Providers. [*The Parties may agree to make this requirement mutual.*]

b. In accordance with health education standards required by the Medi-Cal Managed Care Contract, MCP must provide Members and Network Providers with educational materials related to accessing Covered Services, including for services provided by Regional Center.

c. MCP must provide Regional Center, Members, and Network Providers with training and/or educational materials on how MCP's Covered Services and any carved-out services may be accessed, including during nonbusiness hours.

d. MCP, in collaboration with Regional Center, must ensure that the MCP-Regional Center Liaison is sufficiently trained on Regional Center care coordination, assessments, and referral processes.

[The Parties may agree to additional requirements such as:

- *The Parties must together develop training and education resources covering the services provided or arranged for by the Parties. The Parties must share their*

training and educational materials with each other to ensure the information in their respective training and educational materials includes an accurate set of services provided or arranged for by each Party and is consistent with MCP and Regional Center policies and procedures, and with clinical practice standards.

- *The Parties must develop and share outreach communication materials and develop initiatives to share resources about MCP and Regional Center with individuals who may be eligible for MCP's Covered Services and/or Regional Center programs.*
- *Regional Center must provide the Regional Center Liaison and other Regional Center staff with training and educational materials on MCP's Covered Services to support Regional Center in assisting Members with accessing MCP's Covered Services.]*

7. Referrals.

a. **Referral Process.** The Parties must work collaboratively to develop policies and procedures that ensure Members are referred to the appropriate Regional Center program and/or services.

b. The Parties must facilitate referrals to Regional Center for Members who may potentially be eligible for Regional Center services and ensure Regional Center has procedures for accepting referrals from MCP or responding to referrals where Regional Center cannot accept additional Members. MCP must refer Members using a patient-centered, shared decision-making process.

c. MCP must implement policies and procedures to identify Members who are potentially eligible to receive services provided or arranged for by Regional Center and refer such Members to Regional Center. MCP is encouraged to develop these policies and procedures in collaboration with Regional Center.

d. MCP must notify Regional Center of all Members identified as potentially eligible for Regional Center services.

e. Regional Center is encouraged to share a list of its recipients on a *[weekly, monthly, quarterly]* basis with MCP so that MCP can identify which of the recipients are Members. Regional Center is encouraged to use this information to refer Members for Covered Services as appropriate.

f. Regional Center should refer Members under age 21, regardless of diagnosis, to MCP for evaluation for Medically Necessary Covered Services, including services using the Early Periodic Screening, Diagnostic, and Treatment medical necessity criteria.

g. Regional Center should refer Members to MCP for MCP's Covered Services, as well as any Community Supports services or care management programs for which Members may qualify, such as Enhanced Care Management ("ECM") or Complex Case Management ("CCM"). This MOU does not govern Regional Center's provision of ECM services. ECM services shall be governed by both the ECM Policy Guide and any specific contract between the ECM Provider (in this case, if applicable, Regional Center) and MCP.

[The Parties may agree to additional requirements such as:

Closed Loop Referrals. *By January 1, 2025, the Parties must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Management Policy Guide,[1] APL 22-024, or any subsequent version of the APL, and as set forth by DHCS through an APL or other, similar guidance. The Parties must work collaboratively to develop and implement a process to ensure that MCP and Regional Center comply with the applicable provisions of closed loop referrals guidance within 90 Working Days of issuance of this guidance. The Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.]*

8. **Care Coordination and Collaboration.**

a. **Care Coordination.** The Parties must adopt policies and procedures for coordinating Members' access to care and services that incorporate all the requirements set forth in this MOU.

b. The Parties must collaborate to identify and resolve issues involving timely and appropriate access to, and coordination of, care, including those issues that may delay or prevent Member access to timely and appropriate benefits and services.

c. MCP must provide Regional Center with information about Members' Primary Care Provider ("PCP") assignment to support care coordination.

d. MCP must have policies and procedures in place to maintain collaboration with Regional Center and to identify strategies to monitor and assess the effectiveness of this MOU. MCP's policies and procedures must include:

i. Processes for coordinating with Regional Center that ensure Members do not receive duplicative services through ECM, CCM, Community Supports, and other services;

ii. Processes to track all Members receiving services provided or arranged for by Regional Center and to continue coordinating services with Regional Center for Members, as necessary, using data provided by Regional Center as set forth in Section 11 of this MOU; and

iii. Processes for ensuring the continuation of Basic Population Health Management and care coordination of all Medically Necessary Covered Services to be provided or arranged for by MCP while Members receive services provided or arranged for by Regional Center.

e. MCP must coordinate with Intermediate Care Facilities for the Developmentally Disabled ("ICF/DD") homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing to ensure Members who are individuals with

[1] CalAIM Population Health Management Policy Guide, available at https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.

developmental disabilities receive all Medically Necessary Covered Services in accordance with APL 23-023 or any subsequent version of the APL.

f. MCP must ensure Members in need of ICF/DD home services are placed in a health care facility that provides the level of care most appropriate for the Members' medical needs, as outlined in the Medi-Cal Managed Care Contract. MCP must ensure ICF/DD home services that a Member needs, as determined by the Member's choice of living arrangement and documented by the Member's assigned Regional Center and services and supports provider(s), are authorized.

g. When requested by a Member and their legal representative, MCP must be available to assist Regional Center in the development of the Individual Family Service Plan ("IFSP") or IPP required for Members served by Regional Center, including the identification of all Covered Services such as medical care services, nonemergency transportation services, and Medically Necessary outpatient mental health services.

h. MCP must coordinate with ICF/DD homes to ensure Members receive Nonemergency Medical Transportation and Nonmedical Transportation services as needed.

i. MCP must coordinate care and address coverage needs for Members who are dually Medicare and Medi-Cal covered, or who have other health care coverage regardless of payer source.

9. Quarterly Meetings.

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU, but not less frequently than quarterly, in order to address care coordination, Quality Improvement ("QI") activities, QI outcomes, systemic and case-specific concerns, and communication with others within their organizations about such activities. [*The Parties may agree to meet more frequently.*] These meetings may be conducted virtually.

b. Within 30 Working Days after each quarterly meeting, MCP must post on its website the date and time the quarterly meeting occurred and, as applicable, distribute to meeting participants a summary of any follow-up action items or changes to processes that are necessary to fulfill MCP's obligations under the Medi-Cal Managed Care Contract and this MOU.

c. MCP must invite the Regional Center Responsible Person and appropriate Regional Center program executives to participate in MCP quarterly meetings to ensure appropriate committee representation, including a local presence, and to discuss and address care coordination and MOU-related issues. Subcontractors and Downstream Subcontractors should be permitted to participate in these meetings, as appropriate.

d. MCP must report to DHCS updates from quarterly meetings in a manner and at a frequency specified by DHCS.

e. **Local Representation.** MCP must participate, as appropriate, in meetings or engagements to which MCP is invited by Regional Center, such as local county meetings, local community forums, and Regional Center engagements, to collaborate with Regional Center in equity strategy and wellness and prevention activities.

10. Quality Improvement. The Parties must develop QI activities specifically for the oversight of the requirements of this MOU, including, without limitation, any applicable performance measures and QI initiatives, including those to prevent duplication of services, as well as reports that track referrals, Member engagement, and service utilization. MCP must document these QI activities in its policies and procedures.

[The Parties may agree to additional requirements, such as a requirement that the Parties must adopt policies and procedures that align to establish and address QI activities for coordinating the care and delivery of services for Members.]

11. Data Sharing and Confidentiality. The Parties must implement policies and procedures to ensure that the minimum necessary Member information and data for accomplishing the goals of this MOU are exchanged timely and maintained securely and confidentially and in compliance with the requirements set forth below. The Parties must share information in compliance with applicable law, which may include the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA"), 42 Code of Federal Regulations Part 2, and other State and federal privacy laws.

a. **Data Exchange.** MCP must, and Regional Center is encouraged to, share the minimum necessary data and information to facilitate referrals and coordinate care under this MOU. The Parties must have policies and procedures for supporting the timely and frequent exchange of Member information and data, which may include behavioral health and physical health data; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining Member consent. The minimum necessary information and data elements to be shared as agreed upon by the Parties are set forth in Exhibit C of this MOU. The Parties must annually review and, if appropriate, update Exhibit C of this MOU to facilitate sharing of information and data.

i. MCP must coordinate with Regional Center to receive data and information collected by Regional Center regarding Regional Center services to enable more accurate and precise measurements of health risks and disparities within MCP's Member population, as required by the CalAIM Population Health Management Policy Guide.[2]

ii. MCP must facilitate exchange of medical information between a Member's PCP and Regional Center.

iii. MCP must share the following information with Regional Center within 15 Working Days of receipt of request from Regional Center:

1. The Member's California Department of Education Screening;

2. The Member's current treatment plan, as well as the treatment plans for the past six months;

[2] CalAIM Population Health Management Policy Guide, available at https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.

3. The Member's assessment or comprehensive diagnostic evaluation;
4. The Member's behavioral-analytic assessment;
5. The Member's IFSP/Individualized Education Plan;
6. Whether the Member is currently receiving treatment;
7. The length of such treatment (i.e., the start date of treatment to the current date);
8. The current and past providers of the Member's treatment, including, but not limited to, Behavioral Health Treatment ("BHT") and occupational, physical, and speech therapy;
9. The Member's current medical records; and
10. The Member's signed authorization for release of information to exchange information as required by law.

iv. Regional Center must provide MCP with Member information regarding BHT and other services for those Members for whom Regional Center has such data to ensure appropriate care coordination, including, but not limited to:

1. Comprehensive diagnostic evaluation;
2. Assessment/report for Regional Center services;
3. Treatment plan(s);
4. Utilization data;
5. Functional Behavioral Assessment as well as prior assessments;
6. Confirmation of whether the Member is receiving services as well as current treatment plans, including the plans for the past six months;
7. Development assessment for the Early Start Program;
8. IFSP and IPP information; and
9. Treatment information, including length of treatment, associated treatment reports and recommendations, progress notes, the Member's providers (current and past), the Member's signed authorization for release of information to exchange information (obtained by the provider conducting assessment and treatment), any current Regional Center Annual Review Report and the most recent Regional Center psychological evaluation, and known changes in the Member's condition that may adversely impact the Member's health and/or welfare.

v. MCP must, and Regional Center is encouraged to, share information necessary to facilitate referrals as described in Section 7 of this MOU and provide ongoing care coordination as described in Section 8 of this MOU. The data elements to be shared must be agreed upon jointly by the Parties, reviewed annually, and set forth in Exhibit C this MOU.

vi. MCP must implement policies and procedures to utilize Regional Center data to track Members receiving Regional Center services and provide ongoing care coordination to ensure Members and Regional Center can access available services.

vii. MCP must share with Regional Center information that is necessary for the Regional Center Liaison to identify which Members are also receiving ECM and/or Community Supports, to assist Members with accessing all available services.

[The Parties may agree to additional requirements such as:

- *MCP and Regional Center must enter into the State's Data Exchange Framework Data Sharing Agreement for the safe sharing of information.*
- *If Member authorization is required, the Parties must agree to a standard consent form to obtain Member authorization to share and use information for the purposes of treatment, payment, and care coordination protected under 42 Code of Federal Regulations Part 2.]*

b. **Interoperability.** MCP must make available to Members their electronic health information held by MCP pursuant to 42 Code of Federal Regulations Section 438.10 and in accordance with APL 22-026 or any subsequent version of the APL. MCP must make available an application programming interface that makes complete and accurate Network Provider directory information available through a public-facing digital endpoint on MCP's website pursuant to 42 Code of Federal Regulations Sections 438.242(b) and 438.10(h).

[The Parties may agree to additional requirements such as:

Disaster and Emergency Preparedness. *The Parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the Parties' health care delivery system to ensure the continued coordination and delivery of Regional Center programs and services and MCP's Covered Services for impacted Members.]*

12. Dispute Resolution.

a. The Parties must agree to dispute resolution procedures such that in the event of any dispute or difference of opinion regarding the Party responsible for service coverage arising out of or relating to this MOU, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. MCP must, and Regional Center should, document the agreed-upon dispute resolution procedures in policies and procedures. Pending resolution of any such dispute, the Parties must continue without delay to carry out all their responsibilities under this MOU, including providing Members with access to services under this MOU, unless this MOU is terminated. If the dispute cannot be resolved within [*suggested: 15 Working Days*] of initiating such dispute or such other period as may be mutually agreed to by the Parties in writing, either Party may pursue its available legal and equitable remedies under California law.

b. Disputes between MCP and Regional Center that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP to DHCS and may be reported by Regional Center to the California Department of Developmental Services. Until the dispute is resolved, the Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided.

c. Nothing in this MOU or provision constitutes a waiver of any of the government claim filing requirements set forth in Title I, Division 3.6, of the California Government Code or as otherwise set forth in local, State, and/or federal law.

13. Equal Treatment. Nothing in this MOU is intended to benefit or prioritize Members over persons served by Regional Center who are not Members. Pursuant to Title VI, 42 United States Code Section 2000d, et seq., Regional Center cannot provide any service, financial aid, or other benefit to an individual that is different, or is provided in a different manner, from that provided to others by Regional Center.

14. General.

a. **MOU Posting.** MCP must post this executed MOU on its website.

b. **Documentation Requirements.** MCP must retain all documents demonstrating compliance with this MOU for at least 10 years as required by the Medi-Cal Managed Care Contract. If DHCS requests a review of any existing MOU, MCP must submit the requested MOU to DHCS within 10 Working Days of receipt of the request.

c. **Notice.** Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by in-person delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail, certified, return receipt requested, postage prepaid, are deemed given on the date of delivery indicated on the return receipt. The Parties may change their addresses for purposes of receiving notice hereunder by giving notice of such change to each other in the manner provided for herein.

d. **Delegation.** MCP may delegate its obligations under this MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor as permitted under the Medi-Cal Managed Care Contract, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a Party to this MOU. Further, MCP may enter into Subcontractor Agreements or Downstream Subcontractor Agreements that relate directly or indirectly to the performance of MCP's obligations under this MOU. Other

than in these circumstances, MCP cannot delegate the obligations and duties contained in this MOU.

e. **Annual Review.** MCP must conduct an annual review of this MOU to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. MCP must provide DHCS evidence of the annual review of this MOU as well as copies of any MOU modified or renewed as a result.

f. **Amendment.** This MOU may only be amended or modified by the Parties through a writing executed by the Parties. However, this MOU is deemed automatically amended or modified to incorporate any provisions amended or modified in the Medi-Cal Managed Care Contract, or as required by applicable law or any applicable guidance issued by a State or federal oversight entity.

g. **Governance.** This MOU is governed by and construed in accordance with the laws of the State of California.

h. **Independent Contractors.** No provision of this MOU is intended to create, nor is any provision deemed or construed to create, any relationship between Regional Center and MCP other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this MOU. Neither Regional Center nor MCP, nor any of their respective contractors, employees, agents, or representatives, is construed to be the contractor, employee, agent, or representative of the other.

i. **Counterpart Execution.** This MOU may be executed in counterparts, signed electronically and sent via PDF, each of which is deemed an original, but all of which, when taken together, constitute one and the same instrument.

j. **Superseding MOU.** This MOU constitutes the final and entire agreement between the Parties and supersedes any and all prior oral or written agreements, negotiations, or understandings between the Parties that conflict with the provisions set forth in this MOU. It is expressly understood and agreed that any prior written or oral agreement between the Parties pertaining to the subject matter herein is hereby terminated by mutual agreement of the Parties.

(Remainder of this page intentionally left blank)

The Parties represent that they have authority to enter into this MOU on behalf of their respective entities and have executed this MOU as of the Effective Date.

MCP	**Regional Center**
Signature: **Name:** **Title:** **Notice Address:**	**Signature:** **Name:** **Title:** **Notice Address:**

[Subcontractor or Downstream Subcontractor]

Signature:
Name:
Title:
Notice Address:

[MCP, if multiple MCPs in County]

Signature:
Name:
Title:
Notice Address:

Exhibits A and B

[Placeholder for exhibits to contain MCP and Regional Center Liaisons as referenced in Sections 4.b and 5.b of this MOU]

Exhibit C

Data Elements

[The Parties may agree to additional data elements.]

ATTACHMENT C:

IHSS MEMORANDUM OF UNDERSTANDING TEMPLATE

COVER PAGE

Back to Item

Back to Agenda

Memorandum of Understanding

between [*Medi-Cal Managed Care Plan*] and [*County In-Home Supportive Services*]

This Memorandum of Understanding ("MOU") is entered into by [*name of Managed Care Plan*] ("MCP") and [*name of County IHSS Office*] ("County"), effective as of [*date*] ("Effective Date"). [*Where MCP has a Subcontractor or Downstream Subcontractor arrangement delegating part or all of the responsibilities related to effectuating this MOU to a Knox-Keene licensed health care service plan(s), this Subcontractor or Downstream Subcontractor must be added as an express party to this MOU and named in the MOU as having the responsibilities set forth herein that are applicable to this Subcontractor or Downstream Subcontractor.]* County, MCP, and MCP's relevant Subcontractors and/or Downstream Subcontractors are referred to herein as a "Party" and collectively as "Parties."

WHEREAS, MCP is required under the Medi-Cal Managed Care Contract, Exhibit A, Attachment III, to enter into this MOU, a binding and enforceable contractual agreement, to ensure that Medi-Cal beneficiaries enrolled, or eligible to enroll, in MCP and who are receiving, or are potentially eligible to receive, In-Home Supportive Services ("IHSS") ("Members") are able to access and/or receive services in a coordinated manner from MCP and County; and

WHEREAS, the Parties desire to ensure that Members receive IHSS in a timely manner and that IHSS is coordinated with medical services and long-term services and supports ("LTSS") to promote the health and safety of Members.

[Notation: This MOU template includes language, notated in italics and bracketed, that the Parties may want to add to this MOU to increase collaboration and communication. MCP and County may also agree to additional provisions, provided that they do not conflict with the requirements of this MOU.]

In consideration of the mutual agreements and promises hereinafter, the Parties agree as follows:

1. **Definitions.** Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the California Department of Health Care Services ("DHCS"), unless otherwise defined herein. The Medi-Cal Managed Care Contract is available on the DHCS webpage at www.dhcs.ca.gov.
    a. "MCP Responsible Person" means the person designated by MCP to oversee MCP coordination and communication with County and ensure MCP's compliance with this MOU as described in Section 4 of this MOU.
    b. "MCP-IHSS Liaison" means MCP's designated point of contact responsible for acting as the liaison between MCP and County as described in Section 4 of this MOU. The MCP-IHSS Liaison must ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in

accordance with Section 9 of this MOU, and provide updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.

c. "IHSS Responsible Person" means the person designated by County to oversee coordination and communication with MCP and ensure County's compliance with this MOU as described in Section 5 of this MOU.

d. "IHSS Liaison" means County's designated point of contact responsible for acting as the liaison between MCP and County as described in Section 5 of this MOU. The IHSS Liaison should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the IHSS Responsible Person as appropriate.

2. Term. This MOU is in effect as of the Effective Date and continues for a term of *[The Parties may agree to a term of three years or another term as agreed to by MCP and County.]* or as amended in accordance with Section 14.f of this MOU.

3. Services Covered by This MOU. This MOU governs the coordination of care between County and MCP for Members who may be eligible for and/or are receiving IHSS.

4. MCP Obligations.

a. **Provision of Covered Services.** MCP is responsible for authorizing Medically Necessary Covered Services and coordinating care for Members provided by MCP's Network Providers, providing information necessary to assist Members or their Authorized Representatives in referring themselves to County for IHSS, and coordinating services and other related Medi-Cal LTSS provided by MCP and other providers of carve-out programs, services, and benefits.

b. **Oversight Responsibility.** The [*insert title*], the designated MCP Responsible Person listed in Exhibit A of this MOU, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

i. Meet at least quarterly with County, as required by Section 9 of this MOU;

ii. Report on MCP's compliance with the MOU to MCP's compliance officer no less frequently than quarterly. MCP's compliance officer is responsible for MOU compliance oversight reports as part of MCP's compliance program and must address any compliance deficiencies in accordance with MCP's compliance program policies;

iii. Ensure there is sufficient staff at MCP to support compliance with and management of this MOU;

iv. Ensure the appropriate levels of MCP leadership (i.e., persons with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from County are invited to participate in the MOU engagements, as appropriate;

v. Ensure training and education regarding MOU provisions are conducted annually for MCP's employees responsible for carrying out activities under this MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network Providers; and

vi. Serve, or may designate a person at MCP to serve, as the MCP-IHSS Liaison, the point of contact and liaison with County. The MCP-IHSS Liaison is listed in Exhibit A of this MOU. The MCP-IHSS Liaison functions may be assigned to the MCP-LTSS Liaison as long as the MCP-LTSS Liaison meets the training requirements and has the expertise to work with the IHSS Responsible Person, in accordance with DHCS All-Plan Letter ("APL") 23-004 or any subsequent version of the APL and Section 6 of this MOU. MCP must notify County of any changes to the MCP-IHSS Liaison in writing as soon as reasonably practical but no later than the date of change and must notify DHCS within five Working Days of the change.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

5. County Obligations.

a. **Provision of Services.** County is responsible for assessing, approving, and authorizing each Member's initial and continuing need for IHSS pursuant to California Welfare and Institutions Code Section 12300.

b. **Oversight Responsibility.** The [*insert title*], the designated IHSS Responsible Person listed in Exhibit B of this MOU, is responsible for overseeing County's compliance with this MOU. The IHSS Responsible Person serves, or may designate a person to serve, as the designated IHSS Liaison, the point of contact and liaison with MCP. The IHSS Liaison is listed in Exhibit B of this MOU. County must notify MCP of changes to the IHSS Liaison as soon as reasonably practical but no later than the date of change.

[The Parties may agree to additional requirements such as:

- *The IHSS Responsible Person must ensure there is sufficient staff at County who support compliance with and management of this MOU.*
- *County must develop and implement MOU compliance policies and procedures for IHSS, including oversight reports and mechanisms to address barriers to care coordination.*
- *The IHSS Responsible Person must ensure training and education regarding MOU provisions are conducted annually for employees, Subcontractors, Downstream Subcontractors, and Network Providers, as applicable.*
- *The IHSS Liaison must meet MOU compliance requirements, as determined by policies and procedures established by County, and must report to the IHSS Responsible Person.]*

6. **Training and Education.**

a. To ensure compliance with this MOU, MCP must provide training and orientation for its employees who carry out responsibilities under this MOU and, as applicable, for MCP's Network Providers, Subcontractors, and Downstream Subcontractors who assist MCP with carrying out MCP's responsibilities under this MOU. The training must include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU. For persons or entities performing these responsibilities as of the Effective Date, MCP must provide this training within *[The Parties may agree to 30, 45, or 60 Working Days.]* of the Effective Date. Thereafter, MCP must provide this training prior to any such person or entity performing responsibilities under this MOU and to all such persons or entities at least annually thereafter. MCP must require its Subcontractors and Downstream Subcontractors to provide training on relevant MOU requirements and County IHSS to its Network Providers. [*The Parties may agree to make this requirement mutual.*]

b. In accordance with health education standards required by the Medi-Cal Managed Care Contract, MCP must provide County, Members, and Network Providers with educational materials related to accessing Covered Services, including for services provided by County.

c. MCP must provide County, Members, and Network Providers with training and/or educational materials on how MCP's Covered Services and any carved-out services may be accessed, including during nonbusiness hours.

d. MCP, in collaboration with County, must ensure that the MCP-IHSS Liaison is sufficiently trained on IHSS assessment and referral processes and providers, and on how MCP and Primary Care Providers can support IHSS eligibility applications and coordinate care across IHSS, medical services, and LTSS. This includes training on IHSS referrals for Members in inpatient and Skilled Nursing Facility ("SNF") settings as a part of Transitional Care Service requirements, to support safe and stable transitions to home and community-based settings.

[The Parties may agree to additional requirements such as:

- *County must provide the IHSS Liaison with training and educational materials on MCP's Covered Services, including nonemergency medical transportation and nonmedical transportation, to support IHSS staff providers in assisting Members with accessing MCP's Covered Services.]*

7. **Referrals.**

a. **Referral Process.** The Parties must work collaboratively to develop policies and procedures that ensure Members are referred to County for IHSS and/or MCP for the appropriate services.

b. For Members who may be eligible to receive IHSS, who desire IHSS but are not currently receiving IHSS, MCP must submit Member referrals to IHSS using a patient-centered, shared decision-making process.

c. If MCP learns that a Member who is currently receiving IHSS has a condition that has changed, MCP must advise that Member to contact the County IHSS Office to conduct an eligibility redetermination for IHSS.

d. County should refer Members to MCP for MCP's Covered Services, as well as any Community Supports services or care management programs for which Members may qualify, such as Enhanced Care Management ("ECM") or Complex Case Management ("CCM"). However, if County is also an ECM Provider pursuant to a separate agreement between MCP and County for ECM services, this MOU does not govern County's provision of ECM services.

e. If County is notified that an existing IHSS participant has had a change of condition, County must follow up to determine if a reassessment of IHSS is needed.

[The Parties may agree to additional requirements such as:

Closed Loop Referrals. *By January 1, 2025, the Parties must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Management Policy Guide,[1] DHCS APL 22-024, or any subsequent version of the APL, and as set forth by DHCS through an APL or other, similar guidance. The Parties must work collaboratively to develop and implement a process to ensure that MCP and County comply with the applicable provisions of closed loop referrals guidance within 90 Working Days of issuance of this guidance. The Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.]*

8. Care Coordination and Collaboration.

a. **Care Coordination.**

i. The Parties must adopt policies and procedures for coordinating Members' access to care and services that incorporate all the requirements set forth in this MOU.

ii. The Parties must discuss and address individual care coordination issues or barriers to care coordination efforts at least quarterly.

iii. MCP must have policies and procedures in place to maintain collaboration with County and to identify strategies to monitor and assess the effectiveness of this MOU.

iv. MCP's policies and procedures must include:

1. Processes for coordinating with County that ensure there is no duplication of services for Members enrolled in ECM, Community Supports, and other Covered Services through IHSS and that services (such as ECM, Community

[1] CalAIM Population Health Management Policy Guide, available at https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.

Supports, and IHSS) are provided in a coordinated and complementary manner. IHSS eligibility does not preclude eligibility for ECM and Community Supports;

2. Processes for ensuring the continuation of Basic Population Health Management and care coordination of all Medi-Cal benefits to be provided or arranged for by MCP while Members receive IHSS; and

3. Processes for outreach and coordination with County (and, to the extent possible, Members and IHSS) for Members identified by DHCS as receiving IHSS.

v. MCP must assess Members transferring from one care setting or level of care to another, such as from a hospital or an SNF to the home or community, and provide IHSS referral information to Members and supporting documentation to County if Members or their Authorized Representatives self-refer to IHSS, as appropriate, as a part of Transitional Care Service requirements in accordance with All-County Letter No.: 02-68, All-County Information Notice No.: I-43-06, or any subsequent or superseding guidance.

vi. County should provide Members and their Authorized Representatives, with approval of Members, and IHSS, with information on how to assist Members with obtaining MCP's Covered Services, including any Community Supports or care management programs for which they may qualify, such as ECM or CCM.

9. Quarterly Meetings.

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU, but not less frequently than quarterly, in order to address care coordination, Quality Improvement ("QI") activities, QI outcomes, systemic and case-specific concerns, and communication with others within their organizations about such activities. [*The Parties may agree to meet more frequently*.] These meetings may be conducted virtually.

b. Within 30 Working Days after each quarterly meeting, MCP must post on its website the date and time the quarterly meeting occurred and, as applicable, distribute to meeting participants a summary of any follow-up action items or changes to processes that are necessary to fulfill MCP's obligations under the Medi-Cal Managed Care Contract and this MOU.

c. MCP must invite the IHSS Responsible Person and appropriate IHSS program executives to participate in MCP quarterly meetings to ensure appropriate committee representation, including a local presence, and to discuss and address care coordination and MOU-related issues. Subcontractors and Downstream Subcontractors should be permitted to participate in these meetings, as appropriate.

d. MCP must report to DHCS updates from quarterly meetings in a manner and at a frequency specified by DHCS.

e. **Local Representation.** MCP must participate, as appropriate, in meetings or engagements to which MCP is invited by County, such as local county meetings,

local community forums, and County engagements, to collaborate with County in equity strategy and wellness and prevention activities.

10. Quality Improvement. The Parties must develop QI activities specifically for the oversight of the requirements of this MOU, including, without limitation, any applicable performance measures and QI initiatives, including those to prevent duplication of services, as well as reports that track referrals, Member engagement, and service utilization. MCP must document these QI activities in its policies and procedures.

[The Parties may agree to additional requirements, such as a requirement that the Parties must adopt policies and procedures that align to establish and address QI activities for coordinating the care and delivery of services for Members.]

11. Data Sharing and Confidentiality. The Parties must implement policies and procedures to ensure that the minimum necessary Member information and data for accomplishing the goals of this MOU are exchanged timely and maintained securely and confidentially and in compliance with the requirements set forth below. The Parties must share information in compliance with applicable law, which may include the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA"), 42 Code of Federal Regulations Part 2, and other State and federal privacy laws.

a. **Data Exchange.** MCP must, and County is encouraged to, share the minimum necessary data and information to facilitate referrals and coordinate care under this MOU. The Parties must have policies and procedures for supporting the timely and frequent exchange of Member information and data, which may include behavioral health and physical health data; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining Member consent. The minimum necessary information and data elements to be shared as agreed upon by the Parties are set forth in Exhibit C of this MOU. The Parties must annually review and, if appropriate, update Exhibit C of this MOU to facilitate sharing of information and data. The Parties are not required to obtain specific signed releases of information to exchange Member data for the purpose of sending and receiving referrals.

i. MCP must coordinate with County to receive population data regarding IHSS for Members to enable MCP to have more accurate and precise measurements of health risks and disparities within MCP's Member population, as required by the CalAIM Population Health Management Policy Guide.[2]

ii. MCP must, and County is encouraged to, share information necessary to facilitate referrals as described in Section 7 of this MOU and provide ongoing care coordination as described in Section 8 of this MOU. The data elements to be shared must be agreed upon jointly by the Parties, reviewed annually, and set forth in Exhibit C of this MOU.

[2] CalAIM Population Health Management Policy Guide, available at https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.

iii. MCP must share information with County that is necessary for the IHSS Liaison to identify which Members are also receiving ECM and/or Community Supports, to assist Members with accessing all available services.

[The Parties may agree to additional requirements such as:

- *MCP and County must enter into the State's Data Exchange Framework Data Sharing Agreement for the safe sharing of information.*
- *If Member authorization is required, the Parties must agree to a standard consent form to obtain Member authorization to share and use information for the purposes of treatment, payment, and care coordination protected under 42 Code of Federal Regulations Part 2.]*

b. **Interoperability.** MCP must make available to Members their electronic health information held by MCP pursuant to 42 Code of Federal Regulations Section 438.10 and in accordance with APL 22-026 or any subsequent version of the APL. MCP must make available an application programming interface ("API") that makes complete and accurate Network Provider directory information available through a public-facing digital endpoint on MCP's website pursuant to 42 Code of Federal Regulations Sections 438.242(b) and 438.10(h).

[The Parties may agree to additional requirements such as:

Disaster and Emergency Preparedness. *The Parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the Parties' health care delivery system to ensure the continued coordination and delivery of IHSS and MCP's Covered Services for impacted Members.]*

12. Dispute Resolution.

a. The Parties must agree to dispute resolution procedures such that in the event of any dispute or difference of opinion regarding the Party responsible for service coverage arising out of or relating to this MOU, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. MCP must, and IHSS should, document the agreed-upon dispute resolution procedures in policies and procedures. Pending resolution of any such dispute, the Parties must continue without delay to carry out all their responsibilities under this MOU, including providing Members with access to services under this MOU, unless this MOU is terminated. If the dispute cannot be resolved within *[suggested: 15 Working Days]* of initiating such dispute or such other period as may be mutually agreed to by the Parties in writing, either Party may pursue its available legal and equitable remedies under California law.

b. Disputes between MCP and County that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP to DHCS and may be reported by County to the California Department of Social Services. Until the dispute is

resolved, the Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided.

c. Nothing in this MOU or provision constitutes a waiver of any of the government claim filing requirements set forth in Title I, Division 3.6, of the California Government Code or otherwise set forth in local, State, or federal law.

13. Equal Treatment. Nothing in this MOU is intended to benefit or prioritize Members over persons served by IHSS who are not Members. Pursuant to Title VI, 42 United States Code Section 2000d, et seq., County cannot provide any service, financial aid, or other benefit to an individual that is different, or is provided in a different manner, from that provided to others by IHSS.

14. General.

a. **MOU Posting.** MCP must post this executed MOU on its website.

b. **Documentation Requirements.** MCP must retain all documents demonstrating compliance with this MOU for at least 10 years as required by the Medi-Cal Managed Care Contract. If DHCS requests a review of any existing MOU, MCP must submit the requested MOU to DHCS within 10 Working Days of receipt of the request.

c. **Notice.** Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by in-person delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail, certified, return receipt requested, postage prepaid, are deemed given on the date of delivery indicated on the return receipt. The Parties may change their addresses for purposes of receiving notice hereunder by giving notice of such change to each other in the manner provided for herein.

d. **Delegation.** MCP may delegate its obligations under this MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor as permitted under the Medi-Cal Managed Care Contract, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a Party to this MOU. Further, MCP may enter into Subcontractor Agreements or Downstream Subcontractor Agreements that relate directly or indirectly to the performance of MCP's obligations under this MOU. Other than in these circumstances, MCP cannot delegate the obligations and duties contained in this MOU.

e. **Annual Review.** MCP must conduct an annual review of this MOU to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. MCP must provide DHCS

evidence of the annual review of this MOU as well as copies of any MOU modified or renewed as a result.

f. **Amendment.** This MOU may only be amended or modified by the Parties through a writing executed by the Parties. However, this MOU is deemed automatically amended or modified to incorporate any provisions amended or modified in the Medi-Cal Managed Care Contract, or as required by applicable law or any applicable guidance issued by a State or federal oversight entity.

g. **Governance.** This MOU is governed by and construed in accordance with the laws of the State of California.

h. **Independent Contractors.** No provision of this MOU is intended to create, nor is any provision deemed or construed to create, any relationship between County and MCP other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this MOU. Neither County nor MCP, nor any of their respective contractors, employees, agents, or representatives, is construed to be the contractor, employee, agent, or representative of the other.

i. **Counterpart Execution.** This MOU may be executed in counterparts, signed electronically and sent via PDF, each of which is deemed an original, but all of which, when taken together, constitute one and the same instrument.

j. **Superseding MOU.** This MOU constitutes the final and entire agreement between the Parties and supersedes any and all prior oral or written agreements, negotiations, or understandings between the Parties that conflict with the provisions set forth in this MOU. It is expressly understood and agreed that any prior written or oral agreement between the Parties pertaining to the subject matter herein is hereby terminated by mutual agreement of the Parties.

(Remainder of this page intentionally left blank)

The Parties represent that they have authority to enter into this MOU on behalf of their respective entities and have executed this MOU as of the Effective Date.

MCP	**County**
Signature: **Name:** **Title:** **Notice Address:**	**Signature:** **Name:** **Title:** **Notice Address:**

[Subcontractor or Downstream Subcontractor]

Signature:
Name:
Title:
Notice Address:

[MCP, if multiple MCPs in County]

Signature:
Name:
Title:
Notice Address:

Exhibits A and B.

[Placeholder for exhibits to contain MCP and IHSS Liaisons as referenced in Sections 4.b and 5.b of this MOU]

Exhibit C

Data Elements

[The Parties may agree to additional data elements such as:

a. *MCP and County must share the following data elements:*
    i. *Member demographic information;*
    ii. *Behavioral and physical health information;*
    iii. *Diagnoses, progress notes, and assessments;*
    iv. *Medications prescribed;*
    v. *Laboratory results; and*
    vi. *Known changes in condition that may adversely impact the Member's health and/or welfare and that are relevant to the services.]*

ATTACHMENT B: COUNTY SOCIAL SERVICES AGENCIES FOR CHILD WELFARE MEMORANDUM OF UNDERSTANDING TEMPLATE

COVER PAGE

Back to Item

Back to Agenda

Memorandum of Understanding

between [*Managed Care Plan*] and [*County Social Services Agency for Child Welfare*]

This Memorandum of Understanding ("MOU") is entered into by [*name of Managed Care Plan*] ("MCP") and [*name of County Social Services Agency for Child Welfare or other relevant agency*], ("County"), effective as of [*date*] ("Effective Date"). [*Where MCP has a Subcontractor or Downstream Subcontractor arrangement delegating part or all of the responsibilities related to effectuating this MOU to a Knox-Keene licensed health care service plan(s), this Subcontractor or Downstream Subcontractor must be added as an express party to this MOU and named in this MOU as having the responsibilities set forth herein that are applicable to this Subcontractor or Downstream Subcontractor.*] County, MCP, and MCP's Subcontractor and/or Downstream Subcontractor are referred to herein as a "Party" and collectively as "Parties."

WHEREAS, MCP is required under the Medi-Cal Managed Care Contract Exhibit A, Attachment III, to enter into this MOU, a binding and enforceable contractual agreement, to ensure that Medi-Cal Members enrolled, or eligible to enroll, in MCP and who are County Child Welfare involved and/or receive foster care services ("Members") are able to access and/or receive services in a coordinated manner from MCP and County; and

WHEREAS, the Parties desire to ensure that Members receive MCP and County services set forth in this MOU in a coordinated, non-duplicative manner and to provide a process to continuously evaluate the quality of the care coordination provided.

[Notation: This MOU template includes language, notated in italics and bracketed, that the Parties may want to add to this MOU to increase collaboration and communication. MCP and Other Party may also agree to additional provisions provided that they do not conflict with the requirements of this MOU.]

In consideration of the mutual agreements and promises hereinafter, the Parties agree as follows:

1. **Definitions.** Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the Department of Health Care Services ("DHCS"), unless otherwise defined herein. The Medi-Cal Managed Care Contract is available on the DHCS webpage at www.dhcs.ca.gov.

   a. "County Child Welfare Services" means the services provided by the State's program for child protection services and interventions, including foster care, that are administered by County and monitored by the California Department of Social Services ("CDSS"), Children and Family Services Division.

   b. "MCP Responsible Person" means the person designated by MCP to oversee MCP coordination and communication with County and ensure MCP's compliance with this MOU as described in Section 4 of this MOU.

c. “MCP-County Liaison” means MCP’s designated point of contact responsible for acting as the liaison between MCP and County as described in Section 4 of this MOU. The MCP-County Liaison must ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the MCP Responsible Person and/or MCP’s compliance officer as appropriate.

d. “Foster Care Liaison” means the MCP’s designated individual assigned to ensure the needs of Members covered under this MOU are met as outlined in the Medi-Cal Managed Care Contract.

e. “County Responsible Person” means the person designated by County to oversee coordination and communication with MCP and ensure County’s compliance with this MOU as described in Section 5 of this MOU.

f. “County Liaison” means County’s designated point of contact responsible for acting as the liaison between County and MCP as described in Section 5 of this MOU. The County Liaison should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the County Responsible Person as appropriate.

2. Term. This MOU is in effect as of the Effective Date and continues for a term of *[The Parties may agree to a term of three years or another term as agreed to by MCP and County.]* or as amended in accordance with Section 14.f of this MOU. Each Party is responsible for tracking their own oversight agency guidance and assessing the need for amendments or modifications to this MOU.

3. Services Covered by This MOU. This MOU governs the coordination between County and MCP for the delivery of care and services for Members who are receiving County Child Welfare Services.

4. MCP Obligations.

a. **Provision of Covered Services.** MCP is responsible for authorizing Medically Necessary Covered Services, and for coordinating care for Members provided by MCP’s Network Providers and other providers of carve-out programs, services, and benefits. MCP must ensure Members, and/or their caregivers or legal guardian(s), are provided with information regarding Covered Services for which they are eligible, including Medi-Cal for Kids and Teens (formerly Early and Periodic Screening, Diagnostic and Treatment) services.

i. MCP must provide and cover, or arrange for, as appropriate, all Medically Necessary Medi-Cal for Kids and Teens services, including Behavioral Health Treatment services.

ii. For Members currently receiving Specialty Mental Health Services (“SMHS”) or enrolled in an existing care management program, such as California Wraparound, Full Service Partnership, or Health Care Program for Children in Foster

Care ("HCPCFC"), if the Mental Health Plan ("MHP") for SMHS, a SMHS provider contracted to the MHP, or the care management program has contracted with MCP to be an Enhanced Care Management ("ECM") Provider, MCP must assign the Member to the MHP, SMHS provider contracted to the MHP, or existing care management program as the ECM Provider unless the Member (or parent, legal guardian, or caretaker) requests otherwise.[1] If a Member is enrolled in more than one existing care management program and those programs are each contracted ECM Providers, MCP must assign the Member to the MHP or existing care management program that the Member identifies as the Member's preferred ECM Provider or, if necessary, another ECM Provider that has capacity to accept the Member. However, if County is also an ECM Provider pursuant to a separate agreement between MCP and County for ECM services, this MOU does not govern County's provision of ECM services.

b. **Oversight Responsibility.** The [*insert title*], the designated MCP Responsible Person listed in Exhibit A of this MOU, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

i. Meet at least quarterly with the County Responsible Person and appropriate County program executives, as required by Section 9 of this MOU;

ii. Report on MCP's compliance with the MOU to MCP's compliance officer no less frequently than quarterly. The compliance officer is responsible for MOU compliance oversight reports as part of MCP's compliance program and must address any compliance deficiencies in accordance with MCP's compliance program policies;

iii. Ensure there is sufficient staff at MCP who support compliance with and management of this MOU;

iv. Ensure the appropriate level of MCP leadership (e.g., persons with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from County are invited to participate in the MOU engagements, as appropriate;

v. Ensure training and education regarding MOU provisions are conducted annually for MCP's employees responsible for carrying out activities under this MOU, and as applicable for Subcontractors, Downstream Subcontractors, and Network Providers; and

vi. Serve, or designate a person at MCP to serve, as the MCP-County Liaison, the point of contact and liaison between MCP and County to coordinate care for children and youth receiving County Child Welfare Services. The MCP-County Liaison is listed in Exhibit A of this MOU. As appropriate, the MCP-County Liaison must also serve as a family advocate. MCP must notify County of any changes to the MCP-County Liaison in writing as soon as reasonably practical but no later than the date of change and must notify DHCS within five Working Days of the change.

c. MCP must designate at least one individual to serve as the Foster Care Liaison. Additional Foster Care Liaisons must be designated as needed to ensure the

[1]Additional information available at CalAIM Enhanced Care Management Policy Guide (p. 80): https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf.

needs of Members are met. By January 1, 2024, MCP must implement the role of MCP-Foster Care Liaison who will follow DHCS-issued standards and expectations for this role as set forth in the Medi-Cal Managed Care Contract, DHCS All Plan Letters ("APLs"), or other similar instructions. The MCP-County Liaison and the Foster Care Liaison roles may be assigned to the same designated individual.

d. Compliance by Subcontractors, Downstream Subcontractors, and Network Providers. MCP must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

[The Parties may agree to additional requirements such as:

- *Background: Assembly Bill (AB) 2083 (Chapter 815, Statutes of 2018), Children and Youth System of Care (SOC), requires each county to develop and implement a MOU setting forth roles and responsibilities of agencies and other entities, such as regional centers, county offices of education, county child welfare, juvenile probation, and behavioral health agencies, that serve children and youth in foster care who have experienced severe trauma as outlined in the All County Letter No. 19-116/Behavioral Health Information Notice ("BHIN") 19-053. The purpose of the AB 2083 MOU ("SOC MOU") is to ensure that children and youth in foster care receive coordinated, timely, and trauma-informed services. While AB 2083 focuses on children and youth in foster care who have experienced severe trauma, it reflects a priority to build a locally governed interagency or interdepartmental model on behalf of all children and youth across California who have similar needs and who interact with and are served by multiple agencies. These MOUs between County and other local entities that serve children in child welfare/foster care include California's Integrated Core Practice Model which establishes leadership behaviors and practices through which individuals and organizations must partner and collaborate with one another, and with children and families, to ensure an integrated approach to meeting the needs of children and families.*
- *MCP must collaborate with County to identify opportunities for coordination and alignment of this MOU with County's Interagency Leadership Team's efforts in implementing the SOC MOU to increase Members' ability to receive timely, coordinated care.*
- *County must include MCP as a party to its SOC MOU with local entities to ensure coordination between MCP, County, and local entities as necessary and applicable to ensure Members receive whole person care.]*

5. County Obligations.

a. **Provision of Services.** County is responsible for delivering and coordinating County Child Welfare Services, which may include coordination with an ECM Provider to ensure timely and appropriate access to Member benefits and services

beyond the scope of County program(s), including services provided or arranged for by County.

i. County Foster Care Public Health Nurses ("PHNs"), County-assigned probation officers, Community Health Workers, HCPCFC PHNs, and other county staff and/or secondary case managers, as applicable, should assist Members in accessing ECM, and, as appropriate, refer youth and children involved in child welfare to MCP for ECM.

b. **Oversight Responsibility.** The [*insert title*], the designated County Responsible Person, listed in Exhibit B of this MOU, is responsible for overseeing compliance with this MOU. The County Responsible Person serves, or may designate a person to serve, as the designated County Liaison, the point of contact and liaison with MCP. The County Liaison is listed in Exhibit B of this MOU. County may designate one or more liaisons by program or service line. County must notify MCP of changes to the County Liaison as soon as reasonably practical but no later than the date of change.

[The Parties may agree to additional requirements such as:

- *County must develop and implement MOU compliance policies and procedures, including oversight reports and mechanisms to address barriers to care coordination.*
- *The County Responsible Person must ensure training and education regarding MOU provisions are conducted annually for County's employees who carry out responsibilities under this MOU, as applicable.*
- *County must ensure Members, and/or their caregivers or legal guardian(s), are provided with information regarding Covered Services, including Medi-Cal for Kids and Teens services, for which they are eligible. County must refer Members to MCP for Medi-Cal for Kids and Teens services and other MCP Covered Services when indicated based on screening findings. If the child or youth indicates a need for mental health or substance use services, Member may be served by MCP and/or County's MHP in accordance with Section 8(d) of this MOU.]*

6. Training and Education.

a. To ensure compliance with this MOU, MCP must provide training and orientation for its employees who carry out MCP's responsibilities under this MOU and, as applicable, for MCP's Network Providers, Subcontractors, and Downstream Subcontractors who assist MCP with carrying out responsibilities under this MOU. The training must include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU. For persons or entities performing these responsibilities as of the Effective Date, MCP must provide this training within *[The Parties may agree to 30, 45, or 60 Working Days]* of the Effective Date. Thereafter, MCP must provide this training prior to all such persons or entities performing responsibilities under this MOU and to all such persons or entities at least annually thereafter. MCP must require its Subcontractors and Downstream

Subcontractors to provide training on relevant MOU requirements and County services to their Network Providers. *[The Parties may agree to make this requirement mutual.]*

b. In accordance with health education standards as required by the Medi-Cal Managed Care Contract, MCP must provide Members and Network Providers with educational materials related to accessing Covered Services, including for services provided by County. In addition, MCP must provide its Network Providers with training on Medi-Cal for Kids and Teens services, utilizing the newly developed DHCS Medi-Cal for Kids and Teens Outreach and Education Toolkit as required by APL 23-005 or any subsequent version of the APL.

c. MCP must provide County, Members, and Network Providers with training and/or educational materials on how MCP's Covered Services, and any carved-out services, may be accessed, including during nonbusiness hours.

[The Parties may agree to additional requirements such as:

- *The Parties must together develop training and education resources covering the services provided or arranged for by the Parties. The Parties must share their training and educational materials with each other to ensure the information in their respective training and education materials includes an accurate set of services provided or arranged for by each Party and is consistent with MCP and County policies and procedures, and with clinical practice standards.*
- *The Parties must develop and share outreach communication materials and develop initiatives to share resources about MCP and County with individuals who may be eligible for MCP's Covered Services and/or County services.*
- *County must distribute MCP's current training and educational materials in a timely manner to support the County Liaison, County-assigned HCPCFC social workers, County behavioral health providers, PHNs, Community Health Workers, County Health Education Specialists, and HCPCFC social workers and secondary case managers in assisting Members with accessing Covered Services. The materials must include information on MCP's Covered Services, including nonemergency medical transportation and non-medical transportation; Community Supports; and/or other care management programs and services for which Members may qualify, such as ECM or Complex Care Management ("CCM").*
- *MCP and County must annually provide education to Members about the requirements and obligations set forth in this MOU.]*

7. Referral Process.

[The Parties may agree to additional requirements such as:

***Closed Loop Referrals.** By January 1, 2025, the Parties must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the*

CalAIM Population Health Management Policy Guide,[2] *APL 22-024 or any subsequent version of the APL, and as set forth by DHCS through an APL or other, similar guidance. The Parties must work collaboratively to develop and implement a process to ensure that MCP and County comply with the applicable provisions of closed loop referrals guidance within 90 Working Days of issuance of this guidance. The Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.]*

8. **Care Coordination and Collaboration.**
    a. **Care Coordination.**
        i. The Parties must adopt policies and procedures for coordinating Members' access to care and services that incorporate all the requirements set forth in this MOU.
        ii. The Parties must discuss and address individual care planning and coordination issues or barriers to care coordination efforts at least quarterly *[but can agree to more frequent meetings].*
        iii. MCP must have policies and procedures in place to maintain collaboration with County and to identify strategies to monitor and assess the effectiveness of this MOU.
        iv. MCP and County must collaborate to ensure that Members receiving County Child Welfare Services continue to receive all Medically Necessary Covered Services, including, without limitation, dental, behavioral, and developmental services, when they move to a new location or they transition or age out of receiving County foster care services.
        v. MCP must have processes for ensuring the continuation of Basic Population Health Management[3] and care coordination of all Medically Necessary Covered Services to be provided or arranged for by MCP for Members receiving County Child Welfare Services, with special attention to Members transitioning out of receiving foster care services and Members changing foster care placements.
        vi. MCP's policies and procedures must include processes for coordinating with County to ensure Members receive ECM, CCM, and/or Community Supports and/or other case management services for which they may qualify.
        vii. MCP must ensure Members' Medical Records are readily accessible and up to date for Members transitioning or aging out of receiving County foster care services.

[The Parties may agree additional requirements such as:

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[2] CalAIM Population Health Management Policy Guide, available at: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide-May-Update-0509023.pdf.

[3] Basic Population Health Management is defined as described in the CalAIM Population Health Management Policy Guide, available at: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide-May-Update-0509023.pdf.

- *The Parties must coordinate with the local Interagency Leadership Team to ensure the responsibilities of this MOU are carried out in alignment and coordination with County's SOC MOU as appropriate, to ensure Members receive timely, coordinated care.*
- *The Parties must coordinate to identify Members not receiving periodic preventive services in accordance with the American Academy of Pediatrics ("AAP") Bright Futures Periodicity Schedule using a data-informed methodology and develop a plan to help providers reach out to assigned Members who are not receiving periodic preventive services.*
- *The Parties must coordinate with county social services agencies for child welfare and Medi-Cal MCPs in other counties to ensure Members' utilization of Covered Services, especially evidence-based services that are specific to the needs of children who have experienced trauma.*
- *The Parties must implement mechanisms for implementing care coordination across multiple providers, including a shared comprehensive point of contact list or other mechanisms for supporting cross communication, and for coordinating with HCPCFC in particular, as applicable.]*

b. **Coordination of Medi-Cal for Kids and Teens Services.**[4]

i. Where MCP and County have overlapping responsibilities to coordinate services for Members under age 21, MCP must do the following:

1. Assess the Member's medical and/or behavioral health needs, or follow the Member's physician's or licensed behavioral health professional's recommendations, for Medi-Cal for Kids and Teens Medically Necessary Covered Services;

2. Determine what types of services (if any) are being provided by County, or other third-party programs or services;

3. Coordinate the provision of services with County to ensure that MCP and County are not providing or ensuring the provision of duplicative services and that the Member is receiving all Medically Necessary Medi-Cal for Kids and Teens services within 60 calendar days following the preventive screening or other visit identifying a need for treatment, whether or not the services are Covered Services under the Medi-Cal Managed Care Contract. All Medi-Cal for Kids and Teens services are Covered Services unless expressly excluded under the Medi-Cal Managed Care Contract;

4. Notify the appropriate primary case manager, HCPCFC PHN, and/or social/case worker if the Member (or parent, legal guardian, or caregiver) when the Member refuses services or is unable to be reached to ensure County has

[4] Additional guidance available in APL 23-005: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf.

information necessary to inform investigations, guide County placement decisions, and/or alert County staff to issues of safety or neglect; and

5. Notify the appropriate primary case manager, HCPCFC PHN, and/or HCPCFC social worker at the assumption of care to ensure that the appropriate person is aware of all services being provided to the Member.

c. **Care Coordination for Youth and Children Receiving Foster Care.**

i. MCP must implement policies and procedures to track Members receiving County Child Welfare Services by maintaining an up-to-date database of Members who are involved with child welfare and/or foster care as identified by the CDSS in collaboration with MCP.

ii. The MCP-County Liaison must oversee coordination of care for Members receiving County Child Welfare Services by:

1. Ensuring that each Member is assessed for medical and behavioral health needs;

2. Ensuring that each Member's needs as defined under Medi-Cal for Kids and Teens services have been met through the provision of a care plan and warm hand offs to appropriate Providers. If services are needed, the first encounter must occur without unnecessary delay and in accordance with clinical standards (e.g., AAP Bright Futures Periodicity Schedule, Advisory Committee on Immunization Practices vaccination schedule). This includes collaborating with Providers, foster caregivers, and HCPCFC PHN as necessary to ensure medical and dental exams are provided within 30 calendar days in accordance with the Child Welfare Services Manual Division 31.206.36;

3. Notifying group homes, Short Term Residential Therapeutic Programs, HCPCFC staff, HCPCFC social workers and/or case managers, and foster parents of Members regarding MCP and County services when a Member is placed outside MCP's Service Area;

4. Offering transportation information and resources, as needed, to Members, such as how Members can access non-emergency medical transportation for Medi-Cal services, which include, but are not limited to, appointments and medication, medical equipment, and supplies pickup;

5. Upon request by County or a Network Provider, facilitating scheduling of medical appointments and referrals for dental services for Members;

6. Informing Network Providers about the availability of benefits, including dental benefits, such as assisting Members with scheduling appointments, including behavioral health appointments, and arranging non-emergency medical transportation for Medi-Cal services; and

7. Upon request, providing information regarding the Member's Primary Care Physician ("PCP") or other Network Provider to County to assist with coordination of care.

iii. County should, when requested by Members (or Members' parent(s) or legal guardian(s) and/or caregiver(s) of foster children), assist Members

ages 0-21 years with scheduling appointments for medical services through their assigned PCP and/or alert MCP of barriers to Members' access to services.

d. **Care Coordination for Specialty Mental Health Services for Youth and Children.**

i. MCP and County must coordinate to ensure that Members receiving County Child Welfare Services are directly referred to County's MHP for an SMHS assessment pursuant to BHIN 21-073 if they, or an individual acting on their behalf, contacts the MCP access line or the MHP seeking help.

ii. MCP must ensure that Members are provided with all Medically Necessary Covered Services, as identified by the assessments and communicated to MCP, in a timely and coordinated manner and in accordance with DHCS APLs 22-005, 22-006, and 22-028 or other forthcoming instructions.

iii. The Parties must develop a process for coordinating care for Members receiving County Child Welfare Services who are eligible for or are concurrently receiving Non-Specialty Mental Health Services ("NSMHS") and SMHS consistent with the No Wrong Door for Mental Health Services Policy described in APL 22-005 and BHIN 22-011.

iv. MCP must adopt a "no wrong door" referral process for Members and work collaboratively to ensure that Members may access NSMHS and SMHS through multiple pathways and are not turned away based on which pathway they rely on, including but not limited to adhering to all applicable No Wrong Door for Mental Health Services Policy requirements described in APL 22-005 and BHIN 22-011.

9. Quarterly Meetings.

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU, but not less frequently than quarterly, in order to address care coordination, Quality Improvement activities, Quality Improvement outcomes, systemic and case-specific concerns, and communicating with others within their organizations about such activities. *[Parties may agree to meet more frequently.]* These meetings may be conducted virtually.

i. Within 30 Working Days after each quarterly meeting, MCP must post on its website the date and time the quarterly meeting occurred and, as applicable, distribute to meeting participants a summary of any follow-up action items or changes to processes that are necessary to fulfill MCP's obligations under the Medi-Cal Managed Care Contract and this MOU.

ii. MCP must invite the County Responsible Person and appropriate County program executives to participate in MCP quarterly meetings to ensure appropriate committee representation, including a local presence, to discuss and address care coordination and MOU-related issues. Subcontractors and Downstream Subcontractors should be permitted to participate in these meetings as appropriate.

iii. MCP must report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS.

b. **Local Representation.** MCP must participate, as appropriate, in meetings or engagements to which MCP is invited by County, such as local county meetings, local community forums, Child and Family Team Meetings, and County engagements, to collaborate with County in equity strategy and wellness and prevention activities.

[The Parties may agree to additional requirements such as that MCP must participate in AB 2083 SOC Local Interagency Leadership Team meetings to which MCP is invited by County to discuss aligning care coordination activities required by this MOU with County's efforts to coordinate care through SOC activities, wherever possible.]

10. Quality Improvement. The Parties must develop Quality Improvement activities specifically for the oversight of the requirements of this MOU, including, without limitation, any applicable performance measures and Quality Improvement initiatives, including those to prevent duplication of services, as well as reports that track referrals, Member engagement, and service utilization. MCP must document these Quality Improvement activities in policies and procedures.

[The Parties may agree to additional requirements such as the requirement that the Parties must adopt joint policies and procedures establishing and addressing Quality Improvement activities for coordinating the care of and delivery of services to Members.]

11. Data Sharing and Confidentiality. The Parties must implement policies and procedures to ensure that the minimum necessary Member information and data for accomplishing the goals of this MOU are exchanged timely and maintained securely and confidentially and in compliance with the requirements set forth below. The Parties must share information in compliance with applicable law, which may include the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA"), 42 Code of Federal Regulations Part 2, and other State and federal privacy laws. For additional guidance related to sharing Members' data and information, the Parties may reference the CalAIM Data Sharing Authorization Guidance.[5]

a. **Data and/or Information Exchange.** MCP must, and County is encouraged to, share the minimum necessary data and information to facilitate referrals and coordinate care under this MOU. The Parties must have policies and procedures for supporting the timely and frequent exchange of Member information and data, which may include sharing authorization documentation and Member demographic, contact, behavioral, and physical health information; CANS data; diagnoses; relevant physical assessments and screenings for adverse childhood experiences; medications prescribed; documentation of social or environmental needs identified; individual nursing service plan ("INSP")/Case Plan; and known changes in condition that may adversely impact the Member's health and/or welfare; and, if necessary, obtaining

[5] CalAIM Data Sharing Authorization Guidance VERSION 2.0, available at: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance-Version-2-Draft-Public-Comment.pdf.

Member consent. The minimum necessary information and data elements to be shared as agreed upon by the Parties are set forth in Exhibit C of this MOU. The Parties must annually review and, if appropriate, update Exhibit C of this MOU to facilitate sharing of information and data.

i. MCP must implement processes and procedures to ensure the Medical Records of those Members receiving County Child Welfare Services are readily accessible to ensure prompt information exchange and linkages to services, and to assist with ensuring that this population's complex needs remain met once Members are no longer involved with County Child Welfare and/or foster care.

ii. MCP must share the necessary information with County to ensure the County Liaison is made aware of Members who are enrolled in ECM and/or Community Supports and (i) are receiving County Child Welfare Services; (ii) have been involved with foster care in the past 12 months; (iii) are eligible for and/or enrolled in the Adoption Assistance Program;[6] or (iv) have received Family Maintenance services[7] in the past 12 months, in order to improve collaboration between County and ECM to help ensure Members have access to all available services.

iii. MCP must collaborate with County to develop processes and implement strategies to ensure their systems share data, and work together to improve outcomes that require collaboration across systems, including process measures (such as appropriate cross-sector attendance at Child and Family Teams Meetings), utilization measures (such as timely and appropriate access to Medi-Cal for Kids and Teens services for each Member), and outcome measures (such as shorter intervals until placement stability, shorter time to reunification, social drivers of health disparity gap closure).

[The Parties may agree to additional requirements such as:

- *MCP and County must enter into the State's Data Exchange Framework Data Sharing Agreement for the safe sharing of information.*
- *If Member authorization is required, the Parties must agree to a standard consent form together to obtain a Member's authorization to share and use information for the purposes of treatment, payment, and care coordination protected under 42 Code of Federal Regulations Part 2.]*

b. **Interoperability.** MCP must make available to Members their electronic health information held by MCP pursuant to 42 Code of Federal Regulations Section 438.10 and in accordance with APL 22-026, or any subsequent version of the APL. MCP must make available an application programming interface that makes complete and accurate Network Provider directory information available through a public-facing

[6] More information about the Adoption Assistance Program is available at https://www.cdss.ca.gov/inforesources/adoptions/adoption-assistance-program.
[7] More information about Family Maintenance services is available at https://www.cdss.ca.gov/inforesources/child-welfare-protection.

digital endpoint on MCP's website pursuant to 42 Code of Federal Regulations Sections 438.242(b) and 438.10(h).

[The Parties may agree to additional requirements such as:

Disaster and Emergency Preparedness. *The Parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the Parties' ability to provide services to ensure the continued coordination and delivery of County programs and services and MCP Covered Services for impacted Members.]*

12. Dispute Resolution.

a. The Parties must agree to dispute resolution procedures such that in the event of any dispute or difference of opinion regarding the Party responsible for service coverage arising out of or relating to this MOU, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. MCP must, and County should, document the agreed-upon dispute resolution procedures in policies and procedures. Pending resolution of any such dispute, County and MCP must continue without delay to carry out all their responsibilities under this MOU, including providing Members with access to services under this MOU, unless the MOU is terminated. If the dispute cannot be resolved within *[suggested: 15 Working Days]* of initiating such dispute or such other time period as may be mutually agreed to by the Parties in writing, either Party may pursue its available legal and equitable remedies under California law.

b. Disputes between MCP and County that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP to DHCS and may be reported by County to CDSS. Until the dispute is resolved, the Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided.

c. Nothing in this MOU or provision constitutes a waiver of any of the government claim filing requirements set forth in Title I, Division 3.6, of the California Government Code or otherwise set forth in local, State, and/or federal law.

13. Equal Treatment. Nothing in this MOU is intended to benefit or prioritize Members over persons served by County who are not Members. Pursuant to Title VI, 42 United States Code Section 2000d, et seq., County cannot provide any service, financial aid, or other benefit to an individual that is different, or is provided in a different manner, from that provided to others by County.

14. General.

a. **MOU Posting.** MCP must post this executed MOU on its website.

b. **Documentation Requirements.** MCP must retain all documents demonstrating compliance with this MOU for at least 10 years as required by the Medi-Cal Managed Care Contract. If DHCS requests a review of any existing MOU, MCP

must submit the requested MOU to DHCS within 10 Working Days of receipt of the request.

c. **Notice.** Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by in-person delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail, certified, return receipt requested, postage prepaid, are deemed given on the date of delivery indicated on the return receipt. The Parties may change their addresses for purposes of receiving notice hereunder by giving notice of such change to each other in the manner provided for herein.

d. **Delegation.** MCP may delegate its obligations under this MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor as permitted under the Medi-Cal Managed Care Contract, provided that such Fully Delegated Subcontractor or Partially Delegated Subcontractor is made a Party to this MOU. Further, MCP may enter into Subcontractor Agreements or Downstream Subcontractor Agreements that relate directly or indirectly to the performance of MCP's obligations under this MOU. Other than in these circumstances, MCP cannot delegate the obligations and duties contained in this MOU.

e. **Annual Review.** MCP must conduct an annual review of this MOU to determine whether any modifications, amendments, updates, or renewals of responsibilities and obligations outlined within are required. MCP must provide DHCS evidence of the annual review of this MOU as well as copies of any MOU modified or renewed as a result.

f. **Amendment.** This MOU may only be amended or modified by the Parties through a writing executed by the Parties. However, this MOU is deemed automatically amended or modified to incorporate any provisions amended or modified in the Medi-Cal Managed Care Contract, or as required by applicable law or any applicable guidance issued by a State or federal oversight entity.

g. **Governance.** This MOU is governed by and construed in accordance with the laws of the State of California.

h. **Independent Contractors.** No provision of this MOU is intended to create, nor is any provision deemed or construed to create, any relationship between County and MCP other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this MOU. Neither County nor MCP, nor any of their respective contractors, employees, agents, or representatives, is construed to be the contractor, employee, agent, or representative of the other.

i. **Counterpart Execution.** This MOU may be executed in counterparts, signed electronically and sent via PDF, each of which is deemed an original, but all of which, when taken together, constitute one and the same instrument.

j. **Superseding MOU.** This MOU constitutes the final and entire agreement between the Parties and supersedes any and all prior oral or written agreements, negotiations, or understandings between the Parties that conflict with the provisions set forth in this MOU. It is expressly understood and agreed that any prior written or oral agreement between the Parties pertaining to the subject matter herein is hereby terminated by mutual agreement of the Parties.

(Remainder of this page intentionally left blank)

The Parties represent that they have authority to enter into this MOU on behalf of their respective entities and have executed this MOU as of the Effective Date.

MCP	**County**
Signature: **Name:** **Title:** **Notice Address:**	**Signature:** **Name:** **Title:** **Notice Address:**
[Subcontractor or Downstream Subcontractor]	
Signature: **Name:** **Title:** **Notice Address:**	
[Additional MCP, if multiple MCPs in County]	
Signature: **Name:** **Title:** **Notice Address:**	

Exhibits A and B

[Placeholder for exhibits to contain MCP and County Liaisons as referenced in Sections 4.b and 5.b of this MOU]

Exhibit C

Data Elements

[The Parties may agree to additional data elements such as:

a. *MCP and County must share the following data elements:*
    i. *Member demographic information;*
    ii. *Behavioral and physical health information;*
    iii. *Diagnoses, progress notes, and assessments;*
    iv. *Medications prescribed;*
    v. *Laboratory results; and*
    vi. *Known changes in condition that may adversely impact the Member's health and/or welfare and that are relevant to the services.]*

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

31. Approve Contract Amendments to CalOptima Health Fee-for-Service Professional Services and Ancillary Services Provider Contracts, for Cyber Liability Insurance Requirements, and Ownership and Disclosure Requirements

Contacts

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

Recommended Actions

1. Authorize the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal FFS Professional contracts to comply with DHCS requirements for Medi-Cal ownership and control disclosures in accordance with DHCS APL 23-006 and 42 CFR § 455.104, effective January 1, 2024.

2. Authorize the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal and OneCare FFS Professional contracts to reflect requirements for cyber security insurance coverage of $1,000,000 per occurrence/claim, and $1,000,000 aggregate, effective January 1, 2024.

3. Authorize the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal and OneCare FFS Ancillary Services contracts to reflect requirements for cyber security insurance coverage of $1,000,000 per occurrence/claim, and $1,000,000 aggregate, effective January 1, 2024.

4. Amend Medi-Cal FFS Ancillary Services contracts to comply with DHCS requirements for Medi-Cal ownership & control disclosures in accordance with DHCS APL 23-006 and 42 CFR § 455.104.

Background and Discussion

1. Cyber Security Insurance:

The healthcare industry is a significant target for hackers and cybercriminals, potentially compromising private and confidential healthcare data and placing the safety and health of patients at risk. Most recently, one of Southern California's largest healthcare systems experienced a security breach disrupting the availability of certain IT systems, impacting its acute care hospitals and medical groups. Although the entity had secure systems in place to mitigate breaches, they still fell victim to hacks.

In the event of a potential security breach of CalOptima Health's members' protected health information, staff requests the CalOptima Health Board of Directors (Board) approve an amendment requiring network providers to maintain cyber security insurance coverage in the amount of $1,000,000 per occurrence/claim, and $1,000,000 aggregate.

Back to Agenda

2. Compliance with Medi-Cal Ownership and Control Disclosures:

   In accordance with the Centers for Medicare & Medicaid Services (CMS) requirements, DHCS revised the ownership and control disclosure requirements for providers contracting for Medi-Cal services specifically for compliance with 42 CFR Section 455.104(b), which mandates disclosure of Social Security Numbers. These revisions are also necessary for compliance with 42 CFR, Section 455.436, which mandates that the State Medicaid Agency perform routine checks of federal databases.

   To ensure CalOptima Health's contracts are compliant with federal requirements at 42 CFR Section 455.436 for the collection of Medi-Cal ownership and control disclosures, staff requests the Board approve an amendment mandating that providers complete and submit an ownership and control disclosures form disclosing individuals or entities with a 5 percent or more ownership interest in the provider's business.

To remain compliant with Medi-Cal, state and federal regulations, and ensure operational procedures are aligned with industry standards, staff requests the Board's authorization to execute the above amendments, effective January 1, 2024.

Fiscal Impact
The recommended actions are operational in nature and have no additional fiscal impact beyond what was included in the CalOptima Health Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation
Authorizing the above amendments will ensure compliance with state regulation, and operational alignment with industry standards.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. All LOB Professional Services Contract Draft Amendment for Cyber Liability, Targeted Rate Increase
2. All LOB Ancillary Amendment for Cyber Liability, Targeted Rate Increase, and Ownership and Disclosure
3. APL 23-006: Delegation and Subcontractor Network Certification

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

AMENDMENT [XX] TO

PROFESSIONAL SEVICES CONTRACT

This Amendment [XX] to the Professional Services Contract ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima 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. The Parties desire to amend the Contract to specify additional insurance requirements and ownership disclosure requirements.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete Section 1.1.5 in its entirety.

2. Delete Section 3.13, *Disclosure of Professional Ownership*, and replace it with new Section 3.13 as follows:

"3.13 Disclosure of Professional Ownership. Professional shall fully and accurately complete the disclosure form in Attachment E and submit the disclosure form to CalOptima prior to the Effective Date. Professional shall promptly notify CalOptima of any changes to the information contained in the disclosure form in Attachment E and submit an updated disclosure form to CalOptima within thirty (30) days of any such change."

3. Delete Article 5, *Insurance and Indemnification*, in its entirety and replace with the following new Article 5:

"ARTICLE 5
INSURANCE AND INDEMNIFICATION

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

5.2 Provider Professional Liability. Professional, at its sole cost and expense, shall ensure that Practitioners providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Professional provides. For Physician

Back to Item

insurance, minimums shall be no less than $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Comprehensive General Liability ("CGL")/Automobile Liability. Professional at its sole cost and expense shall maintain such Policies of comprehensive general liability and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives, including automobile liability insurance if motor vehicles are owned, leased or operated in furtherance of providing services under this Contract, against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Professional, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Professional at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employers' liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Cyber Liability Insurance. Professional 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.

5.5.1 Cyber Liability Insurance requirements: [$1,000,000] each occurrence/claim and [$1,000,000] aggregate.

5.6 Insurer Ratings. All above insurance shall be provided by an insurer:

5.6.1 Rated by Best's with a rating of B or better; and

5.6.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code § 12180.7.

5.7 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.8 Cancellation or Material Change. Insurance required in this Article 5 shall not be canceled or materially changed during the term of this Contract.

5.9 Certificates of Insurance. Prior to execution of this Contract, Professional shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further, to the extent that no expenditure by Professional is required, providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and that coverage is primary and non-contributory as to any other insurance with respect to performance hereunder."

4. The Parties agree to delete Attachment E, *Disclosure Form*, of the Contract in its entirety and replace it with the new Attachment E, *Disclosure Form*, attached to this Amendment and incorporated into the Contract by this reference.

5. Delete Section 25.10 of Addendum 1, *Medi-Cal Program Requirements*, in its entirety and replace it with the following Section 25.10:

   "25.10 An agreement to hold harmless the State, Members, and CalOptima in the event the Professional 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 III.9 of Attachment B of the Contract."

6. The Parties agree to delete Addendum 3, *Cal MediConnect Program Requirements*, in its entirety

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. 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*)

Back to Item

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PROFESSIONAL:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ATTACHMENT E
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: _____

AMENDMENT [XX] TO

ANCILLARY SEVICES CONTRACT

This Amendment [XX] to the Ancillary Services Contract ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and, [add provider name] ("**Provider**"). CalOptima and Provider may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Provider have entered into an Ancillary Services Contract, originally effective [insert date], ("**Contract**"), by which Provider has agreed to provide or arrange for the provision of Covered Services to Members.

B. The Parties desire to amend the Contract to specify additional insurance requirements and disclosure of ownership requirements.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete Section 2.10, *Disclosure of Provider Ownership*, and replace it with new Section 2.10 as follows:

"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. Delete Article 5, *Insurance and Indemnification*, in its entirety and replace with the following new Article 5:

"ARTICLE 5
INSURANCE AND INDEMNIFICATION

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

5.2 Provider Professional Liability. Provider, at its sole cost and expense, shall ensure that it and Subcontractors providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Provider provides, with a minimum of $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Provider Commercial General Liability ("CGL")/Automobile Liability. Provider at its sole cost and expense shall maintain such policies of commercial general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Provider, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year

5.4 Workers Compensation Insurance. Provider at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employers liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 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.

5.5.1 Cyber Liability Insurance requirements: [$1,000,000] each occurrence/claim and [$1,000,000] aggregate.

5.6 Insurer Ratings. All above insurance shall be provided by an insurer:

5.6.1 Rated by Best's with a rating of B or better; and

5.6.2 "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code § 12180.7.

5.7 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.8 Cancellation or Material Change. Provider shall not of its own initiative cause such insurances as addressed in this Article 5 to be canceled or materially changed during the Term.

5.9 Certificates of Insurance. Prior to execution of this Contract, Provider shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and coverage is primary and non-contributory as to any other insurance with respect to performance hereunder."

3. The Parties agree to delete Attachment D, *Disclosure Form*, of the Contract in its entirety and replace it with the new Attachment D, *Disclosure Form*, 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.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PROVIDER:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ATTACHMENT D
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: _____

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: March 28, 2023

ALL PLAN LETTER 23-006
SUPERSEDES ALL PLAN LETTER 17-004

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: DELEGATION AND SUBCONTRACTOR NETWORK CERTIFICATION

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on the requirements for delegation and monitoring of Subcontractors. This APL also details the Subcontractor Network Certification (SNC) process wherein MCPs must provide assurances that each Subcontractor's and Downstream Subcontractor's Provider Network meets state and federal Network adequacy and access requirements.

BACKGROUND:
Title 42 Code of Federal Regulations (CFR) section 438.230 specifies the requirements MCPs must include in all contracts or written agreements with any Subcontractors.[1] This regulation addresses the duties and obligations of MCPs and their Subcontractors. The regulation also emphasizes that regardless of the relationship the MCP has with a Subcontractor, whether direct or indirect through additional layers of contracting or delegation, the MCP has the ultimate responsibility for adhering to, and fully complying with, all terms and conditions of its contract with the Department of Health Care Services (DHCS).

Furthermore, MCPs must ensure, through their contracts with any Subcontractors, that their Subcontractors provide written disclosures of information on ownership and control as required under 42 CFR 455.104.[2] To address frequent findings relating to 42 CFR 455.104, the Centers for Medicare and Medicaid Services (CMS) has issued guidance, in the form of a toolkit.[3] In the toolkit, CMS clarifies that a board member should be listed as a "person with ownership or control interest" or as a "managing employee," to the extent they meet either definition pursuant to 42 CFR 455.101. MCPs must comply

[1] 42 CFR 438. The CFR is searchable at: https://www.ecfr.gov/.
[2] 42 CFR 438.608
[3] The CMS-issued toolkit is available at: https://www.cms.gov/sites/default/files/repo-new/25/Toolkit%20for%20Disclosures%20of%20Ownership%20and%20Control%2042%20CFR%20455%20104%20_final.pdf

with the ownership and control disclosure requirement 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.

Additionally, the California Advancing and Innovating Medi-Cal (CalAIM) 1915(b) Waiver Special Terms and Conditions (STCs) requires DHCS to provide CMS with assurances that MCPs are holding all Subcontractors who assume risk to DHCS' Network adequacy and access standards as of the 2022 Reporting Year (RY).[4, 5] As a result, MCPs will be required to undergo an annual SNC as part of its Annual Network Certification.[6]

POLICY:

Definitions

For purposes of this APL, the following definitions apply:

- Subcontractor – an individual or entity that has a Subcontractor Agreement with the MCP that relates directly or indirectly to the performance of the MCP's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

- Downstream Subcontractor – an individual or entity that has a Downstream Subcontractor Agreement with a Subcontractor of the MCP or a Downstream Subcontractor that relates directly or indirectly to the performance of the Subcontractor's obligations under its Subcontractor Agreement with the MCP.

- Subcontractor Network – a Provider Network of a Subcontractor or Downstream Subcontractor, wherein the Subcontractor or Downstream Subcontractor is delegated risk and is responsible for arranging for the provision of and paying for Covered Services as stated in their Subcontractor or Downstream Subcontractor Agreement.

[4] See the CalAIM Waiver Special Terms and Conditions, available at: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915b-STCs.pdf
[5] For purposes of this APL, the RY is the calendar year.
[6] For more information on the Annual Network Certification process, see APL 23-001, or any superseding APL. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

- Subcontracted Network Certification (SNC) – a process that entails MCPs reporting on their monitoring of Subcontractors' and Downstream Subcontractors' Provider Networks and submitting documentation to DHCS verifying the compliance and/or noncompliance reported.

I. MONITORING SUBCONTRACTORS

A. Delegation Accountability

If an MCP delegates any activity or obligation to a Subcontractor, whether directly or indirectly, the Subcontractor Agreement must:

1) Specify any and all delegated activities, obligations, and related reporting responsibilities;

2) Include the Subcontractor's agreement to perform the delegated activities, obligations, and reporting responsibilities; and

3) Provide for the revocation of the delegation of activities or obligations, or specify other remedies where DHCS or the MCP determines the Subcontractor is not performing satisfactorily.[7]

The Subcontractor Agreement must also state that the Subcontractor agrees to comply with all applicable Medicaid laws and regulations, including all subregulatory guidance and Contract provisions, as well as the applicable state and federal laws.[8] MCPs must maintain and communicate to Subcontractors their policies and procedures for monitoring Subcontractors' compliance with all requirements related to all delegated activities, obligations, and related reporting responsibilities as described in this APL. All policies and procedures must be made available to DHCS upon request.

B. Ownership and Control Disclosures

To identify potential conflicts of interest, MCPs are required to collect and review their Subcontractors' ownership and control disclosures as set forth in 42 CFR 455.104.[9] The review of ownership and control disclosures applies to all

[7] 42 CFR 438.230(c)(1)
[8] 42 CFR 438.230(c)(2)
[9] 42 CFR 438.608(c)

Subcontractors that contract with the MCP, including disclosing entities, fiscal agents, and managed care entities.

MCPs must require and ensure Subcontractors accurately provide all required information in their disclosures. This information includes the date of birth and social security number for each person with an ownership or control interest and for each managing employee. An officer or director of a disclosing entity that is organized as a corporation should be considered a person with control interest.[10] The CMS toolkit specifies that a board member of a disclosing entity must be listed as a "managing employee" to the extent that they meet that definition in 42 CFR 455.101. The CMS toolkit also specifies that a board member of the disclosing entity must be listed as a "person with an ownership or control interest" to the extent that they meet that definition in 42 CFR 455.101.

MCPs must review to identify potential conflicts of interest and make Subcontractors' ownership and control disclosures available upon request, as the information is subject to audit by DHCS. MCPs must alert their Managed Care Operations Division (MCOD) Contract Manager within ten Working Days upon discovery that a Subcontractor is noncompliant with these requirements, and/or if a disclosure reveals any potential violations of the ownership and control requirements.

C. Data Reporting

MCPs must monitor the quality and compliance of Subcontractor data that MCPs submit to DHCS or other entities, pursuant to reporting responsibilities under state and federal laws. MCPs must ensure the data reported by Subcontractors is complete, accurate, reasonable, and timely. This includes, but is not limited to, encounter data, monthly 274 Provider Network data files, data reported through quarterly templates, electronic visit verification reporting, and any other ad hoc data requests required by DHCS.

MCPs must require Subcontractors to submit complete, accurate, and timely Network Provider encounter data to the MCPs for all items and services furnished to Members either directly or through Downstream Subcontractors or other arrangements with Providers. MCPs must have in place mechanisms, including data validation and reporting systems, sufficient to ensure a

[10] 42 CFR 455.104(b)(1)

Subcontractor's Network Provider encounter data is complete, accurate, reasonable, and timely prior to submission to DHCS.

D. Monitoring, Corrective Action, and Sanctions

MCPs must regularly monitor all functional areas delegated to Subcontractors. MCPs must also impose corrective action and/or financial sanctions on Subcontractors upon discovery of noncompliance with the terms of their Subcontractor Agreement or any Medi-Cal requirements. MCPs must report any significant instances (i.e., in terms of gravity, scope and/or frequency) of noncompliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the contract with DHCS to their MCOD Contract Managers within three Working Days of the discovery or imposition.

II. SUBCONTRACTOR NETWORK CERTIFICATION

A. Circumstances for Submission

DHCS is required by state and federal laws to annually certify each MCP's full Provider Network for compliance with Network adequacy and access requirements and provide an assurance of that compliance to CMS for the RY.[11] As of the 2022 RY, the CalAIM 1915(b) Waiver STCs also require DHCS to provide the same assurances of Network adequacy and access for the Provider Networks of all MCP Subcontractors and Downstream Subcontractors that have assumed risk per their Subcontractor and Downstream Subcontractor Agreements. Henceforth, MCPs are required to undergo a SNC annually that is separate and distinct from the submission process for the Annual Network Certification (ANC).

SNC is also required (1) when a Subcontractor Network experiences a significant change, and (2) when the MCP enters into a new risk-based Subcontractor Agreement with a Subcontractor that expands the MCP's existing Provider Network. A significant change is (1) an event that impacts the provision of health care services for 2,000 or more Members or (2) when a Subcontractor Network change causes the MCP to become noncompliant with any of the Network adequacy and access standards outlined in APL 23-001 or any superseding APL. In either instance, MCPs must submit the applicable SNC documentation for only

[11] 42 CFR section 438.207(d).

the Network adequacy and access standards impacted by the significant change or noncompliance. If a significant change occurs within the 90 calendar days prior to the SNC annual submission date, the MCP can document the change as part of that RY SNC filing. For any significant changes that occur after the SNC annual submission date, the MCP should submit the applicable SNC documentation for only the Network adequacy and access standards impacted by the significant change and report the change in the SNC for that RY.

B. Subcontractor Network Criteria

Subcontractors and Downstream Subcontractors can be MCPs that are delegated to arrange for the provision of Covered Services on behalf of another MCP, or any other entities that are delegated responsibility by MCPs and Subcontractors for specific services and/or populations such as medical groups, independent physician associations, clinics, and community-based organizations. Whether a Subcontractor or Downstream Subcontractor is fully or partially delegated for functions and obligations under their Subcontractor or Downstream Subcontractor Agreement, Subcontractor Networks are only required to meet the Network adequacy and access standards for the Members assigned to the Subcontractor Network, and for Covered Services the Subcontractor or Downstream Subcontractor is contracted to arrange for Members on behalf of the MCP or Subcontractor. Refer to the SNC Instruction Manual (Attachment A) for details on determining which standards each Subcontractor Network must meet based on populations served and services covered.

For the annual SNC, MCPs must include all Subcontractor Networks reported via the 274 Provider Network data file, unless the Subcontractor Network is exempt per the criteria listed below and the required documentation provided substantiates the exemption.[12] In addition to Service Areas where MCPs only contract directly with individual Providers and no Subcontractor Networks exist, the following describes the Subcontractor Networks that are exempt from SNC:

1) MCP only contracts with one Subcontractor Network in the Service Area, and no Providers directly contract with the MCP;

[12] The documentation for submission to substantiate exemptions is outlined in the Subcontractor Network Certification Instruction Manual (Attachment A)

2) The Subcontractor Network only provides specialty or ancillary services; or

3) The Subcontractor Network only provides care through single case agreements and is not available to all the MCP's Members upon enrollment.

MCPs are to submit exemption requests with their SNC submission per the instructions provided in Attachment A using the Subcontractor Network Exemptions Request template (Attachment B). DHCS will review each exemption request and provide a formal notification of the disposition to the MCP. Approvals are valid for one calendar year until the next annual SNC filing.

C. Submission

MCPs must submit the required SNC documentation to DHCS that accurately reflects the MCP's monitoring of Subcontractor Networks, no later than 45 days following the RY or, if the date falls on a weekend, the next Working Day. MCPs must submit all required SNC documentation as described in Attachment A with the correct file naming conventions through the DHCS Secure File Transfer Protocol site. MCPs that fail to submit complete and accurate SNC documentation by the SNC annual submission date are subject to the imposition of a corrective action plan (CAP) and/or other enforcement actions pursuant to the MCP Contract, Welfare and Institutions Code (WIC) section 14197.7(e), and APL 22-015 or any superseding APL.[13]

The SNC submission consists of three parts: (1) the Subcontractor Network Exemptions Request template (Attachment B), (2) the Network Adequacy and Access Assurances Report (NAAAR) (Attachment C), and (3) verification documents. The NAAAR, Attachment C, is a modified CMS reporting template containing two sections, Sections B and C, that MCPs are required to complete. Section A of the template is prepopulated with the state's Network adequacy and access standards for which MCPs must hold their Subcontractors accountable, as applicable per Subcontractor Network. Because these Network adequacy and access standards are the same as those DHCS uses to certify MCPs' Provider Networks through the ANC process, please refer to APL 23-001, or any superseding APL, for the specific time or distance, timely access, Provider to

[13] State law is searchable at: https://leginfo.legislature.ca.gov/. MCP boilerplate contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

Member ratios, and mandatory Provider types standards MCPs must use to monitor the compliance of their Subcontractor Networks.

In Section B of the NAAAR, MCPs must delineate the types of analyses they use to monitor and determine the Network adequacy and access compliance of Subcontractor Networks. In Section C, MCPs report, in detail, the compliance results and findings of all the Subcontractor Network monitoring analyses conducted within the RY. Refer to Attachment A for detailed instructions on how to fill out the NAAAR.

The third part of the SNC submission is submission of documents for DHCS' review that verify the compliance results and findings reported on the NAAAR. Due to the size of California's Medicaid managed care program and the number of Subcontractor Networks, DHCS will verify documents for a subset of an MCP's Subcontractor Networks. DHCS will notify MCPs of the Subcontractor Networks to be sampled, at a minimum, at least 30 days in advance of the annual SNC submission date of 45 days after the end of the RY, or the next Working Day if the date falls on a weekend. MCPs are only required to send verification documents for Subcontractor Networks that DHCS notifies MCPs of that are to be sampled per Services Area/county for the specified RY.

A Service Area is the county or counties that the MCP is approved to operate in under the terms of their DHCS Contract. If the Service Area for a Subcontractor or Downstream Subcontractor is otherwise designated differently in the Subcontractor or Downstream Subcontractor Agreement, the MCP must show proof of that definition using the Subcontractor Network Exemptions Request (Attachment B).

To ensure every Subcontractor Network is verified, DHCS will remove the previously approved Subcontractor Network(s) from the MCP's pool of Subcontractor Networks after every annual SNC until all of the MCP's Subcontractor Networks have been sampled and verified. Once all of the MCP's Subcontractor Networks have been sampled and verified, the random selection cycle will begin again. Please refer to the Subcontractor Network Certification Instruction Manual (Attachment A) for more information about the required verification documents, including the list of acceptable types of documentation MCPs may submit to DHCS. DHCS may request additional MCP verification documents at any time in order to confirm that the information provided on the NAAAR is accurate. An MCP's failure to provide the requested documentation or

a determination by DHCS that the information in the SNC submission is invalid or inaccurate may lead to implementation of a CAP and/or other enforcement actions.

D. Noncompliance

All Subcontractor Network deficiencies impacting Member access to care, as identified by an MCP while monitoring, must result in the MCP, or the Subcontractor (if delegated utilization management), authorizing Covered Services from Out-of-Subcontractor Network (OOSN) Providers for Members in the deficient Subcontractor Network. OOSN Providers used to supplement a deficient Subcontractor Network may include Providers from an MCP's own direct Provider Network or those Out-of-Network when necessary. The MCP, or Subcontractor or Downstream Subcontractor which is delegated utilization management, must authorize Covered Services from OOSN Providers regardless of associated transportation or Provider costs until the deficiency is addressed. An MCP or Subcontractor must also ensure that the deficient Subcontractor or Downstream Subcontractor informs Members that OOSN access to services is available, and that the MCP's or Subcontractor's Member services staff are trained on Members' right to request OOSN access for Covered Services and transportation to Providers where the Subcontractor or Downstream Subcontractor is unable to comply with Network adequacy or access standards.

E. Deficiencies and Corrective Action

Upon completing the review of SNC submissions, DHCS will provide a CAP notification letter to each MCP found non-compliant with the SNC requirements of this APL, outlining the deficiencies and specific issues of noncompliance that the MCP must address. MCPs must provide an initial CAP response, no later than 30 calendar days after the issuance of the CAP notification letter, that details a plan of action and sets forth steps the MCP will take to correct the deficiencies identified.

MCPs have six months to correct all deficiencies during which time MCPs must provide DHCS with monthly status updates that demonstrate action steps the MCP is undertaking to address the CAP. DHCS may impose sanctions, or other appropriate enforcement actions, for failure to comply with Network adequacy

and access standards at the end of the six-month CAP period. If monetary sanctions are to be imposed, DHCS will consider the factors set forth in WIC section 14197.7(g) when assessing and determining the amount.

The requirements contained in this APL will necessitate a change in an MCP's contractually required P&Ps. MCPs must submit their updated P&Ps to their MCOD Contract Manager within 90 calendar days of the release of this APL.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable State and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.[14] These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[14] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

32. Approve Contract Amendments for CalOptima Medi-Cal Health Network Providers Reflecting Cyber Liability Insurance Requirements, New Hospital Referral Procedures, Ownership and Disclosure Requirements, and Pay for Value Performance Program Incentive Payment Requirements

Contacts

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

Recommended Actions

1. Authorize the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal Shared-Risk Group (SRG), Health Maintenance Organization (HMO), and Physician-Hospital Consortia (PHC) health network contracts to reflect requirements for cyber security insurance coverage of $5,000,000 per occurrence/claim, and $5,000,000 aggregate, effective January 1, 2024.

2. Authorize the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal SRG health network contracts to reflect requirements to refer CalOptima Members to providers that have hospital privileges at CalOptima Health contracted hospitals, effective January 1, 2024.

3. Authorize the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal SRG, HMO and PHC health Network contracts to comply with DHCS requirements for Medi-Cal ownership and control disclosures in accordance with DHCS APL 23-006 and 42 CFR § 455.104, effective January 1, 2024.

4. Authorize the Chief Executive Officer to execute an amendment to the CalOptima Health Medi-Cal SRG, HMO, PHC Health Network contracts to distribute 85% of incentive payments passed down through the CalOptima Health Medi-Cal Pay for Value Performance Program (P4V Program) to contracted physicians, beginning with Measurement Year 2024.

Background and Discussion

Cyber Security Insurance:

The healthcare industry is a significant target for hackers and cybercriminals, potentially compromising private and confidential healthcare data and placing the safety and health of patients at risk. Most recently, one of Southern California's largest healthcare systems experienced a security breach disrupting the availability of certain IT systems, impacting its acute care hospitals and medical groups. Although the entity had secure systems in place to mitigate breaches, they still fell victim to hacks. In the event of a potential security breach of CalOptima Health's members' protected health information, staff requests the CalOptima Health Board of Directors (Board) approve an amendment requiring CalOptima Health's health networks maintain cyber security insurance coverage in the amount of $5,000,000 per occurrence/claim, and $5,000,000 aggregate.

Back to Agenda

Contractual Requirements Regarding Referrals to CalOptima Health Contracted Hospitals:
Approximately 80%-85% of CalOptima Health's total membership is assigned to health networks that are delegated for authorization and coordination of member care. As an industry standard practice and contractual requirement, managed care plans (MCPs) require their contracted delegated health networks to refer members to providers that maintain hospital privileges at hospitals that are contracted and credentialed by the MCP. When members are directed to and or admitted at non-contracted hospitals CalOptima Health is not able to ensure members are being directed to hospitals that are appropriately licensed, is unable to obtain medical records when required to support regulatory audits and may be required to pay claims at billed charges.

To ensure the health, safety, and welfare of CalOptima Health members; ensure members are directed to hospitals that are properly licensed and approved by Medi-Cal and Medicare regulatory agencies, and credentialed by CalOptima Health, as well as, mitigate its exposure of paying claims greater than Medi-Cal or Medicare rates, staff requests the Board require CalOptima Health's contracts with health networks contain a language provision for CalOptima members to be referred to CalOptima Health contracted providers that have hospital privileges at CalOptima Health contracted hospitals, whenever possible.

Compliance with Medi-Cal Ownership and Control Disclosures:
In accordance with the Centers for Medicare & Medicaid Services (CMS) requirements, DHCS revised the ownership and control disclosure requirements for providers contracting for Medi-Cal services specifically for compliance with 42 CFR Section 455.104(b), which mandates disclosure of Social Security Numbers. These revisions are also necessary for compliance with 42 CFR Section 455.436, which mandates that the State Medicaid Agency perform routine checks of federal databases.

On March 28, 2023, DHCS released the All-Plan Letter 23-006, Delegation and Subcontractor Network Certification (APL 23-006) to provide MCPs with guidance on the requirements for delegation and monitoring of subcontractors. APL 23-006 requires that MCPs ensure, through their contracts with any subcontractors, that their subcontractors provide written disclosures of information on ownership and control as required by 42 CFR 455.104.

To ensure CalOptima Health's contracts with health networks are in compliance with DHCS APL 23-006, as it relates to requirements for the collection of Medi-Cal ownership and control disclosures, staff requests approve an amendment mandating that health networks complete and submit an ownership and control disclosure form disclosing individuals or entities with a 5 percent or more ownership interest in the health network's business.

Medi-Cal P4V Program Incentive Payment Requirements
CalOptima Health has maintained a P4V Program to recognize outstanding performance and support ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks and CalOptima Health community network primary care physicians (PCPs) are eligible to participate in the P4V Program. In recognition that PCPs are providing direct care to ensure that members receive appropriate

preventive and chronic care, CalOptima Health is requiring that its contracted health networks distribute directly to their contracted physicians at least 85% of any quality P4V Program incentive payments that CalOptima Health makes to the contracted health networks beginning with measurement year 2024.

To remain compliant with Medi-Cal and Medicare regulations, ensure the health, safety and welfare of member PHI and ensure operational procedures are aligned with industry standards, staff requests the Board's authorization to execute the above amendments, effective January 1, 2024.

Fiscal Impact
The recommended actions are operational in nature and have no additional fiscal impact beyond what was included in the CalOptima Health Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation
Authorizing the above amendments will ensure compliance with state regulations and operational alignment with industry standards.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered this Recommended Board Action
2. SRG Health Network Draft Amendment
3. PHC-Physician Health Network Draft Amendment Increase
4. PHC-Hospital Health Network Draft Amendment
5. HMO Health Network Draft Amendment
6. APL 23-006: Delegation and Subcontractor Network Certification

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Health Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Health Services	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
HPN Regal Medical Group	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Kaiser Permanente	393 E. Walnut St.	Pasadena	CA	91188
Noble Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
Optum Care Network -Arta	3390 Harbor Blvd., Ste. 100	Costa Mesa	CA	92626
Optum Care - Monarch	1 Technology Dr.	Irvine	CA	92618
Optum Care -Talbert	3390 Harbor Blvd. Ste. 100	Costa Mesa	CA	92626
Prospect Medical Group	600 City Parkway West Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

Back to Item

Back to Agenda

AMENDMENT [XX] TO

CONTRACT FOR HEALTH CARE SERVICES

This Amendment [XX] to the Contract for Health Care Services ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima 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 Parties desire to amend the Contract to specify additional insurance and ownership disclosure requirements and other requirements.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete Section 2.3, *Insurance Requirements*, of the Contract in its entirety and replace it with the following new Section 2.3:

"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

2.3.2 Commercial General Liability/Commercial Automobile Liability:
Physician 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 Physician's Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:
Physician 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:
Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

Managed Care Errors and Omissions:
$10,000,000 each claim/$10,000,000 aggregate

2.3.5 Cyber Liability:
Physician 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 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 Shared Risk Group 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 Physician shall be provided to CalOptima prior to execution of the Contract and annually thereafter. Physician 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. Delete Section 3.22, *Disclosure of Ownership*, and replace it with new Section 3.22 as follows:

"3.22 DISCLOSURE OF OWNERSHIP -- Physician shall fully and accurately complete the disclosure form in Attachment B and submit the disclosure form to CalOptima prior to the Effective Date. Physician 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.

3.22.1 If Physician is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, Physician 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. Add the following new Section 4.1.10:

"4.1.10 Physician shall refer CalOptima Members to providers that have hospital privileges at CalOptima contracted facilities, whenever possible."

4. Add the following new Section 13.12.1:

"13.12.1 Physician will distribute directly to Participating Providers at minimum of eighty-five percent (85%) of any quality pay for value incentive payment(s) that CalOptima may makes to Physician directly to Participating Providers, beginning with Measurement Year 2024."

5. The Parties agree to delete Attachment B, *Disclosure Form*, of the Contract in its entirety and replace it with the new Attachment B, *Disclosure Form*, attached to this Amendment and incorporated into the Contract by this reference.

6. 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.

7. 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 PHYSICIAN:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

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: _____

AMENDMENT [XX] TO

CONTRACT FOR HEALTH CARE SERVICES

This Amendment [XX] to the Contract for Health Care Services ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima 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 Parties desire to amend the Contract to specify additional insurance and ownership disclosure requirements and other requirements.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete Section 2.3, *Insurance Requirements*, of the Contract in its entirety and replace it with the following new Section 2.3:

"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

2.3.2 Commercial General Liability/Commercial Automobile Liability:
Physician 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 Physician's Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:
Physician 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:
Physician 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:
Physician 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-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 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 PHC 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 Physician shall be provided to CalOptima prior to execution of the Contract and annually thereafter. Physician 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. Delete Section 3.23, *Disclosure of Ownership*, and replace it with new Section 3.23 as follows:

"3.23 DISCLOSURE OF OWNERSHIP -- Physician shall fully and accurately complete the disclosure form in Attachment B and submit the disclosure form to CalOptima prior to the

Effective Date. Physician 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 Physician is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, Physician 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. Add the following new Section 13.13.1:

"13.13.1 Physician 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 Physician, begging with Measurement Year 2024."

4. The Parties agree to delete Attachment B, *Disclosure Form*, of the Contract in its entirety and replace it with the new Attachment B, *Disclosure Form*, attached to this Amendment and incorporated into the Contract by this reference.

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 PHYSICIAN:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

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: _____

AMENDMENT [XX] TO

CONTRACT FOR HEALTH CARE SERVICES

This Amendment [XX] to the Contract for Health Care Services ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and, [health network hospital 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 Parties desire to amend the Contract to specify additional insurance and ownership disclosure requirements and other requirements.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete Section 2.3, *Insurance Requirements*, of the Contract in its entirety and replace it with the following new Section 2.3:

"2.3 INSURANCE REQUIREMENTS:

2.3.1 Professional/Medical Malpractice:
Each Hospital providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy with minimum limits as follows:

Hospital providing covered services:
$10,000,000 per incident/$10,000,000 aggregate

2.3.2 Commercial General Liability/Commercial Automobile Liability:
Hospital 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 Hospital's Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:
Each Hospital providing Covered Services to Members 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 Not applicable to this Contract.

2.3.5 Cyber Liability:
Hospital 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 Hospital 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 Hospital shall be provided to CalOptima prior to execution of the Contract and annually thereafter. Hospital 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. Delete Section 3.18, *Disclosure of Ownership*, and replace it with new Section 3.18 as follows:

"3.18 DISCLOSURE OF OWNERSHIP -- Hospital shall fully and accurately complete the disclosure form in Attachment B and submit the disclosure form to CalOptima prior to the Effective Date. Hospital 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.

3.18.1 If Hospital is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, Hospital 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. Add the following new Section 13.12.1:

"13.12.1 Hospital will distribute directly to Participating Providers a minimum eighty-five percent (85%) of any quality pay for value incentive payment(s) that CalOptima makes to Hospital, beginning with Measurement Year 2024."

4. The Parties agree to delete Attachment B, *Disclosure Form*, of the Contract in its entirety and replace it with the new Attachment B, *Disclosure Form*, attached to this Amendment and incorporated into the Contract by this reference.

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 HOSPITAL:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

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: _____

AMENDMENT [XX] TO

CONTRACT FOR HEALTH CARE SERVICES

This Amendment [XX] to the Contract for Health Care Services ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima 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 Parties desire to amend the Contract to specify additional insurance and ownership disclosure requirements and other requirements.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete Section 2.3, *Insurance Requirements*, of the Contract in its entirety and replace it with the following new Section 2.3:

"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. Delete Section 3.23, *Disclosure of Ownership*, and replace it with new Section 3.23 as follows:

"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. Add the following new Section 13.13.1:

"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."

4. The Parties agree to delete Attachment B, *Disclosure Form*, of the Contract in its entirety and replace it with the new Attachment B, *Disclosure Form*, attached to this Amendment and incorporated into the Contract by this reference.

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 HMO:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

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: _____

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: March 28, 2023

ALL PLAN LETTER 23-006
SUPERSEDES ALL PLAN LETTER 17-004

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: DELEGATION AND SUBCONTRACTOR NETWORK CERTIFICATION

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on the requirements for delegation and monitoring of Subcontractors. This APL also details the Subcontractor Network Certification (SNC) process wherein MCPs must provide assurances that each Subcontractor's and Downstream Subcontractor's Provider Network meets state and federal Network adequacy and access requirements.

BACKGROUND:
Title 42 Code of Federal Regulations (CFR) section 438.230 specifies the requirements MCPs must include in all contracts or written agreements with any Subcontractors.[1] This regulation addresses the duties and obligations of MCPs and their Subcontractors. The regulation also emphasizes that regardless of the relationship the MCP has with a Subcontractor, whether direct or indirect through additional layers of contracting or delegation, the MCP has the ultimate responsibility for adhering to, and fully complying with, all terms and conditions of its contract with the Department of Health Care Services (DHCS).

Furthermore, MCPs must ensure, through their contracts with any Subcontractors, that their Subcontractors provide written disclosures of information on ownership and control as required under 42 CFR 455.104.[2] To address frequent findings relating to 42 CFR 455.104, the Centers for Medicare and Medicaid Services (CMS) has issued guidance, in the form of a toolkit.[3] In the toolkit, CMS clarifies that a board member should be listed as a "person with ownership or control interest" or as a "managing employee," to the extent they meet either definition pursuant to 42 CFR 455.101. MCPs must comply

[1] 42 CFR 438. The CFR is searchable at: https://www.ecfr.gov/.
[2] 42 CFR 438.608
[3] The CMS-issued toolkit is available at: https://www.cms.gov/sites/default/files/repo-new/25/Toolkit%20for%20Disclosures%20of%20Ownership%20and%20Control%2042%20CFR%20455%20104%20_final.pdf

with the ownership and control disclosure requirement 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.

Additionally, the California Advancing and Innovating Medi-Cal (CalAIM) 1915(b) Waiver Special Terms and Conditions (STCs) requires DHCS to provide CMS with assurances that MCPs are holding all Subcontractors who assume risk to DHCS' Network adequacy and access standards as of the 2022 Reporting Year (RY).[4, 5] As a result, MCPs will be required to undergo an annual SNC as part of its Annual Network Certification.[6]

POLICY:

Definitions

For purposes of this APL, the following definitions apply:

- Subcontractor – an individual or entity that has a Subcontractor Agreement with the MCP that relates directly or indirectly to the performance of the MCP's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

- Downstream Subcontractor – an individual or entity that has a Downstream Subcontractor Agreement with a Subcontractor of the MCP or a Downstream Subcontractor that relates directly or indirectly to the performance of the Subcontractor's obligations under its Subcontractor Agreement with the MCP.

- Subcontractor Network – a Provider Network of a Subcontractor or Downstream Subcontractor, wherein the Subcontractor or Downstream Subcontractor is delegated risk and is responsible for arranging for the provision of and paying for Covered Services as stated in their Subcontractor or Downstream Subcontractor Agreement.

[4] See the CalAIM Waiver Special Terms and Conditions, available at: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915b-STCs.pdf
[5] For purposes of this APL, the RY is the calendar year.
[6] For more information on the Annual Network Certification process, see APL 23-001, or any superseding APL. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

Back to Item

Back to Agenda

- Subcontracted Network Certification (SNC) – a process that entails MCPs reporting on their monitoring of Subcontractors' and Downstream Subcontractors' Provider Networks and submitting documentation to DHCS verifying the compliance and/or noncompliance reported.

I. MONITORING SUBCONTRACTORS

A. Delegation Accountability

If an MCP delegates any activity or obligation to a Subcontractor, whether directly or indirectly, the Subcontractor Agreement must:

1) Specify any and all delegated activities, obligations, and related reporting responsibilities;

2) Include the Subcontractor's agreement to perform the delegated activities, obligations, and reporting responsibilities; and

3) Provide for the revocation of the delegation of activities or obligations, or specify other remedies where DHCS or the MCP determines the Subcontractor is not performing satisfactorily.[7]

The Subcontractor Agreement must also state that the Subcontractor agrees to comply with all applicable Medicaid laws and regulations, including all subregulatory guidance and Contract provisions, as well as the applicable state and federal laws.[8] MCPs must maintain and communicate to Subcontractors their policies and procedures for monitoring Subcontractors' compliance with all requirements related to all delegated activities, obligations, and related reporting responsibilities as described in this APL. All policies and procedures must be made available to DHCS upon request.

B. Ownership and Control Disclosures

To identify potential conflicts of interest, MCPs are required to collect and review their Subcontractors' ownership and control disclosures as set forth in 42 CFR 455.104.[9] The review of ownership and control disclosures applies to all

[7] 42 CFR 438.230(c)(1)
[8] 42 CFR 438.230(c)(2)
[9] 42 CFR 438.608(c)

Back to Item

Back to Agenda

Subcontractors that contract with the MCP, including disclosing entities, fiscal agents, and managed care entities.

MCPs must require and ensure Subcontractors accurately provide all required information in their disclosures. This information includes the date of birth and social security number for each person with an ownership or control interest and for each managing employee. An officer or director of a disclosing entity that is organized as a corporation should be considered a person with control interest.[10] The CMS toolkit specifies that a board member of a disclosing entity must be listed as a "managing employee" to the extent that they meet that definition in 42 CFR 455.101. The CMS toolkit also specifies that a board member of the disclosing entity must be listed as a "person with an ownership or control interest" to the extent that they meet that definition in 42 CFR 455.101.

MCPs must review to identify potential conflicts of interest and make Subcontractors' ownership and control disclosures available upon request, as the information is subject to audit by DHCS. MCPs must alert their Managed Care Operations Division (MCOD) Contract Manager within ten Working Days upon discovery that a Subcontractor is noncompliant with these requirements, and/or if a disclosure reveals any potential violations of the ownership and control requirements.

C. Data Reporting

MCPs must monitor the quality and compliance of Subcontractor data that MCPs submit to DHCS or other entities, pursuant to reporting responsibilities under state and federal laws. MCPs must ensure the data reported by Subcontractors is complete, accurate, reasonable, and timely. This includes, but is not limited to, encounter data, monthly 274 Provider Network data files, data reported through quarterly templates, electronic visit verification reporting, and any other ad hoc data requests required by DHCS.

MCPs must require Subcontractors to submit complete, accurate, and timely Network Provider encounter data to the MCPs for all items and services furnished to Members either directly or through Downstream Subcontractors or other arrangements with Providers. MCPs must have in place mechanisms, including data validation and reporting systems, sufficient to ensure a

[10] 42 CFR 455.104(b)(1)

Back to Item

Back to Agenda

Subcontractor's Network Provider encounter data is complete, accurate, reasonable, and timely prior to submission to DHCS.

D. Monitoring, Corrective Action, and Sanctions

MCPs must regularly monitor all functional areas delegated to Subcontractors. MCPs must also impose corrective action and/or financial sanctions on Subcontractors upon discovery of noncompliance with the terms of their Subcontractor Agreement or any Medi-Cal requirements. MCPs must report any significant instances (i.e., in terms of gravity, scope and/or frequency) of noncompliance, imposition of corrective actions, or financial sanctions pertaining to their obligations under the contract with DHCS to their MCOD Contract Managers within three Working Days of the discovery or imposition.

II. SUBCONTRACTOR NETWORK CERTIFICATION

A. Circumstances for Submission

DHCS is required by state and federal laws to annually certify each MCP's full Provider Network for compliance with Network adequacy and access requirements and provide an assurance of that compliance to CMS for the RY.[11] As of the 2022 RY, the CalAIM 1915(b) Waiver STCs also require DHCS to provide the same assurances of Network adequacy and access for the Provider Networks of all MCP Subcontractors and Downstream Subcontractors that have assumed risk per their Subcontractor and Downstream Subcontractor Agreements. Henceforth, MCPs are required to undergo a SNC annually that is separate and distinct from the submission process for the Annual Network Certification (ANC).

SNC is also required (1) when a Subcontractor Network experiences a significant change, and (2) when the MCP enters into a new risk-based Subcontractor Agreement with a Subcontractor that expands the MCP's existing Provider Network. A significant change is (1) an event that impacts the provision of health care services for 2,000 or more Members or (2) when a Subcontractor Network change causes the MCP to become noncompliant with any of the Network adequacy and access standards outlined in APL 23-001 or any superseding APL. In either instance, MCPs must submit the applicable SNC documentation for only

[11] 42 CFR section 438.207(d).

Back to Item

Back to Agenda

the Network adequacy and access standards impacted by the significant change or noncompliance. If a significant change occurs within the 90 calendar days prior to the SNC annual submission date, the MCP can document the change as part of that RY SNC filing. For any significant changes that occur after the SNC annual submission date, the MCP should submit the applicable SNC documentation for only the Network adequacy and access standards impacted by the significant change and report the change in the SNC for that RY.

B. Subcontractor Network Criteria

Subcontractors and Downstream Subcontractors can be MCPs that are delegated to arrange for the provision of Covered Services on behalf of another MCP, or any other entities that are delegated responsibility by MCPs and Subcontractors for specific services and/or populations such as medical groups, independent physician associations, clinics, and community-based organizations. Whether a Subcontractor or Downstream Subcontractor is fully or partially delegated for functions and obligations under their Subcontractor or Downstream Subcontractor Agreement, Subcontractor Networks are only required to meet the Network adequacy and access standards for the Members assigned to the Subcontractor Network, and for Covered Services the Subcontractor or Downstream Subcontractor is contracted to arrange for Members on behalf of the MCP or Subcontractor. Refer to the SNC Instruction Manual (Attachment A) for details on determining which standards each Subcontractor Network must meet based on populations served and services covered.

For the annual SNC, MCPs must include all Subcontractor Networks reported via the 274 Provider Network data file, unless the Subcontractor Network is exempt per the criteria listed below and the required documentation provided substantiates the exemption.[12] In addition to Service Areas where MCPs only contract directly with individual Providers and no Subcontractor Networks exist, the following describes the Subcontractor Networks that are exempt from SNC:

1) MCP only contracts with one Subcontractor Network in the Service Area, and no Providers directly contract with the MCP;

[12] The documentation for submission to substantiate exemptions is outlined in the Subcontractor Network Certification Instruction Manual (Attachment A)

Back to Item

Back to Agenda

2) The Subcontractor Network only provides specialty or ancillary services; or

3) The Subcontractor Network only provides care through single case agreements and is not available to all the MCP's Members upon enrollment.

MCPs are to submit exemption requests with their SNC submission per the instructions provided in Attachment A using the Subcontractor Network Exemptions Request template (Attachment B). DHCS will review each exemption request and provide a formal notification of the disposition to the MCP. Approvals are valid for one calendar year until the next annual SNC filing.

C. Submission

MCPs must submit the required SNC documentation to DHCS that accurately reflects the MCP's monitoring of Subcontractor Networks, no later than 45 days following the RY or, if the date falls on a weekend, the next Working Day. MCPs must submit all required SNC documentation as described in Attachment A with the correct file naming conventions through the DHCS Secure File Transfer Protocol site. MCPs that fail to submit complete and accurate SNC documentation by the SNC annual submission date are subject to the imposition of a corrective action plan (CAP) and/or other enforcement actions pursuant to the MCP Contract, Welfare and Institutions Code (WIC) section 14197.7(e), and APL 22-015 or any superseding APL.[13]

The SNC submission consists of three parts: (1) the Subcontractor Network Exemptions Request template (Attachment B), (2) the Network Adequacy and Access Assurances Report (NAAAR) (Attachment C), and (3) verification documents. The NAAAR, Attachment C, is a modified CMS reporting template containing two sections, Sections B and C, that MCPs are required to complete. Section A of the template is prepopulated with the state's Network adequacy and access standards for which MCPs must hold their Subcontractors accountable, as applicable per Subcontractor Network. Because these Network adequacy and access standards are the same as those DHCS uses to certify MCPs' Provider Networks through the ANC process, please refer to APL 23-001, or any superseding APL, for the specific time or distance, timely access, Provider to

[13] State law is searchable at: https://leginfo.legislature.ca.gov/. MCP boilerplate contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

Back to Item

Back to Agenda

Member ratios, and mandatory Provider types standards MCPs must use to monitor the compliance of their Subcontractor Networks.

In Section B of the NAAAR, MCPs must delineate the types of analyses they use to monitor and determine the Network adequacy and access compliance of Subcontractor Networks. In Section C, MCPs report, in detail, the compliance results and findings of all the Subcontractor Network monitoring analyses conducted within the RY. Refer to Attachment A for detailed instructions on how to fill out the NAAAR.

The third part of the SNC submission is submission of documents for DHCS' review that verify the compliance results and findings reported on the NAAAR. Due to the size of California's Medicaid managed care program and the number of Subcontractor Networks, DHCS will verify documents for a subset of an MCP's Subcontractor Networks. DHCS will notify MCPs of the Subcontractor Networks to be sampled, at a minimum, at least 30 days in advance of the annual SNC submission date of 45 days after the end of the RY, or the next Working Day if the date falls on a weekend. MCPs are only required to send verification documents for Subcontractor Networks that DHCS notifies MCPs of that are to be sampled per Services Area/county for the specified RY.

A Service Area is the county or counties that the MCP is approved to operate in under the terms of their DHCS Contract. If the Service Area for a Subcontractor or Downstream Subcontractor is otherwise designated differently in the Subcontractor or Downstream Subcontractor Agreement, the MCP must show proof of that definition using the Subcontractor Network Exemptions Request (Attachment B).

To ensure every Subcontractor Network is verified, DHCS will remove the previously approved Subcontractor Network(s) from the MCP's pool of Subcontractor Networks after every annual SNC until all of the MCP's Subcontractor Networks have been sampled and verified. Once all of the MCP's Subcontractor Networks have been sampled and verified, the random selection cycle will begin again. Please refer to the Subcontractor Network Certification Instruction Manual (Attachment A) for more information about the required verification documents, including the list of acceptable types of documentation MCPs may submit to DHCS. DHCS may request additional MCP verification documents at any time in order to confirm that the information provided on the NAAAR is accurate. An MCP's failure to provide the requested documentation or

Back to Item

Back to Agenda

a determination by DHCS that the information in the SNC submission is invalid or inaccurate may lead to implementation of a CAP and/or other enforcement actions.

D. Noncompliance

All Subcontractor Network deficiencies impacting Member access to care, as identified by an MCP while monitoring, must result in the MCP, or the Subcontractor (if delegated utilization management), authorizing Covered Services from Out-of-Subcontractor Network (OOSN) Providers for Members in the deficient Subcontractor Network. OOSN Providers used to supplement a deficient Subcontractor Network may include Providers from an MCP's own direct Provider Network or those Out-of-Network when necessary. The MCP, or Subcontractor or Downstream Subcontractor which is delegated utilization management, must authorize Covered Services from OOSN Providers regardless of associated transportation or Provider costs until the deficiency is addressed. An MCP or Subcontractor must also ensure that the deficient Subcontractor or Downstream Subcontractor informs Members that OOSN access to services is available, and that the MCP's or Subcontractor's Member services staff are trained on Members' right to request OOSN access for Covered Services and transportation to Providers where the Subcontractor or Downstream Subcontractor is unable to comply with Network adequacy or access standards.

E. Deficiencies and Corrective Action

Upon completing the review of SNC submissions, DHCS will provide a CAP notification letter to each MCP found non-compliant with the SNC requirements of this APL, outlining the deficiencies and specific issues of noncompliance that the MCP must address. MCPs must provide an initial CAP response, no later than 30 calendar days after the issuance of the CAP notification letter, that details a plan of action and sets forth steps the MCP will take to correct the deficiencies identified.

MCPs have six months to correct all deficiencies during which time MCPs must provide DHCS with monthly status updates that demonstrate action steps the MCP is undertaking to address the CAP. DHCS may impose sanctions, or other appropriate enforcement actions, for failure to comply with Network adequacy

Back to Item

Back to Agenda

and access standards at the end of the six-month CAP period. If monetary sanctions are to be imposed, DHCS will consider the factors set forth in WIC section 14197.7(g) when assessing and determining the amount.

The requirements contained in this APL will necessitate a change in an MCP's contractually required P&Ps. MCPs must submit their updated P&Ps to their MCOD Contract Manager within 90 calendar days of the release of this APL.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable State and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.[14] These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[14] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

Back to Item

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

33. Authorize Amendment to CalOptima Health Medi-Cal Fee-for-Service Contract for Long Term Care Facility Services with Alta Newport Hospital, Inc, dba Foothill Regional Medical Center

Contacts

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to execute an amendment to CalOptima Health's Contract for Long Term Care Facility Services (Contract) with Alta Newport Hospital, Inc., dba Foothill Regional Medical Center (Foothill Regional) to increase reimbursement rates from 136% to 142% of the CalOptima Health Medi-Cal Fee Schedule, effective January 1, 2024.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $350,000 from existing reserves to fund the increased reimbursement rates for the six-month period of January 1, 2024, through June 30, 2024.

Background and Discussion

Staff requests the CalOptima Health Board of Directors (Board) authorize the CEO to amend its Contract with Foothill Regional, to increase reimbursement rates effective January 1, 2024. Foothill Regional is a 42-bed pediatric subacute facility which has been contracted with CalOptima Health since 2004. Foothill Regional is a fee-for-service Medi-Cal provider that treats pediatric members needing treatment at a step-down facility from acute care to long-term care. Services rendered by Foothill Regional include treatment of complications resulting from severe neurological problems, head injury, muscular disorders, premature birth, and respiratory disease.

Foothill Regional is one of only two pediatric subacute facilities in Orange County. The other pediatric subacute facility is HealthBridge Children's Hospital (HealthBridge) with 21 beds. Together, these two facilities provide long-term pediatric subacute care to all of Orange County's pediatric population, which numbers approximately 620,000 and of which approximately 346,300 are CalOptima Health members. At present, CalOptima Health has 20 members admitted at Foothill Regional and 14 admitted at HealthBridge. Pediatric subacute facility admissions are long term in nature, and CalOptima Health member admissions averaged 32 days for 2023. As such, it is vital to preserve access to pediatric subacute care services with both of CalOptima Health's contracted providers.

Most recently Foothill Regional expressed the need to mitigate factors affecting business costs, including the increased cost of supplies and overhead, as well as the cessation of a 10 percent supplemental increase the facility was previously receiving, as of May 2023. Following ongoing negotiations, Foothill Regional has agreed to CalOptima Health's offer to increase reimbursement from 136% to 142% of the CalOptima Health Medi-Cal Fee Schedule. CalOptima Health's offer to increase reimbursement is being proposed in an effort to support and preserve its provider network, and ensure continued member access to pediatric subacute care, of which Orange County has only two facilities.

Back to Agenda

Therefore, staff requests the Board authorize an amendment to grant this increase, effective January 1, 2024, to prevent any disruption to member care and CalOptima Health's relationship with Foothill Regional will continue in good faith.

Fiscal Impact

The recommended action is unbudgeted. The increase from 136% to 142% of the CalOptima Health Medi-Cal Fee Schedule is approximately $700,000 or 4.4% annually. An appropriation of up to $350,000 from existing reserves will fund this action for the six-month period of January 1, 2024, through June 30, 2024. Management will include updated medical expenses in future operating budgets.

Rationale for Recommendation

Approving the amendment to CalOptima Health's Contract with Foothill Regional will preserve both CalOptima Health's provider network and member access to care.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Proposed Amendment to Contract for Long Term Care Facility with Foothill Regional

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Foothill Regional Medical Center	14662 Newport Ave.	Tustin	CA	92780
HealthBridge Orange Specialty Pediatric Hospital	393 S. Tustin St.	Orange	CA	92866

Back to Agenda Back to Item

AMENDMENT 7 TO

CONTRACT FOR LONG TERM CARE FACILITY SERVICES

THIS AMENDMENT 7 TO THE CONTRACT FOR LONG TERM CARE FACILITY SERVICES ("Amendment ") shall be effective on **January 1, 2024**, by and between Orange County Health Authority, a Public Agency, dba CalOptima Health ("CalOptima"), and **Alta Newport Hospital, Inc., dba Foothill Regional Medical Center** ("Facility"), with respect to the following facts:

RECITALS

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

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

NOW, THEREFORE, the parties agree as follows:

1. Section 7.2, Termination Without Cause shall be added as follows:

   "TERMINATION WITHOUT CAUSE --- Either party may terminate this Contract, without cause, upon ninety (90) days prior written notice to the other party as provided herein."

2. Section 2.36 shall be added to the Contract as follows:

   "Section 2.36 DISCLOSURE OF FACILITY OWNERSHIP --- Facility shall fully and accurately complete the disclosure form in Exhibit D and submit the disclosure form to CalOptima prior to the Effective Date. Facility shall promptly notify CalOptima of any changes to the information contained in the disclosure form in Exhibit D and submit an updated disclosure form to CalOptima within thirty (30) days of any such change."

3. Exhibit C, Compensation, Pediatric Subacute Long Term Care Services, shall be deleted in its entirety and replaced with attached Exhibit C – Amendment 7, Compensation - Pediatric Subacute Long Term Care Sercvices.

4. Exhibit D, Disclosure Form shall be added to this Contract, attached therein.

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

IN WITNESS WHEREOF, CalOptima and Facility have executed this Amendment.

FOR FACILITY:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

EXHIBIT C – AMENDMENT 7

COMPENSATION – PEDIATRIC SUBACUTE LONG TERM CARE SERVICES

Effective: January 1, 2024

For Covered Services provided to CalOptima Medi-Cal members under this Contract, CalOptima shall reimburse Facility, and Facility shall accept as payment in full from CalOptima the lesser of the billed charges or the following rate:

____ of the Medi-Cal Fee Schedule

NOTE:

- Long term care services to billed on LTC 25-1 or successor claim forms as required by DHCS.
- Facility shall submit claims with the applicable DHCS Accommodation Codes.
- Rates include transportation services for medically necessary appointments.

EXHIBIT D

DISCLOSURE FORM

_____

Name of Facility

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)

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
34. Adopt CalOptima Health Board of Directors' Rules of Procedure

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

Recommended Action
Adopt Rosenberg's Rules of Order as the CalOptima Health's Board Rules of Procedure.

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 Chair, along with Director Isabel Becerra and Supervisor Vicente Sarmiento to the Ad Hoc Committee.

Discussion
The Ad Hoc Committee has met several times since the September Board meeting and reviewed current practices by surrounding health plans and other public agencies regarding the election of officers and parliamentary procedures.

The Ad Hoc Committee recommends the Board adopt Rosenberg's Rules of Order. Rosenberg's Rules of Order are a simplified set of parliamentary rules widely used in California.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended action will formalize Rules of Parliamentary Procedure for the CalOptima Health Board of Directors.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Rosenberg's Rules of Order

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

Rosenberg's Rules of Order

REVISED 2011

Simple Rules of Parliamentary Procedure for the 21st Century

By Judge Dave Rosenberg

LEAGUE® OF CALIFORNIA CITIES

MISSION AND CORE BELIEFS

To expand and protect local control for cities through education and advocacy to enhance the quality of life for all Californians.

VISION

To be recognized and respected as the leading advocate for the common interests of California's cities.

About the League of California Cities

Established in 1898, the League of California Cities is a member organization that represents California's incorporated cities. The League strives to protect the local authority and automony of city government and help California's cities effectively serve their residents. In addition to advocating on cities' behalf at the state capitol, the League provides its members with professional development programs and information resources, conducts education conferences and research, and publishes Western City magazine.

About the Author

Dave Rosenberg is a Superior Court Judge in Yolo County. He has served as presiding judge of his court, and as presiding judge of the Superior Court Appellate Division. He also has served as chair of the Trial Court Presiding Judges Advisory Committee (the committee composed of all 58 California presiding judges) and as an advisory member of the California Judicial Council. Prior to his appointment to the bench, Rosenberg was member of the Yolo County Board of Supervisors, where he served two terms as chair. Rosenberg also served on the Davis City Council, including two terms as mayor. He has served on the senior staff of two governors, and worked for 19 years in private law practice. Rosenberg has served as a member and chair of numerous state, regional and local boards. Rosenberg chaired the California State Lottery Commission, the California Victim Compensation and Government Claims Board, the Yolo-Solano Air Quality Management District, the Yolo County Economic Development Commission, and the Yolo County Criminal Justice Cabinet. For many years, he has taught classes on parliamentary procedure and has served as parliamentarian for large and small bodies.

Table of Contents

Introduction

The rules of procedure at meetings should be simple enough for most people to understand. Unfortunately, that has not always been the case. Virtually all clubs, associations, boards, councils and bodies follow a set of rules — *Robert's Rules of Order* — which are embodied in a small, but complex, book. Virtually no one I know has actually read this book cover to cover. Worse yet, the book was written for another time and for another purpose. If one is chairing or running a parliament, then *Robert's Rules of Order* is a dandy and quite useful handbook for procedure in that complex setting. On the other hand, if one is running a meeting of say, a five-member body with a few members of the public in attendance, a simplified version of the rules of parliamentary procedure is in order.

Hence, the birth of *Rosenberg's Rules of Order*.

What follows is my version of the rules of parliamentary procedure, based on my decades of experience chairing meetings in state and local government. These rules have been simplified for the smaller bodies we chair or in which we participate, slimmed down for the 21st Century, yet retaining the basic tenets of order to which we have grown accustomed. Interestingly enough, *Rosenberg's Rules* has found a welcoming audience. Hundreds of cities, counties, special districts, committees, boards, commissions, neighborhood associations and private corporations and companies have adopted *Rosenberg's Rules* in lieu of *Robert's Rules* because they have found them practical, logical, simple, easy to learn and user friendly.

This treatise on modern parliamentary procedure is built on a foundation supported by the following four pillars:

1. **Rules should establish order.** The first purpose of rules of parliamentary procedure is to establish a framework for the orderly conduct of meetings.
2. **Rules should be clear.** Simple rules lead to wider understanding and participation. Complex rules create two classes: those who understand and participate; and those who do not fully understand and do not fully participate.
3. **Rules should be user friendly.** That is, the rules must be simple enough that the public is invited into the body and feels that it has participated in the process.
4. **Rules should enforce the will of the majority while protecting the rights of the minority.** The ultimate purpose of rules of procedure is to encourage discussion and to facilitate decision making by the body. In a democracy, majority rules. The rules must enable the majority to express itself and fashion a result, while permitting the minority to also express itself, but not dominate, while fully participating in the process.

Establishing a Quorum

The starting point for a meeting is the establishment of a quorum. A quorum is defined as the minimum number of members of the body who must be present at a meeting for business to be legally transacted. The default rule is that a quorum is one more than half the body. For example, in a five-member body a quorum is three. When the body has three members present, it can legally transact business. If the body has less than a quorum of members present, it cannot legally transact business. And even if the body has a quorum to begin the meeting, the body can lose the quorum during the meeting when a member departs (or even when a member leaves the dais). When that occurs the body loses its ability to transact business until and unless a quorum is reestablished.

The default rule, identified above, however, gives way to a specific rule of the body that establishes a quorum. For example, the rules of a particular five-member body may indicate that a quorum is four members for that particular body. The body must follow the rules it has established for its quorum. In the absence of such a specific rule, the quorum is one more than half the members of the body.

The Role of the Chair

While all members of the body should know and understand the rules of parliamentary procedure, it is the chair of the body who is charged with applying the rules of conduct of the meeting. The chair should be well versed in those rules. For all intents and purposes, the chair makes the final ruling on the rules every time the chair states an action. In fact, all decisions by the chair are final unless overruled by the body itself.

Since the chair runs the conduct of the meeting, it is usual courtesy for the chair to play a less active role in the debate and discussion than other members of the body. This does not mean that the chair should not participate in the debate or discussion. To the contrary, as a member of the body, the chair has the full right to participate in the debate, discussion and decision-making of the body. What the chair should do, however, is strive to be the last to speak at the discussion and debate stage. The chair should not make or second a motion unless the chair is convinced that no other member of the body will do so at that point in time.

The Basic Format for an Agenda Item Discussion

Formal meetings normally have a written, often published agenda. Informal meetings may have only an oral or understood agenda. In either case, the meeting is governed by the agenda and the agenda constitutes the body's agreed-upon roadmap for the meeting. Each agenda item can be handled by the chair in the following basic format:

First, the chair should clearly announce the agenda item number and should clearly state what the agenda item subject is. The chair should then announce the format (which follows) that will be followed in considering the agenda item.

Second, following that agenda format, the chair should invite the appropriate person or persons to report on the item, including any recommendation that they might have. The appropriate person or persons may be the chair, a member of the body, a staff person, or a committee chair charged with providing input on the agenda item.

Third, the chair should ask members of the body if they have any technical questions of clarification. At this point, members of the body may ask clarifying questions to the person or persons who reported on the item, and that person or persons should be given time to respond.

Fourth, the chair should invite public comments, or if appropriate at a formal meeting, should open the public meeting for public input. If numerous members of the public indicate a desire to speak to the subject, the chair may limit the time of public speakers. At the conclusion of the public comments, the chair should announce that public input has concluded (or the public hearing, as the case may be, is closed).

Fifth, the chair should invite a motion. The chair should announce the name of the member of the body who makes the motion.

Sixth, the chair should determine if any member of the body wishes to second the motion. The chair should announce the name of the member of the body who seconds the motion. It is normally good practice for a motion to require a second before proceeding to ensure that it is not just one member of the body who is interested in a particular approach. However, a second is not an absolute requirement, and the chair can proceed with consideration and vote on a motion even when there is no second. This is a matter left to the discretion of the chair.

Seventh, if the motion is made and seconded, the chair should make sure everyone understands the motion.

This is done in one of three ways:

1. The chair can ask the maker of the motion to repeat it;
2. The chair can repeat the motion; or
3. The chair can ask the secretary or the clerk of the body to repeat the motion.

Eighth, the chair should now invite discussion of the motion by the body. If there is no desired discussion, or after the discussion has ended, the chair should announce that the body will vote on the motion. If there has been no discussion or very brief discussion, then the vote on the motion should proceed immediately and there is no need to repeat the motion. If there has been substantial discussion, then it is normally best to make sure everyone understands the motion by repeating it.

Ninth, the chair takes a vote. Simply asking for the "ayes" and then asking for the "nays" normally does this. If members of the body do not vote, then they "abstain." Unless the rules of the body provide otherwise (or unless a super majority is required as delineated later in these rules), then a simple majority (as defined in law or the rules of the body as delineated later in these rules) determines whether the motion passes or is defeated.

Tenth, the chair should announce the result of the vote and what action (if any) the body has taken. In announcing the result, the chair should indicate the names of the members of the body, if any, who voted in the minority on the motion. This announcement might take the following form: "The motion passes by a vote of 3-2, with Smith and Jones dissenting. We have passed the motion requiring a 10-day notice for all future meetings of this body."

Motions in General

Motions are the vehicles for decision making by a body. It is usually best to have a motion before the body prior to commencing discussion of an agenda item. This helps the body focus.

Motions are made in a simple two-step process. First, the chair should recognize the member of the body. Second, the member of the body makes a motion by preceding the member's desired approach with the words "I move … "

A typical motion might be: "I move that we give a 10-day notice in the future for all our meetings."

The chair usually initiates the motion in one of three ways:

1. **Inviting the members of the body to make a motion,** for example, "A motion at this time would be in order."
2. **Suggesting a motion to the members of the body,** "A motion would be in order that we give a 10-day notice in the future for all our meetings."
3. **Making the motion.** As noted, the chair has every right as a member of the body to make a motion, but should normally do so only if the chair wishes to make a motion on an item but is convinced that no other member of the body is willing to step forward to do so at a particular time.

The Three Basic Motions

There are three motions that are the most common and recur often at meetings:

The basic motion. The basic motion is the one that puts forward a decision for the body's consideration. A basic motion might be: "I move that we create a five-member committee to plan and put on our annual fundraiser."

The motion to amend. If a member wants to change a basic motion that is before the body, they would move to amend it. A motion to amend might be: "I move that we amend the motion to have a 10-member committee." A motion to amend takes the basic motion that is before the body and seeks to change it in some way.

The substitute motion. If a member wants to completely do away with the basic motion that is before the body, and put a new motion before the body, they would move a substitute motion. A substitute motion might be: "I move a substitute motion that we cancel the annual fundraiser this year."

"Motions to amend" and "substitute motions" are often confused, but they are quite different, and their effect (if passed) is quite different. A motion to amend seeks to retain the basic motion on the floor, but modify it in some way. A substitute motion seeks to throw out the basic motion on the floor, and substitute a new and different motion for it. The decision as to whether a motion is really a "motion to amend" or a "substitute motion" is left to the chair. So if a member makes what that member calls a "motion to amend," but the chair determines that it is really a "substitute motion," then the chair's designation governs.

A "friendly amendment" is a practical parliamentary tool that is simple, informal, saves time and avoids bogging a meeting down with numerous formal motions. It works in the following way: In the discussion on a pending motion, it may appear that a change to the motion is desirable or may win support for the motion from some members. When that happens, a member who has the floor may simply say, "I want to suggest a friendly amendment to the motion." The member suggests the friendly amendment, and if the maker and the person who seconded the motion pending on the floor accepts the friendly amendment, that now becomes the pending motion on the floor. If either the maker or the person who seconded rejects the proposed friendly amendment, then the proposer can formally move to amend.

Multiple Motions Before the Body

There can be up to three motions on the floor at the same time. The chair can reject a fourth motion until the chair has dealt with the three that are on the floor and has resolved them. This rule has practical value. More than three motions on the floor at any given time is confusing and unwieldy for almost everyone, including the chair.

When there are two or three motions on the floor (after motions and seconds) at the same time, the vote should proceed *first* on the *last* motion that is made. For example, assume the first motion is a basic "motion to have a five-member committee to plan and put on our annual fundraiser." During the discussion of this motion, a member might make a second motion to "amend the main motion to have a 10-member committee, not a five-member committee to plan and put on our annual fundraiser." And perhaps, during that discussion, a member makes yet a third motion as a "substitute motion that we not have an annual fundraiser this year." The proper procedure would be as follows:

First, the chair would deal with the *third* (the last) motion on the floor, the substitute motion. After discussion and debate, a vote would be taken first on the third motion. If the substitute motion *passed*, it would be a substitute for the basic motion and would eliminate it. The first motion would be moot, as would the second motion (which sought to amend the first motion), and the action on the agenda item would be completed on the passage by the body of the third motion (the substitute motion). No vote would be taken on the first or second motions.

Second, if the substitute motion *failed*, the chair would then deal with the second (now the last) motion on the floor, the motion to amend. The discussion and debate would focus strictly on the amendment (should the committee be five or 10 members). If the motion to amend *passed*, the chair would then move to consider the main motion (the first motion) as *amended*. If the motion to amend *failed,* the chair would then move to consider the main motion (the first motion) in its original format, not amended.

Third, the chair would now deal with the first motion that was placed on the floor. The original motion would either be in its original format (five-member committee), or if *amended*, would be in its amended format (10-member committee). The question on the floor for discussion and decision would be whether a committee should plan and put on the annual fundraiser.

To Debate or Not to Debate

The basic rule of motions is that they are subject to discussion and debate. Accordingly, basic motions, motions to amend, and substitute motions are all eligible, each in their turn, for full discussion before and by the body. The debate can continue as long as members of the body wish to discuss an item, subject to the decision of the chair that it is time to move on and take action.

There are exceptions to the general rule of free and open debate on motions. The exceptions all apply when there is a desire of the body to move on. The following motions are not debatable (that is, when the following motions are made and seconded, the chair must immediately call for a vote of the body without debate on the motion):

Motion to adjourn. This motion, if passed, requires the body to immediately adjourn to its next regularly scheduled meeting. It requires a simple majority vote.

Motion to recess. This motion, if passed, requires the body to immediately take a recess. Normally, the chair determines the length of the recess which may be a few minutes or an hour. It requires a simple majority vote.

Motion to fix the time to adjourn. This motion, if passed, requires the body to adjourn the meeting at the specific time set in the motion. For example, the motion might be: "I move we adjourn this meeting at midnight." It requires a simple majority vote.

Motion to table. This motion, if passed, requires discussion of the agenda item to be halted and the agenda item to be placed on "hold." The motion can contain a specific time in which the item can come back to the body. "I move we table this item until our regular meeting in October." Or the motion can contain no specific time for the return of the item, in which case a motion to take the item off the table and bring it back to the body will have to be taken at a future meeting. A motion to table an item (or to bring it back to the body) requires a simple majority vote.

Motion to limit debate. The most common form of this motion is to say, "I move the previous question" or "I move the question" or "I call the question" or sometimes someone simply shouts out "question." As a practical matter, when a member calls out one of these phrases, the chair can expedite matters by treating it as a "request" rather than as a formal motion. The chair can simply inquire of the body, "any further discussion?" If no one wishes to have further discussion, then the chair can go right to the pending motion that is on the floor. However, if even one person wishes to discuss the pending motion further, then at that point, the chair should treat the call for the "question" as a formal motion, and proceed to it.

When a member of the body makes such a motion ("I move the previous question"), the member is really saying: "I've had enough debate. Let's get on with the vote." When such a motion is made, the chair should ask for a second, stop debate, and vote on the motion to limit debate. The motion to limit debate requires a two-thirds vote of the body.

NOTE: A motion to limit debate could include a time limit. For example: "I move we limit debate on this agenda item to 15 minutes." Even in this format, the motion to limit debate requires a two-thirds vote of the body. A similar motion is a *motion to object to consideration of an item.* This motion is not debatable, and if passed, precludes the body from even considering an item on the agenda. It also requires a two-thirds vote.

Majority and Super Majority Votes

In a democracy, a simple majority vote determines a question. A tie vote means the motion fails. So in a seven-member body, a vote of 4-3 passes the motion. A vote of 3-3 with one abstention means the motion fails. If one member is absent and the vote is 3-3, the motion still fails.

All motions require a simple majority, but there are a few exceptions. The exceptions come up when the body is taking an action which effectively cuts off the ability of a minority of the body to take an action or discuss an item. These extraordinary motions require a two-thirds majority (a super majority) to pass:

Motion to limit debate. Whether a member says, "I move the previous question," or "I move the question," or "I call the question," or "I move to limit debate," it all amounts to an attempt to cut off the ability of the minority to discuss an item, and it requires a two-thirds vote to pass.

Motion to close nominations. When choosing officers of the body (such as the chair), nominations are in order either from a nominating committee or from the floor of the body. A motion to close nominations effectively cuts off the right of the minority to nominate officers and it requires a two-thirds vote to pass.

Motion to object to the consideration of a question. Normally, such a motion is unnecessary since the objectionable item can be tabled or defeated straight up. However, when members of a body do not even want an item on the agenda to be considered, then such a motion is in order. It is not debatable, and it requires a two-thirds vote to pass.

Motion to suspend the rules. This motion is debatable, but requires a two-thirds vote to pass. If the body has its own rules of order, conduct or procedure, this motion allows the body to suspend the rules for a particular purpose. For example, the body (a private club) might have a rule prohibiting the attendance at meetings by non-club members. A motion to suspend the rules would be in order to allow a non-club member to attend a meeting of the club on a particular date or on a particular agenda item.

Counting Votes

The matter of counting votes starts simple, but can become complicated.

Usually, it's pretty easy to determine whether a particular motion passed or whether it was defeated. If a simple majority vote is needed to pass a motion, then one vote more than 50 percent of the body is required. For example, in a five-member body, if the vote is three in favor and two opposed, the motion passes. If it is two in favor and three opposed, the motion is defeated.

If a two-thirds majority vote is needed to pass a motion, then how many affirmative votes are required? The simple rule of thumb is to count the "no" votes and double that count to determine how many "yes" votes are needed to pass a particular motion. For example, in a seven-member body, if two members vote "no" then the "yes" vote of at least four members is required to achieve a two-thirds majority vote to pass the motion.

What about tie votes? In the event of a tie, the motion always fails since an affirmative vote is required to pass any motion. For example, in a five-member body, if the vote is two in favor and two opposed, with one member absent, the motion is defeated.

Vote counting starts to become complicated when members vote "abstain" or in the case of a written ballot, cast a blank (or unreadable) ballot. Do these votes count, and if so, how does one count them? The starting point is always to check the statutes.

In California, for example, for an action of a board of supervisors to be valid and binding, the action must be approved by a majority of the board. (California Government Code Section 25005.) Typically, this means three of the five members of the board must vote affirmatively in favor of the action. A vote of 2-1 would not be sufficient. A vote of 3-0 with two abstentions would be sufficient. In general law cities in

California, as another example, resolutions or orders for the payment of money and all ordinances require a recorded vote of the total members of the city council. (California Government Code Section 36936.) Cities with charters may prescribe their own vote requirements. Local elected officials are always well-advised to consult with their local agency counsel on how state law may affect the vote count.

After consulting state statutes, step number two is to check the rules of the body. If the rules of the body say that you count votes of "those present" then you treat abstentions one way. However, if the rules of the body say that you count the votes of those "present and voting," then you treat abstentions a different way. And if the rules of the body are silent on the subject, then the general rule of thumb (and default rule) is that you count all votes that are "present and voting."

Accordingly, under the "present and voting" system, you would **NOT** count abstention votes on the motion. Members who abstain are counted for purposes of determining quorum (they are "present"), but you treat the abstention votes on the motion as if they did not exist (they are not "voting"). On the other hand, if the rules of the body specifically say that you count votes of those "present" then you **DO** count abstention votes both in establishing the quorum and on the motion. In this event, the abstention votes act just like "no" votes.

How does this work in practice?
Here are a few examples.

Assume that a five-member city council is voting on a motion that requires a simple majority vote to pass, and assume further that the body has no specific rule on counting votes. Accordingly, the default rule kicks in and we count all votes of members that are "present and voting." If the vote on the motion is 3-2, the motion passes. If the motion is 2-2 with one abstention, the motion fails.

Assume a five-member city council voting on a motion that requires a two-thirds majority vote to pass, and further assume that the body has no specific rule on counting votes. Again, the default rule applies. If the vote is 3-2, the motion fails for lack of a two-thirds majority. If the vote is 4-1, the motion passes with a clear two-thirds majority. A vote of three "yes," one "no" and one "abstain" also results in passage of the motion. Once again, the abstention is counted only for the purpose of determining quorum, but on the actual vote on the motion, it is as if the abstention vote never existed — so an effective 3-1 vote is clearly a two-thirds majority vote.

Now, change the scenario slightly. Assume the same five-member city council voting on a motion that requires a two-thirds majority vote to pass, but now assume that the body **DOES** have a specific rule requiring a two-thirds vote of members "present." Under this specific rule, we must count the members present not only for quorum but also for the motion. In this scenario, any abstention has the same force and effect as if it were a "no" vote. Accordingly, if the votes were three "yes," one "no" and one "abstain," then the motion fails. The abstention in this case is treated like a "no" vote and effective vote of 3-2 is not enough to pass two-thirds majority muster.

Now, exactly how does a member cast an "abstention" vote? Any time a member votes "abstain" or says, "I abstain," that is an abstention. However, if a member votes "present" that is also treated as an abstention (the member is essentially saying, "Count me for purposes of a quorum, but my vote on the issue is abstain.") In fact, any manifestation of intention not to vote either "yes" or "no" on the pending motion may be treated by the chair as an abstention. If written ballots are cast, a blank or unreadable ballot is counted as an abstention as well.

Can a member vote "absent" or "count me as absent?" Interesting question. The ruling on this is up to the chair. The better approach is for the chair to count this as if the member had left his/her chair and is actually "absent." That, of course, affects the quorum. However, the chair may also treat this as a vote to abstain, particularly if the person does not actually leave the dais.

The Motion to Reconsider

There is a special and unique motion that requires a bit of explanation all by itself; the motion to reconsider. A tenet of parliamentary procedure is finality. After vigorous discussion, debate and a vote, there must be some closure to the issue. And so, after a vote is taken, the matter is deemed closed, subject only to reopening if a proper motion to consider is made and passed.

A motion to reconsider requires a majority vote to pass like other garden-variety motions, but there are two special rules that apply only to the motion to reconsider.

First, is the matter of timing. A motion to reconsider must be made at the meeting where the item was first voted upon. A motion to reconsider made at a later time is untimely. (The body, however, can always vote to suspend the rules and, by a two-thirds majority, allow a motion to reconsider to be made at another time.)

Second, a motion to reconsider may be made only by certain members of the body. Accordingly, a motion to reconsider may be made only by a member who voted in the majority on the original motion. If such a member has a change of heart, he or she may make the motion to reconsider (any other member of the body — including a member who voted in the minority on the original motion — may second the motion). If a member who voted in the minority seeks to make the motion to reconsider, it must be ruled out of order. The purpose of this rule is finality. If a member of minority could make a motion to reconsider, then the item could be brought back to the body again and again, which would defeat the purpose of finality.

If the motion to reconsider passes, then the original matter is back before the body, and a new original motion is in order. The matter may be discussed and debated as if it were on the floor for the first time.

Courtesy and Decorum

The rules of order are meant to create an atmosphere where the members of the body and the members of the public can attend to business efficiently, fairly and with full participation. At the same time, it is up to the chair and the members of the body to maintain common courtesy and decorum. Unless the setting is very informal, it is always best for only one person at a time to have the floor, and it is always best for every speaker to be first recognized by the chair before proceeding to speak.

The chair should always ensure that debate and discussion of an agenda item focuses on the item and the policy in question, not the personalities of the members of the body. Debate on policy is healthy, debate on personalities is not. The chair has the right to cut off discussion that is too personal, is too loud, or is too crude.

Debate and discussion should be focused, but free and open. In the interest of time, the chair may, however, limit the time allotted to speakers, including members of the body.

Can a member of the body interrupt the speaker? The general rule is "no." There are, however, exceptions. A speaker may be interrupted for the following reasons:

Privilege. The proper interruption would be, "point of privilege." The chair would then ask the interrupter to "state your point." Appropriate points of privilege relate to anything that would interfere with the normal comfort of the meeting. For example, the room may be too hot or too cold, or a blowing fan might interfere with a person's ability to hear.

Order. The proper interruption would be, "point of order." Again, the chair would ask the interrupter to "state your point." Appropriate points of order relate to anything that would not be considered appropriate conduct of the meeting. For example, if the chair moved on to a vote on a motion that permits debate without allowing that discussion or debate.

Appeal. If the chair makes a ruling that a member of the body disagrees with, that member may appeal the ruling of the chair. If the motion is seconded, and after debate, if it passes by a simple majority vote, then the ruling of the chair is deemed reversed.

Call for orders of the day. This is simply another way of saying, "return to the agenda." If a member believes that the body has drifted from the agreed-upon agenda, such a call may be made. It does not require a vote, and when the chair discovers that the agenda has not been followed, the chair simply reminds the body to return to the agenda item properly before them. If the chair fails to do so, the chair's determination may be appealed.

Withdraw a motion. During debate and discussion of a motion, the maker of the motion on the floor, at any time, may interrupt a speaker to withdraw his or her motion from the floor. The motion is immediately deemed withdrawn, although the chair may ask the person who seconded the motion if he or she wishes to make the motion, and any other member may make the motion if properly recognized.

Special Notes About Public Input

The rules outlined above will help make meetings very public-friendly. But in addition, and particularly for the chair, it is wise to remember three special rules that apply to each agenda item:

Rule One: Tell the public what the body will be doing.

Rule Two: Keep the public informed while the body is doing it.

Rule Three: When the body has acted, tell the public what the body did.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
35. Election of Officers of the CalOptima Health Board of Directors for Fiscal Year 2023-24

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

Recommended Action
Elect the Board Chair and Vice Chair, in accordance with the Board Officer Election Policy, for terms effective December 7, 2023 through June 30, 2024, or until the election of a successor(s), unless the Board 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 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, including the chair (if applicable), of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. The Chair shall perform all other 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 at an organizational meeting one of its Directors to serve as Vice Chair. The Vice Chair shall perform the duties of the Chair if the Chair is absent from a meeting or otherwise unable to act.

At the September 7, 2023, Board meeting, current Board 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 Chair, along with Director Isabel Becerra and Supervisor Vicente Sarmiento to the Ad Hoc Committee.

On November 2, 2023, the Board approved the Election of Officers Policy (Policy). In accordance with Policy Section C(2), *Procedure*, the Chair shall call the agenda item.

The Clerk of the Board (Clerk) then will conduct the election for Board Officers with the assistance of CalOptima Health Legal Counsel. All Directors nominated under Policy Section III.B shall appear on the initial ballot for the respective Board Officer position. 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

Back to Agenda

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.

Under the Policy, the standard process moving forward is for the Chair and Vice Chair terms to 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. Board of Directors' Officer Election Policy
2. Election of Officers Ballots
   a. Chair Ballot
   b. Vice Chair Ballot

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

Back to Agenda

Policy: Board Policy 11_23
Title: **Board of Directors' Officer Election Policy**
Department: Board of Directors
Section: Not Applicable

CEO Approval:

Effective Date: 11/02/2023

Board-Approved 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 Board Policy 11_23.

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 submit all nominations for a Board Officer to CalOptima

[1] CalOptima Health Bylaws §§ 8.1, 8.2.
[2] CalOptima Health Bylaws § 8.3.
[3] *Id*.

Health Legal Counsel at least ten (10) days prior to any Organizational Meeting or Regular Meeting at which the election will take place.

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. 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.

BOARD OF DIRECTORS' ELECTION OF OFFICERS

FISCAL YEAR 2023-24

VOTING BALLOT

CHAIR

VOTING DIRECTOR'S NAME: _____

- DOUG CHAFFEE ☐
- CLAYTON CORWIN ☐

Back to Agenda Back to Item

BOARD OF DIRECTORS' ELECTION OF OFFICERS

FISCAL YEAR 2023-24

VOTING BALLOT

VICE CHAIR

VOTING DIRECTOR'S NAME: _____

- ISABEL BECERRA ☐