NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

AUGUST 5, 2021
2:00 P.M.

505 CITY PARKWAY WEST, SUITES 108-109
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Supervisor Andrew Do, Chair	Clayton Corwin, Vice Chair
Isabel Becerra	Supervisor Doug Chaffee
Clayton Chau, M.D.	Mary Giammona, M.D.
Victor Jordan	J. Scott Schoeffel
Nancy Shivers, R.N.	Trieu Tran, M.D.

Supervisor Lisa Bartlett, Alternate

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Richard Sanchez	Gary Crockett	Sharon Dwiers

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

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

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

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

1) **Listen to the live audio at 1 (562)247-8422 and 634-740-932 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/990549342590303756 rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. Executive Director, Compliance
   b. OneCare, OneCare Connect Audit
   c. National Committee for Quality Assurance Accreditation
   d. Vaccine Clinic and Resource Fair Events
   e. Enacted State Budget
   f. California Advancing and Innovating Medi-Cal (CalAIM)
   g. Congressional Meetings
   h. School-Based Behavioral Health
   i. Housing Support at Be Well OC
   j. Social Determinants of Health and Health Equity
   k. UCI/County Public Health Program
   l. Medicare Wellness Visits
   m. Brand Awareness Survey
   n. Mentoring, Leadership Programs
   o. New Medical Director

2. Chief Medical Officer Updates
   a. COVID-19 Update

3. California Advancing and Innovating Medi-Cal (CalAIM) Update

PUBLIC COMMENTS

CONSENT CALENDAR

4. Minutes
   a. Approve Minutes of the June 3, 2021 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the April 22, 2021 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee; the Minutes of the May 13, 2021 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee; and the Minutes of the May 13, 2021 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee

5. Consider Authorizing Ratification of Amendment 16-93274 with the California Department of Health Care Services (DHCS) in Order to Continue Operation of the OneCare Program

6. Consider Authorizing Execution of Amendment(s) to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Insurance Portability and Accountability Act (HIPAA)

7. Consider Approval of Modification to CalOptima Policy AA.1223: Participation in Community Events with External Entities to Update Staff Approval Threshold

8. Consider Approving CalOptima Positions on Proposed Legislation

9. Receive and File:
   a. May and June 2021 Financial Summary
   b. Compliance Report
   c. Federal and State Legislative Advocates Reports
   d. CalOptima Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

ADMINISTRATION

10. Consider Adoption of Resolution Approving and Adopting Updated CalOptima Policy GA.8058: Salary Schedule, Appropriation of Funds and Authorization of Unbudgeted Expenditures

11. Consider Ratification of New Finance Policy: MA.3003: Medicare Shared Risk Pool

12. Consider Approval of New CalOptima Policies IS.1600: Provider Access to In-House Portal and IS.1601: In-House Provider Portal Administration and Support (Internal)

13. Consider Ratification of Contract with Hunn Group, LLC and Authorization of Related Unbudgeted Expenditures

CLINICAL OPERATIONS

14. Consider Authorizing a Diabetes Mellitus (DM) Pilot Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetes

NETWORK OPERATIONS

15. Consider Authorizing a Contract with and Funding of a Consultant to Perform Readiness Assessment Activities Related to the California Advancing and Innovating Medi-Cal (CalAIM) Initiative

ADVISORY COMMITTEE UPDATES

16. Member Advisory Committee Update

17. Provider Advisory Committee Update

18. OneCare Connect Member Advisory Committee Update

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

How to Join

1. Please register for Regular Meeting of the CalOptima Board of Directors on August 5, 2021 2:00 PM PDT at: https://attendee.gotowebinar.com/register/990549342590303756

2. After registering, you will **receive a confirmation email containing a link to join** the webinar at the specified time and date.

   Note: This link should not be shared with others; it is unique to you.

   Before joining, be sure to check system requirements to avoid any connection issues.

3. **Choose** one of the following **audio options:**

   TO USE YOUR COMPUTER'S AUDIO:

   When the webinar begins, you will be connected to audio using your computer's microphone and speakers (VoIP). A headset is recommended.

   --OR--

   TO USE YOUR TELEPHONE:

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   United States: (562) 247-8422

   Access Code: 634-740-932

   Audio PIN: Shown after joining the webinar

MEMORANDUM

DATE:	July 28, 2021
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Chief Executive Officer
SUBJECT:	CEO Report — August 5, 2021, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

a. Executive Director, Compliance Carmen Dobry Joins CalOptima

On July 12, CalOptima welcomed Carmen Dobry, M.S., CHC, as Executive Director, Compliance. She is responsible for maintaining CalOptima's relationships with regulatory agencies, ensuring readiness for all internal and external compliance and auditing activities, and overseeing fraud, waste and abuse and HIPAA privacy activities. She has more than 20 years of payor and provider leadership experience in creating cultures of proactive compliance and corporate responsibility, detecting and correcting compliance shortfalls, monitoring changing compliance standards, and maintaining compliance. Prior to CalOptima, Ms. Dobry held compliance leadership roles at other health plans and provider organizations, including Verity Health System of California, Chinese Community Health Plan and Inland Empire Health Plan. In addition to being certified in health care compliance, she holds a master's degree in Health Services Administration and a bachelor's degree in Health Science from California State University, San Bernardino.

b. OneCare and OneCare Connect Audit Underway

On June 7, CalOptima was formally engaged by the Centers for Medicare & Medicaid Services (CMS) for a full-scope program audit of OneCare and OneCare Connect. CalOptima submitted audit data in late June, and CMS commenced the audit, which is being conducted virtually, with an entrance conference on July 19. As of this writing, the audit is ongoing. Staff was aware that CMS planned to conduct an audit this year and, in partnership with CalOptima's health networks, had completed many hours and tasks in preparation. Staff is presently working with compliance consultant BluePeak to manage the audit and coach health networks to respond effectively during the audit sessions. Seven program areas are included in the audit scope:

- Compliance Program Effectiveness
- Part D Formulary and Benefit Administration
- Part D Coverage Determinations, Appeals and Grievances
- Part C Organization Determinations, Appeals and Grievances
- Special Needs Plan Model of Care
- Medicare-Medicaid Plan – Service Authorization Request, Appeals and Grievances
- Medicare-Medicaid Plan – Care Coordination Quality Improvement Program Effectiveness

For audit oversight, an ad hoc committee of your Board was formed and has been informed daily about audit progress. The audit concludes with an exit conference on August 6.

Back to Agenda

c. National Committee for Quality Assurance (NCQA) Accreditation for Medi-Cal Renewed Through 2024

Reflecting CalOptima's longstanding commitment to Medi-Cal quality, the agency recently and successfully completed an NCQA Accreditation renewal review process. The virtual file review was conducted July 12–13 and included assessment of CalOptima and health network records in areas such as utilization management denials and appeals, population health management (complex case management), and credentialing. The NCQA's final report stated that CalOptima had no issues, awarding the agency 100% of the allowable points. As a result, CalOptima's accredited status has been extended through July 27, 2024.

d. CalOptima and County of Orange Vaccinate More Than 5,000 in Pop-Up Events

CalOptima and County of Orange hosted the last of six joint Vaccine Clinic and Resource Fair events on July 10. At the event, 495 individuals were vaccinated, bringing the six-event total to 5,073 vaccines delivered from May 15–July 10. With vaccinations at the events and elsewhere, 53% of CalOptima's membership age 12 and older is now vaccinated, which equates to about 355,000 people, as of July 27. As of the final event, 2,339 Member Health Rewards, worth more than $58,000, were distributed. Of note, the final two events featured a special drive-thru lane for individuals with Autism Spectrum Disorder or disabilities, allowing them to get their vaccine without leaving their vehicle. The outstanding turnout to the event series was driven by a variety of factors, including through direct text messaging to members, word-of-mouth among members' friends and family, and walk-in traffic from the nearby Outlets at Orange. Further, the Resource Fair component differentiated the events from other vaccine clinics and was designed to address members' social determinants of health. Participating organizations included Social Services Agency, 2-1-1 Orange County, Community Action Partnership, and Pacific Health and Wellness. Nearly 110 CalOptima staff worked — many at more than one event —— to help with check-in, line control, temperature check/hand sanitizing stations, post-vaccine observation and Member Health Rewards distribution among other tasks. For a broader perspective on vaccination, the Department of Health Care Services (DHCS) released statewide data from June about vaccination rates among Medi-Cal members in various health plans. Among 104 Medi-Cal health plans, CalOptima ranked 14th, with an overall rate of 44.4%. The difference between the state's percentage and CalOptima's percentage above is due to the reporting dates. CalOptima appreciates the successful partnerships that made the clinics possible and looks forward to continuing to promote vaccination widely.

e. Enacted State Budget Includes Increased Spending on Health Care

On July 12, following negotiations with the Legislature, Gov. Gavin Newsom signed into law Senate Bill 129, implementing California's Fiscal Year 2021–22 Enacted State Budget. Total Medi-Cal spending is $124.5 billion ($28.2 billion General Fund). Compared with Medi-Cal funding in the FY 2020–21 Enacted Budget, this is an increase of nearly 8%. Key health care initiatives with a significant impact to CalOptima include:

- Behavioral health services for youth
- California Advancing and Innovating Medi-Cal (CalAIM) proposal
- Medi-Cal expansion to older adults ages 50 and older, regardless of immigration status

CalOptima's Government Affairs team is compiling an analysis of the Enacted State Budget that I will share with your Board in the near future.

Back to Agenda

f. CalOptima Makes First Model of Care Submission to Launch CalAIM in January

In June, DHCS released final documents and supporting resources for the Enhanced Care Management (ECM) and In Lieu of Services (ILOS) components of CalAIM. The documents are posted on the ECM and ILOS webpage and cover a range of issues, including the contract template, provider terms and conditions, model of care templates, design implementation and more. With this guidance in mind and your Board's approval to proceed, CalOptima staff prepared and submitted the first of three Model of Care (MOC) documents to the state by July 1. A summary of the required submissions is below:

- July 1: MOC Submission 1 — Initial ECM and ILOS provider capacity questions, Whole Person Care and Health Homes Program transitions questions, and preliminary ILOS selections.
- September 1: MOC Submission 2 — Majority of ECM/ILOS policies and procedures and final ILOS selections.
- October 1: MOC Submission 3 — Final ECM and ILOS provider capacity network submission.

Staff will provide a comprehensive update on CalAIM implementation work at your August Board meeting and anticipates bringing additional CalAIM-related contracts and policies in September. In the meantime, planning has begun on a second meeting to engage stakeholders, following up on the successful May event that was attended by more than 300 providers and community representatives.

g. Association for Community Affiliated Plans (ACAP) Promotes Congressional Meetings

Throughout June, Executive Director, Public Affairs Rachel Selleck and I met with members of Congress and their staffs as part of ACAP's Virtual Legislative Fly-In. This includes with Reps. Michelle Steel and Young Kim as well as the staffs of Sen. Dianne Feinstein and Rep. Linda Sanchez. During these online meetings, we shared details about CalOptima's programs, vaccination efforts and federal legislative priorities. The priorities discussed include expanding Medicaid funding flexibility to address social determinants of health (SDOH), ensuring Medicaid access and establishing payment parity for audio-only telehealth services in Medicare and PACE. Officials and their staffs expressed interest in further collaborating with CalOptima on these issues, and CalOptima plans to request your Board's formal support of related federal legislation at the August meeting.

h. Local Health Plans of California (LHPC) Discusses School-Based Behavioral Health

On July 19–20, Rachel Selleck, Executive Director, Public Affairs, attended the LHPC Strategic Planning Retreat. LHPC is CalOptima's state trade association representing publicly governed Medi-Cal managed care plans. During the retreat, health plan representatives participated in a variety of sessions covering topics such as COVID-19, health equity, rate setting and future priorities. Of particular interest was Gov. Newsom's Children and Youth Behavioral Health Initiative, included in the Fiscal Year 2021–22 Enacted Budget. As part of the initiative, Medi-Cal plans will be eligible to receive incentive payments to expand access to school-based behavioral health services. Specific details are pending guidance from DHCS in the coming months. In the meantime, CalOptima will begin discussions with local school districts in an effort to build stronger relationships.

Back to Agenda

i. CalOptima Meets With Organization About Housing Support at Be Well OC

CalOptima recently met with Housing for Healthy OC, LLC (HHOC) to learn more about a pilot in development to support needs for CalOptima members experiencing homelessness and receiving services at the Be Well OC campus. The proposed pilot is expected to have HHOC staff on-site to make referrals for members to existing housing navigation and supportive services programs. HHOC includes four agencies — American Family Housing, Friendship Shelter, Jamboree Housing and Mercy Housing — that together provide affordable, permanent supportive and bridge housing throughout Orange County. Friendship Shelter and Mercy Housing also operate shelters. CalOptima will return to the Board for consideration of a future partnership on the pilot program with HHOC as needed in the future.

j. Staff Prioritizes SDOH and Health Equity Efforts

With guidance from your Board, CalOptima has identified the development of an SDOH and Health Equity framework as a strategic initiative. A multidepartment workgroup has been convened to support this effort. While the framework is being created, CalOptima is focusing on food insecurity, an issue that has been exacerbated by the pandemic. Staff is working collaboratively with the Social Services Agency, for example, to obtain a comprehensive list of CalOptima members who are already enrolled in CalFresh as a way to identify those who are not enrolled. To empower providers to help patients needing food support, staff is developing tools to simplify the process of providers making referrals to CalOptima or offering resource information to patients. Staff is also planning provider education about how do submit claims and encounter data regarding these patients so we can better identify food insecure members and assess progress. On the health equity side, Population Health Management (PHM) has kicked off member outreach with a series of back-to-school immunization clinics in July–September and in partnership with schools and community-based organizations. These events are focused on bridging the gaps for missed well visits and immunizations due to the pandemic and ensuring readiness for CalOptima school-aged children. A new CalOptima webpage carries information about the scheduled events. Additionally, PHM is focused on addressing heath equity by working with Orange County Community Action Partnership for diaper bank services and mobile mammography for Korean and Chinese communities. Examining 2020 quality data among Asian populations, Korean and Chinese members have the lowest rates of breast cancer screening at 58% and 45%, respectively, and Vietnamese members have the highest rate at 67%. The mammography events are scheduled for fourth quarter of 2021.

k. CalOptima Plans to Support UCI/County Participation in Public Health Program

UC Irvine and Orange County Health Care Agency are jointly applying for a federally funded program that trains the next generation of public health workers to be proficient at informatics and technology. The program supports curriculum development, student recruitment and training, paid internships, career development services, and tuition discounts for working professionals. CalOptima plans to provide a letter of support for their application. If funded, the initiative will use a consortium approach to help participants develop a better understanding of the skills required for a 21st century public health workforce and improve curriculum design. In addition, as a consortium participant, CalOptima may consider providing internships or other experiential learning opportunities, and identify employees who may benefit from obtaining a continuing education certificate in public health informatics, technology and data science.

Back to Agenda

l. Effort to Boost Medicare Wellness Visits in Progress

CalOptima staff from across several departments are working on an effort to improve completion of Medicare annual wellness visits, which have been affected by the pandemic and other factors. Finance shared that annual wellness visit completion rates have an impact on quality incentives and risk adjustment scores. Community Relations shared information about an annual wellness visit provider toolkit and consumer outreach materials developed by the OC Strategic Plan for Aging health care committee (co-chaired by CalOptima staff) and OC Healthy Aging Initiative. Communications, Provider Relations, Health Network Relations and PHM also participated in the discussion to coordinate efforts to enhance awareness of the provider toolkit and outreach materials as well as promote annual wellness visits for the member and provider communities. Staff will continue to meet to focus on this important aspect of preventive care for CalOptima seniors.

m. CalOptima Preparing for a Public Brand Awareness and Perception Survey

CalOptima's Communications team is making progress on the survey initiative mentioned at your Board's June meeting. Objectives for the public survey have been identified: measure residents' overall awareness of CalOptima and its programs; identify the extent to which residents have a favorable view of CalOptima, including perceptions regarding quality of care; and understand the health care priorities/concerns of residents and identify opportunities to position CalOptima as a partner in addressing those issues. A combination of survey methods will be used, including Redirected Inbound Call Sampling and grassroots surveying, in English, Spanish and Vietnamese. Staff will provide an update to your Board upon survey completion. Results will inform CalOptima's future advertising and marketing campaigns.

n. Mentoring, Leadership Programs Offered for Staff Development

In June, CalOptima offered two major programs to promote staff development. CalOptima reactivated the mentoring program, which was paused during the pandemic. There are nine mentor/mentee pairings across 10 departments. Although the program was founded six years ago, it aligns with the 2020–2022 Strategic Plan initiative to enhance operational excellence and efficiency by engaging and developing the workforce. For a broader audience, CalOptima held the quarterly Leadership Series for directors, managers and supervisors, offering a 90-minute training session by an external speaker. Business consultant and author Shari Harley presented "Getting the Best From Employees: Coaching and Developing for Performance" to an online group of more than 130 leaders. She provided practical tips about how to engage employees in the ways they learn best, set expectations as a manager and follow up on performance.

o. CalOptima Welcomes New Medical Director

On June 28, Michael Collins, D.O., MPH, MS, began as a CalOptima Medical Director working on Utilization Management and Case Management for the Medi-Cal, OneCare and OneCare Connect programs. Most recently, Dr. Collins was medical director of ambulatory care at Monarch HeathCare. Prior to that, he held a medical leadership position at Inland Empire Health Plan and was a staff physician in occupational medicine at Kaiser Permanente in Ontario/Fontana. Dr. Collins earned his medical degree from Western University of Health Sciences and his master's in public health from Loma Linda University.

Back to Agenda

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CalOptima

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COVID-19 Update

Board of Directors Meeting
August 5, 2021

Emily Fonda, M.D., MMM
Chief Medical Officer

Back to Agenda

CalOptima Membership, COVID-19 Cases and Vaccination Data

- As of July 23, 2021, CalOptima has 846,914 members (664,347 age 12 and older)
  - 4.8% members tested positive for COVID-19 (0.1% expired)
  - 354,731 members are vaccinated
  - 327,940 members are eligible for incentives
    - 56% members 16 years and older received at least one dose of vaccine
    - 53% members 12 years and older received at least one dose vaccine
- More than 153,000 gift cards processed for general members, as of July 23
  - Fulfillment vendor has processed approximately 75,000

Covid Case Source: CalOptima Claims & Encounters
Vaccine Source: CalOptima Claims & Encounters, CAIR2, CAIRs, CMS, DHCS, Health Network Submissions

Back to Agenda

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CalOptima COVID-19 Vaccination Data (July 2021)

- Highest vaccination rate: 62%~67% for Garden Grove, Irvine and Westminster
- 65 and older vaccination rate: ~74% (statewide Medi-Cal* 69.9%)
  - LTC members vaccination rate: ~92%
  - PACE participants vaccination rate: ~99%
- Asian population: 75% vaccinated (statewide Medi-Cal* 66.2%)
- Black population: 36% vaccinated (statewide Medi-Cal* 27.5%)

By Ethnicity

Grand Total	663,268	327,039	49%
Alaskan Nat / Amer Indian	1,273	434	34%
Asian	154,593	110,823	72%
Black	12,694	4,095	32%
Hispanic	263,398	102,054	39%
Others	103,751	52,738	51%
White	127,559	56,895	45%

By Age Group

Grand Total	663,268	327,039	49%
Age 12-15	76,213	16,643	22%
Age 16-49	364,574	164,116	45%
Age 50-64	122,673	74,620	61%
Age 65-74	52,752	37,550	71%
Age 75+	47,056	34,110	72%

* Statewide Medi-Cal data as of June 27

Back to Agenda

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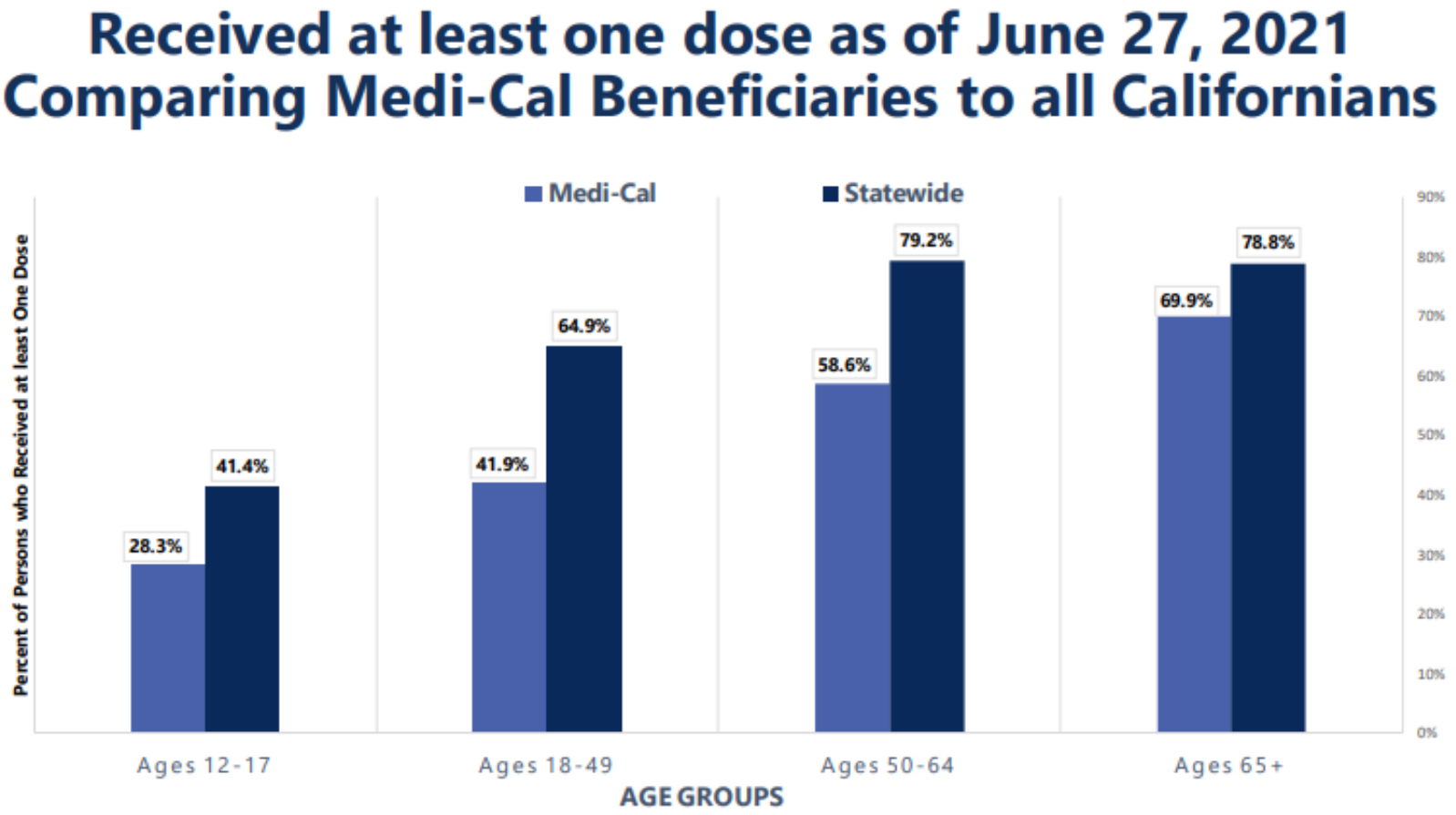
Statewide Medi-Cal Vaccination Rate



https://www.dhcs.ca.gov/Documents/COVID-19/COVID-19-Vaccine-Stats-07-08-21.pdf

Back to Agenda

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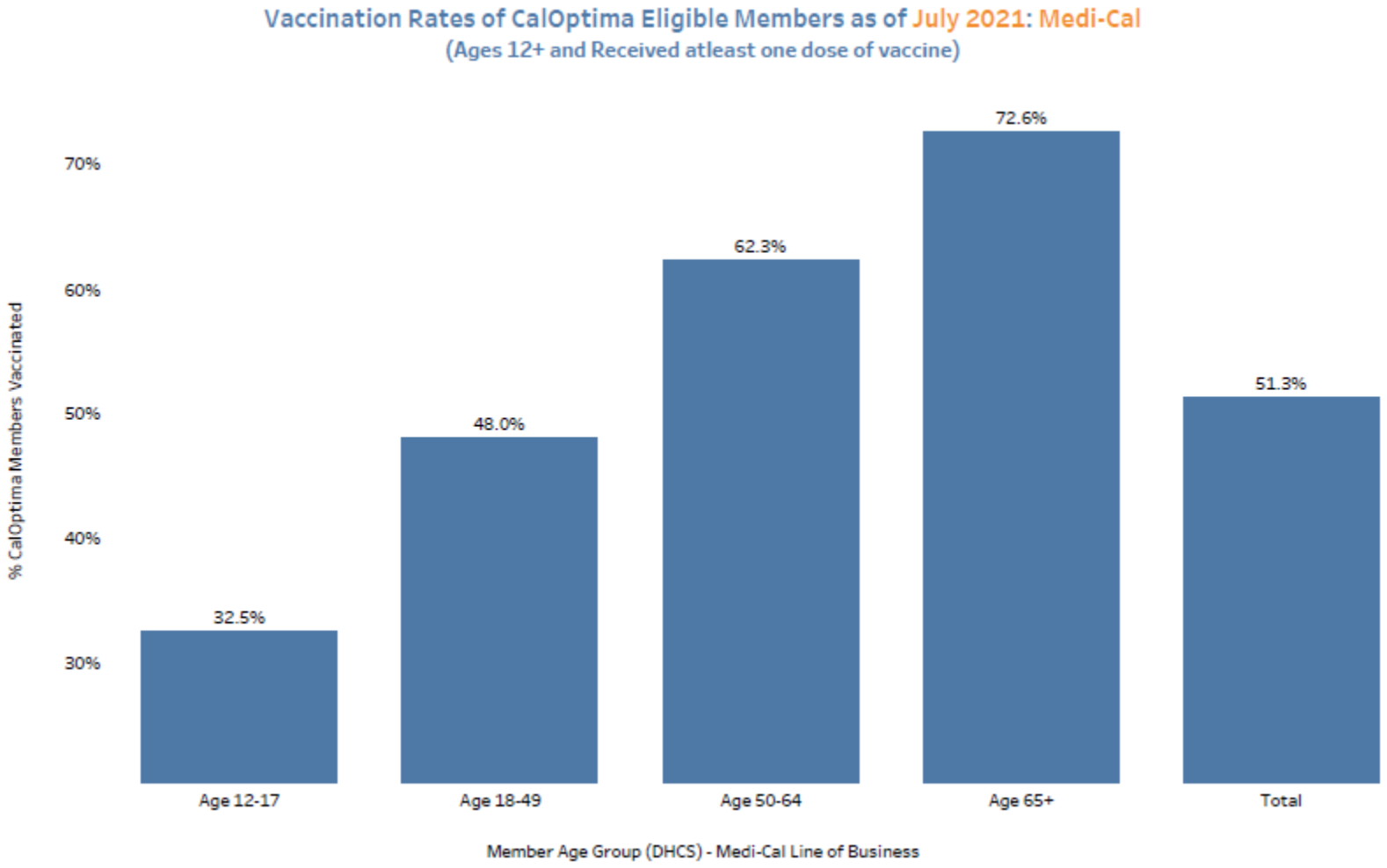
CalOptima Vaccination Rate



Vaccine Source: CalOptima Claims & Encounters, CAIR2, CAIRs, CMS, DHCS, Health Network Submissions

Back to Agenda

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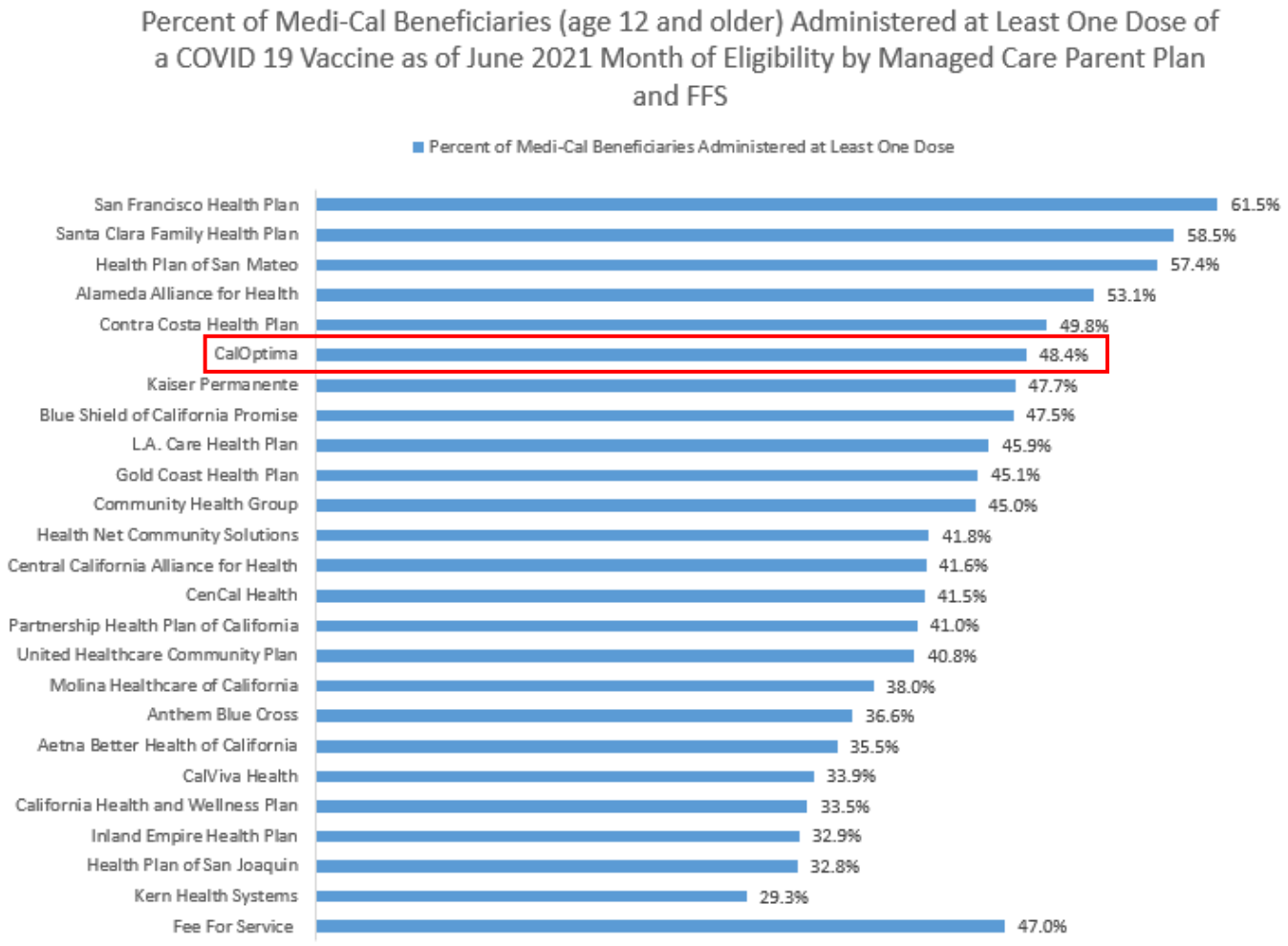
Percent of Medi-Cal Members Vaccinated By Managed Care Parent Plans



State of California, Department of Health Care Services Medi-Cal COVID-19 One Dose Vaccination Rates, June 2021 MOE.

Back to Agenda

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Recent COVID-19 Vaccination Efforts

- CalOptima/County of Orange Vaccine Events
  - May 15
    - 820 individuals vaccinated; 252 gift cards distributed
  - May 22
    - 1,244 individuals vaccinated; 531 gift cards distributed
  - June 5
    - 808 individuals vaccinated; 355 gift cards distributed
  - June 12
    - 1,316 individuals vaccinated; 643 gift cards distributed
  - June 19
    - 390 individuals vaccinated; 233 gift cards distributed
  - July 10
    - 495 individuals vaccinated; 326 gift cards distributed

Total: 5,073 individuals vaccinated; 2,340 gift cards distributed

Back to Agenda

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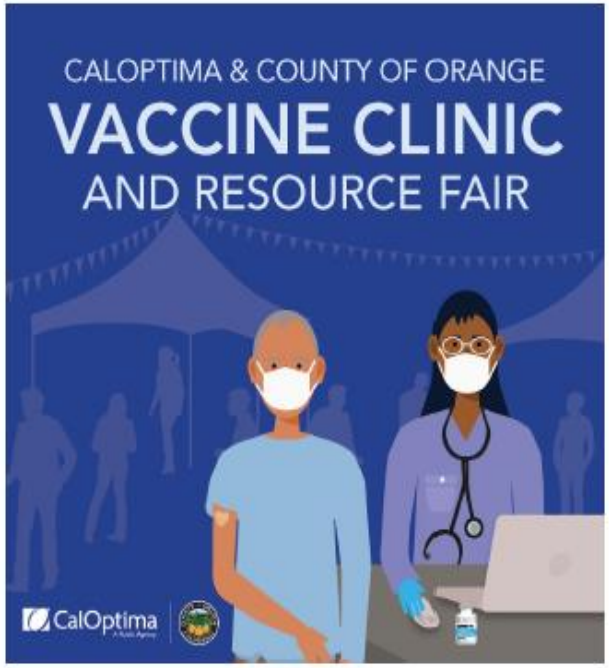
COVID-19 Vaccination Efforts for Children with Special Needs

- June 19 and July 10 Events
  - CalOptima and the County of Orange agencies partnered to hold a vaccine clinic to boost access to COVID-19 vaccines for hard-to-reach community members and individuals with disabilities
  - The goal was to minimize disruption to members with special health care needs and their families and maximize safety while providing vaccination
  - Member incentives were distributed on-site



Back to Agenda

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COVID-19 Vaccination Efforts for Members Experiencing Homelessness

- 1,310 gift cards distributed, as of July 23
  - CalOptima is collaborating with the following entities to promote vaccination through health rewards:
    - Orange County Health Care Agency (OCHCA)
    - AltaMed
    - Families Together
    - Korean Community Services
    - Share Our Selves
  - Gift cards provided on-site after receiving the COVID-19 vaccine dose
  - Weekly reports sent to CalOptima from Federally Qualified Health Centers and OCHCA

Back to Agenda

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COVID-19 Outreach Efforts

- Texts sent to all members in all threshold languages
  - Arabic, Farsi, Chinese, Korean, Spanish, Vietnamese and English
- May 15 Vaccine Event
  - 259,000 text messages to age 16 and older
- May 22 Vaccine Event
  - 198,000 text messages to age 12 and older
- June 19 Vaccine Event
  - 236,466 text messages to age 12 and older
- Overall opt-out rate is 9.3% as of June 28

Back to Agenda

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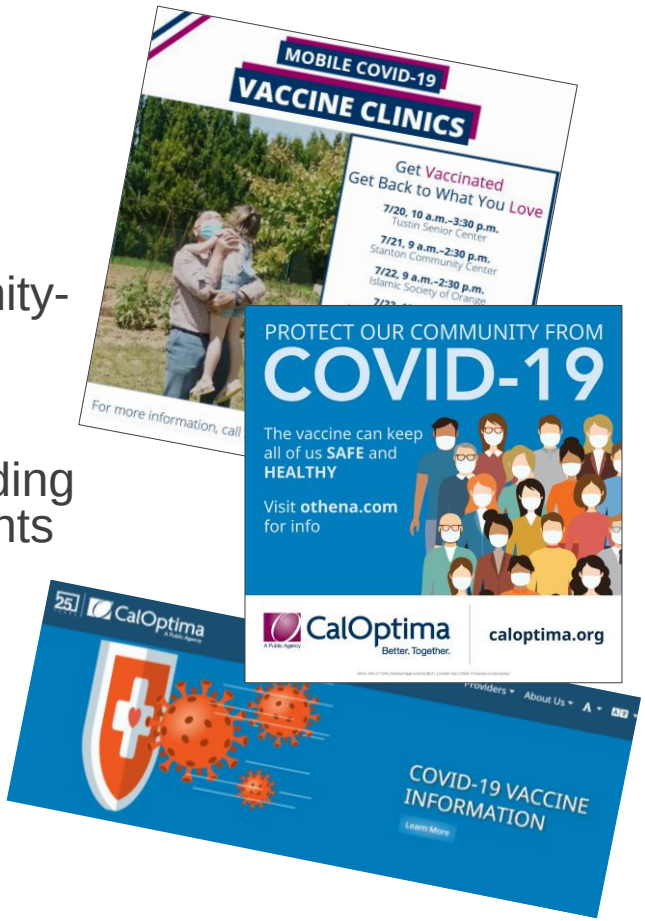
Ongoing Communications Efforts

- Social Media
  - Using Facebook, Instagram and Twitter to actively promote vaccine clinics, resources
- Community Announcements
  - Distributing a weekly newsletter to community-based organizations
- Website
  - Maintaining timely information online, including recent posting of FAQs on COVID-19 variants
- Member Outreach
  - Texting
    - Homebound members
    - Support Mobile COVID-19 Vaccine Clinics
  - CareNet CalOptima Community Network member outreach
    - Priority zip codes



Back to Agenda

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Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Back to Agenda

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California Advancing and Innovating Medi-Cal (CalAIM) Update

Board of Directors Meeting

August 5, 2021

Ladan Khamseh, Chief Operating Officer

Pallavi Patel, Director, Process Excellence/Business Integration

Back to Agenda

Agenda

- Enhanced Care Management (ECM) and In Lieu of Services (ILOS) implementation approach
- Health Homes Program (HHP) and Whole Person Care (WPC) Member transition to ECM
- Provider readiness assessment and pricing guidance
- Department of Health Care Services (DHCS) timelines
- Implementation activities to date

Back to Agenda

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ECM/ILOS Implementation Approach

- CalOptima's approach is to leverage WPC and HHP infrastructure:
  - ECM: Leverage current HHP care management model for health networks and CalOptima Community Network to provide ECM services
    - Accompaniment services will remain delegated to the health networks as part of the ECM core service components
  - ILOS: CalOptima will provide four ILOS on January 1, 2022
    - Housing Transition/Navigation Services, Housing Tenancy and Sustaining Services, Housing Deposits and Recuperative Care (Medical Respite)
    - CalOptima will retain financial responsibility for these ILOS
    - Offer contracts to existing WPC and HHP ILOS providers
- This approach will ensure a seamless transition and align with CalAIM expectations.

Back to Agenda

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Member Transition for ECM

- HHP
  - All members enrolled or in the process of being enrolled in HHP will automatically transition and be eligible to receive ECM services.
- WPC
  - Managed Care Plans (MCPs) must automatically authorize ECM for all Members enrolled in a WPC Pilot:
    - Who belong to an ECM Population of Focus and receiving care coordination
  - If an MCP Member is not automatically authorized under ECM Population of Focus, the WPC Pilot is responsible for the transition of the Member to other appropriate services.
- Members transitioned from both programs are assessed within six months to confirm whether ECM or a lower level of care coordination best meets their needs.

Back to Agenda

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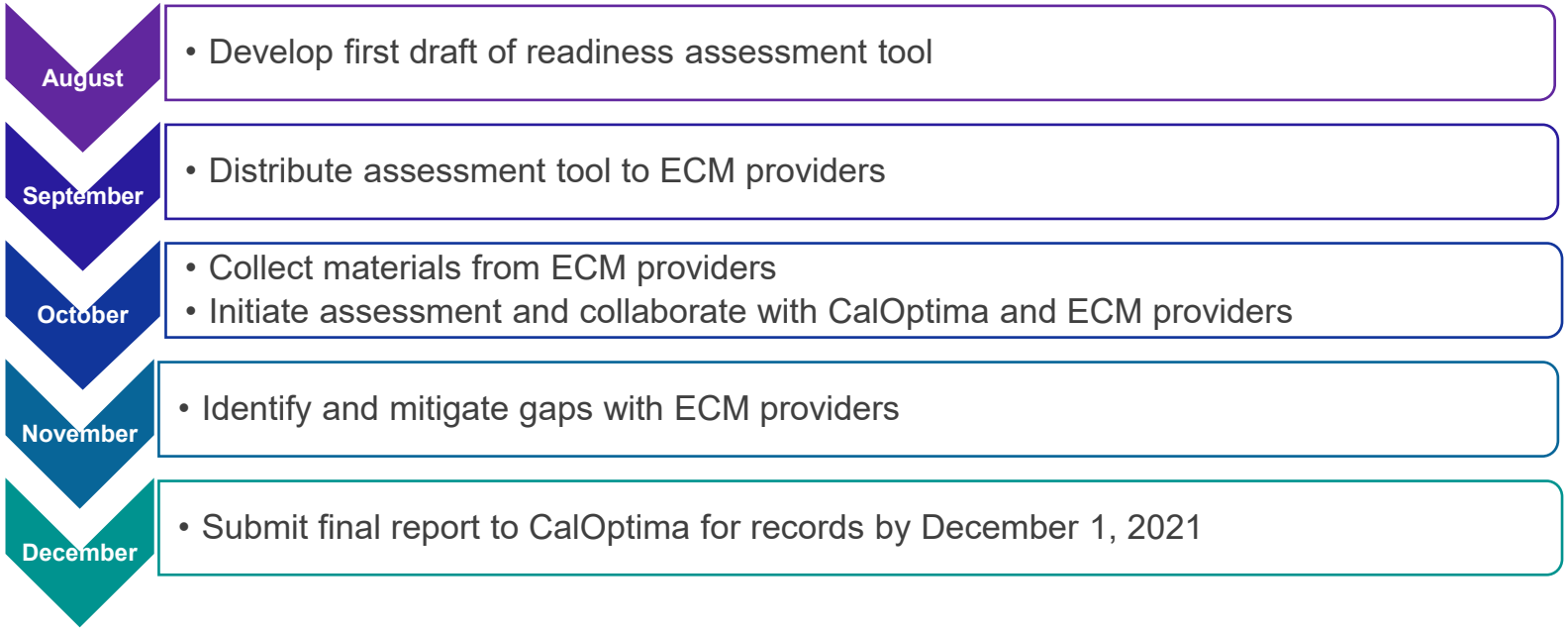
ECM Provider Readiness Assessment

- CalOptima will conduct readiness assessment activities prior to January 1, 2022 using Public Consulting Group (PCG).
- PCG will perform the following:



- To complete the assessments in a timely manner, in August 2021, staff requests Board of Directors approval on contracting and funding for readiness activities

Due to the similarities between HHP and ECM services, PCG will conduct the ECM Provider readiness, similar to the one PCG did for HHP.

Back to Agenda

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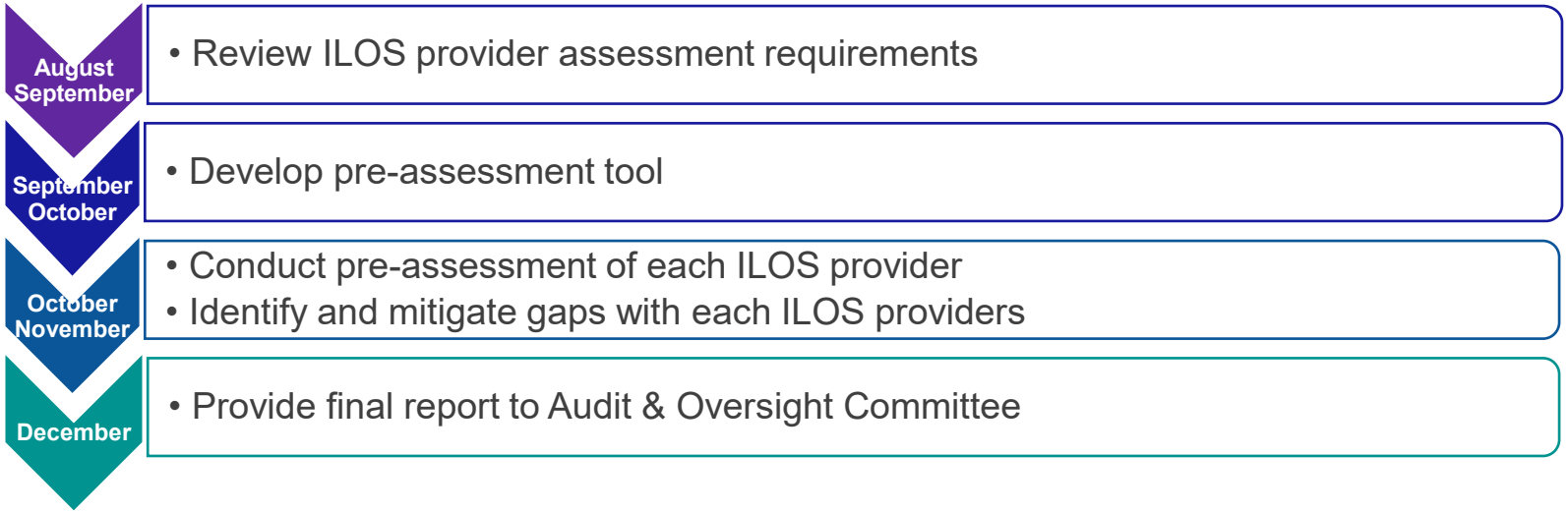
ILOS Provider Pricing Guidance and Pre-assessment

- ILOS Pricing Guidance: As per the draft non-binding ILOS pricing guidance, CalOptima anticipates final pricing guidance to be significantly lower than the reimbursements ILOS providers are currently experiencing
- Pre-assessments: CalOptima's Audit & Oversight (A&O) department to conduct a pre-assessment to ensure the ILOS providers meet readiness requirements prior to go-live
- A&O plans to perform the following activities for ILOS provider assessment:



Back to Agenda

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DHCS Guidance Timeline

Date	DHCS Guidance
July	○ ECM and ILOS Program Guides ○ Draft ECM and ILOS Reporting Guidance* ○ ILOS Pricing Guidance
August	○ Incentive Payment All Plan Letter ○ Final ECM Rates ○ Draft ECM and ILOS Data Sharing Authorization Guidance for Participants
September	○ Final ECM and ILOS Reporting Guidance
October	○ Final ECM and ILOS Data Sharing Authorization Guidance for Participants

* ECM & ILOS reporting guidance includes ECM/ILOS Provider Invoicing, ECM Member Assignment File, and ECM Encounter History File reporting standards.

Back to Agenda

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CalOptima's DHCS Deliverables Timeline

Date	DHCS Deliverables	Status
July	○ Model of Care (MOC) Part 1 ▪ Requirement responses	▪ Submitted by July 1, 2021
September	○ MOC Part 2 ▪ Requirement responses ▪ New policies for ECM and ILOS ▪ Updated CalOptima policies ▪ Written notices/call scripts ▪ ECM provider contract template	▪ On track for September 1, 2021 submission
October	○ MOC Part 3: ▪ Requirement responses ▪ ILOS provider contract template	▪ On track for October 1, 2021 submission
Fall 2021	○ Incentive Payment (PY1) ▪ Includes Infrastructure, ECM, ILOS Provider Capacity (workforce, operational readiness)	▪ Completion of the gap analysis will ensure maximum DHCS Incentive Payments allocation ▪ Allocation driven by needs vs. initial selection of ILOS services

* ECM & ILOS reporting guidance includes ECM/ILOS Provider Invoicing, ECM Member Assignment File, and ECM Encounter History File reporting standards.

Back to Agenda

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Implementation Activities To Date

- MOC Part 1 (approach) submitted to DHCS on June 30, 2021 with preliminary ILOS services
- MOC Part 2 (policies) in progress for DHCS submission by September 1, 2021 with final ILOS services
- CalOptima community-based organization ILOS survey completed to evaluate community needs
- Meetings with health networks and the County:
  - Provide DHCS guidance, as received
  - Understand existing end-to-end processes and begin the transition plan
  - Exchange of data to understand utilization trends

Back to Agenda

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Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Back to Agenda

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

June 3, 2021

A Regular Meeting of the CalOptima Board of Directors was held on June 3, 2021 at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act. Chair Andrew Do called the meeting to order at 2:01 p.m. and Vice Chair Becerra led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chair; Isabel Becerra, Vice Chair; Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting) (at 2:08 p.m.); Clayton Corwin; Mary Giammona, M.D.; Victor Jordan; Scott Schoeffel; Nancy Shivers; Trieu Tran, M.D. (at 2:25 p.m.)
(All Board Members participated remotely except Chairman Do, who attended in person)

Members Absent: None.

Others Present: Richard Sanchez, Chief Executive Officer; Gary Crockett, Chief Counsel; Ladan Khamseh, Chief Operating Officer; Nancy Huang, Chief Financial Officer; Sharon Dwiers, Clerk of the Board

PRESENTATIONS/INTRODUCTIONS

None.

Chairman Do noted that he was reordering the agenda to hear Agenda Item 27 at the end of Report Items and prior to the Advisory Committee Updates.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Richard Sanchez, Chief Executive Officer, highlighted several items in his report, including the recent vaccination efforts in collaboration with the Orange County Health Care Agency (OCHCA). Mr. Sanchez also noted that the Governor had released his May Revise proposed budget for the upcoming fiscal year, which includes many changes that affect the Medi-Cal program and CalOptima. He also noted that staff will keep the Board updated as the state budget for the upcoming year is finalized.

2. Chief Medical Officer Updates

Emily Fonda, M.D., Chief Medical Officer, provided an update on CalOptima's COVID-19 vaccination activities. Dr. Fonda reported that as of May 2021, approximately 259,565 members had been fully vaccinated, and over 45% of members aged 16 years and over have received at least one dose, and over 40% of members aged 12 years and older have received at least one dose. She also provided details on

vaccination efforts for CalOptima's members experiencing homelessness, as well as overall vaccination results broken down by member ethnicity and age. Dr. Fonda highlighted the successful vaccination events recently hosted by CalOptima and OCHCA, and noted that second dose events are scheduled for June 5 and June 12, 2021. She added that everyone is welcome to attend the upcoming vaccination events, even if it is for a first dose of the vaccine.

3. CalOptima FY 2021-22 Marketing and Communications Plan

Rachel Selleck, Executive Director, Public Affairs, introduced the CalOptima FY 2021-22 Marketing and Communications Plan. Ms. Selleck noted that CalOptima will be conducting a survey to better understand the public's perception of CalOptima. This data is expected to be helpful as staff develops a marketing campaign to reach a wider audience, including potential members that may not be aware that they are eligible to receive CalOptima's benefits.

Chairman Do directed staff to bring the proposed marketing strategy back to the Board for review and input, and that staff work with the Orange County Social Services Agency, which is responsible for determining member eligibility.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

Director Schoeffel did not participate in any of the Consent Calendar items due to potential conflicts of interest.

4. Minutes

a. Approve Minutes of the May 6, 2021 Regular Meeting of the CalOptima Board of Directors

b. Receive and File Minutes of the February 18, 2021 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; the Minutes of the February 25,2021 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the Minutes of the March 11, 2021 Special Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee; the March 11,2021 Special Joint Meeting of the CalOptima Board of Directors Member Advisory, OneCare Connect Member Advisory, Provider Advisory, and Whole-Child Model Family Advisory Committees; the Minutes of the April 8, 2021 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee; and the Minutes of the April 8, 2021 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee

5. Consider Authorizing and Directing Execution of an Amendment to Agreement 16-93274 with the California Department of Health Care Services in Order to Continue Operation of the OneCare Program

6. Consider Reappointment to CalOptima Board of Directors Investment Advisory Committee

Back to Agenda

7. Consider Appointments to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

8. Consider Appointments to the CalOptima Board of Directors' Member Advisory Committee

9. Consider Appointments to the CalOptima Board of Directors' Provider Advisory Committee

10. Consider Appointments to the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

11. Consider Selecting and Contracting with Investment Managers for CalOptima's Operating, Tier One and Tier Two Investment Accounts; Authorize Allocation of these Assets Amongst the Recommended Investment Managers

12. Consider Approval of Modifications to CalOptima Medical Affairs Policies and Procedures: GG.1304, GG.1325, GG.1500 and GG.1508

13. Consider Ratification of New Finance Policy: MA.3003
This item was pulled from the Consent Calendar for discussion.

14. Consider Approval of Modifications to Policy GG.1900 Behavioral Health Services to Support the Administration of Behavioral Health Services for Medi-Cal Members

15. Consider Approval of Extension of Reimbursement for Necessary Business Expenditures Incurred by Employees on Temporary Telework Due to the Coronavirus (COVID-19) Pandemic

16. Consider the Continued Use of the Methodology Previously Approved for the Distribution of OneCare Connect Quality Withhold Payments to Contracted Health Networks in Demonstration Years 2 Through 5 for Distribution of Such Payment for Demonstration Years 6 Through 8
This item was pulled from the Consent Calendar for discussion.

17. Consider Authorizing a Diabetes Mellitus Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetics
This item was continued for further study.

18. Consider Ratifying a Letter of Commitment in Support of the Orange County Health Care Agency Health Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19 Grant Application
Director Chau did not participate in the item due to his role as Director of the Orange County Health Care Agency.

19. Consider Recommendations Related to Previously Approved and Prepaid Expenditures in Support of CalOptima's Participation in Community Events Impacted by the COVID-19 Pandemic

20. Consider Approving CalOptima Positions on Proposed Legislation

Back to Agenda

21. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year 2021-22

22. Receive and File
- a. April 2021 Financial Summary
- b. Compliance Report
- c. Federal and State Legislative Advocates Reports
- d. CalOptima Community Outreach and Program Summary

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors approved Consent Calendar Items 4 through 22, excluding Consent Calendar Items 13, 16, and 17, as presented. (Motion carried 8-0-0 (except as noted); Director Schoeffel absent)***

13. Consider Ratification of New Finance Policy: MA.3003: Medicare Shared Risk Pool
After brief discussion, this item was continued for further study.

16. Consider the Continued Use of the Methodology Previously Approved for the Distribution of OneCare Connect Quality Withhold Payments to Contracted Health Networks in Demonstration Years 2 Through 5 for Distribution of Such Payment for Demonstration Years 6 Through 8
Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest based on campaign contributions under the Levine Act.

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors approved Consent Calendar Item 16, as presented. (Motion carried 7-0-1; Chairman Do abstained; Director Schoeffel absent)***

REPORTS/DISCUSSION ITEMS

ADMINISTRATION

23. Consider Approval of the Fiscal Year (FY) 2021-22 Operating Budget
Vice Chair Becerra, as Chair of the Finance and Audit Committee (FAC), provided introductory comments. She noted that the FAC had a very thorough discussion on the proposed operating budget. She also added that, only in unusual circumstances such as the current situation, would the FAC support a budget that includes a projected loss of $58 million for FY 2021-22. She noted that this recommendation to dip into reserves to fund a deficit budget reflects CalOptima leadership's commitment to the delivery system, and to ensuring that members have access to quality health care services following the COVID pandemic. The budget also reflects anticipated higher utilization by our members who have been deferring needed care due to the pandemic.

The Vice Chair also noted that the proposed budget includes the following provider rate changes: increases in Hospital rates, unit price increases for Skilled Nursing Facilities and Mental Health Providers, and continued right-sizing of Medi-Cal Expansion (MCE) capitation rates to align reimbursement with the actual risk and utilization for MCE members. This right sizing translates into a 9% decrease in Profession capitation and a 12% decrease in Hospital capitation for the MCE population.

Back to Agenda

Vice Chair Becerra added that, while the FAC is never enthusiastic about recommending rate reductions, a lot of time was spent reviewing utilization trends ahead of the FAC members getting comfortable that what is recommended is appropriate based on the actual risk associated with the MCE population and the cost of providing their care. In addition, specific to the administrative budget, a number of new FTEs have been included to support growth in membership, new program implementation, and meeting regulatory and compliance requirements.

Vice Chair Becerra also thanked staff for the work that went into developing the budget. She also thanked her colleagues on the FAC for putting in the work and getting into the details to the degree necessary to get comfortable with the proposed budget.

Nancy Huang, Chief Financial Officer, provided a high-level overview of the FY 2021-22 CalOptima Operating Budget. She reviewed the consolidated budget for the current fiscal year compared with the proposed FY 2021-22 budget, highlighting the differences. Ms. Huang noted the projected enrollment increases, as well as the changes in providers rates, most significantly in the MCE rates, which the state decreased to better align with patient acuity. She noted that when the state implemented Medi-Cal Expansion, it set the rates based on those that apply to seniors and persons with disabilities (SPD), as the health status of the MCE population was initially unknown. Now, with more data, the state has found that the MCE population's acuity is much closer the Medi-Cal Classic population, which requires far fewer services than the SPD population. Ms. Huang also noted that, factoring in changes in enrollment, MCE rate changes, changes in eligibility, the inclusion of coverage for undocumented adults, and 41 new positions to meet regulatory requirements, the recommended FY 2021-22 budget assumes a deficit of $58 million.

Mr. Sanchez added that, he will be adding one additional position, a Chief of Staff, that is not included in today's recommended budget due to timing, but the position will be brought to a future Board meeting for consideration.

Action: ***On motion of Vice Chair Becerra, seconded and carried, the Board of Directors: 1.) Approved the CalOptima Fiscal Year (FY) 2021-22 Operating Budget; and 2.) Authorized the expenditures and appropriated the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy. (Motion carried 9-0-0)***

24. Consider Approval of the CalOptima Fiscal Year 2021-22 Capital Budget

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors: 1.) Approved the CalOptima Fiscal Year (FY) 2021-22 Capital Budget; and 2.) Authorized the expenditures and appropriated the funds for the items listed in Attachment A: Fiscal Year 2021-22 Capital Budget by Project, which shall be procured in accordance with CalOptima Board-approved policies. (Motion carried 9-0-0)***

25. Consider Adoption of Resolution Approving and Adopting Updated CalOptima Policy GA.8044:

Telework Program, Authorization of the Expansion of the Telework Program, Continuation of the Temporary Telework Program, and Authorization of Related Unbudgeted Expenditures
After discussion, this item was continued for further study.

Chairman Do commented that he was forming a Board Ad Hoc to review CalOptima's Telework Policy. The ad hoc will consist of Chairman Do, Supervisor Chaffee and Director Corwin, and it will bring recommendations back to the Board for consideration.

26. Consider Authorizing Lease Extension Agreement for the Real Property Located at 13300 Garden Grove Boulevard, Garden Grove, California

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into a Lease Extension Agreement for the real property located at 13300 Garden Grove Boulevard, Garden Grove, California to extend its term for ten (10) additional years, through December 31, 2031. (Motion carried 9-0-0)***

CLINICAL OPERATIONS
28. Consider Approval of Modifications to CalOptima Medical Affairs Policies: GG.1102, GG.1301, and GG.1313

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved recommended modifications to the following existing medical policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows: 1.) Policy GG.1102: Experimental and Investigational Service Coverage; 2.) Policy GG.1301: Comprehensive Case Management Process; and 3.) Policy GG.1313: Coordination of Care for Transplant Members. (Motion carried 9-0-0)***

29. Consider Authorizing Amendment to Contract with Infomedia Group, Inc., dba Carenet Healthcare Services to Support Member Outreach Calls

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the contract with Infomedia Group, Inc., dba Carenet Healthcare Services (Carenet), to include reimbursement for member engagement services to support timely communications to CalOptima Community Network (CCN) members, as well as correct the term section of the contract to align with the Request for Proposal (RFP) to reflect a three year term, along with two one year extension options, each exercisable at CalOptima's sole discretion. (Motion carried 9-0-0)***

NETWORK OPERATIONS
30. Consider Approval of Modifications to CalOptima Policy HH.2003: Health Network and Delegated

Entity Reporting

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors approved modifications to CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting [Medi-Cal, OneCare, OneCare Connect]. (Motion carried 9-0-0)***

Chairman Do noted he was not participating in Agenda Items 31 and 33 due to conflicts of interest based on campaign contributions under the Levine Act and passed the gavel to Vice Chair Becerra for consideration of these two items.

31. Consider Authorizing Extension and Amendments of the Fee-For-Service Hospital Contracts for Medi-Cal, OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly
In addition to Chairman Do, Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Jordan did not participate in this item due to his affiliation with Providence St. Joseph Health Care.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO) to extend the terms of existing CalOptima Fee-for-Service (FFS), hospital contracts through June 30, 2022, and, with the assistance of Legal Counsel, to enter into amendments of those contracts to: 1.) Standardize reimbursement rates for Medicare-based programs OneCare (OC), OneCare Connect (OCC), and Program of All-Inclusive Care for the Elderly (PACE); 2.) Reflect updated Medi-Cal reimbursement for contracted FFS hospitals' All Patients Refined-Diagnosis Related Groups (APR-DRG) and blended per diem-based schedule, as applicable; 3.) Reflect updated Medi-Cal reimbursement rates for contracted FFS hospital outpatient services, other than hospital-administered drugs; and 4.) Reflect updated Medi-Cal reimbursement for outpatient hospital-administered drugs. (Motion carried 6-0-1; Chairman Do abstained; Directors Jordan and Schoeffel absent)***

33. Consider Authorizing the Extension of and Other Amendments to the CalOptima Medi-Cal Full-Risk Health Maintenance Organization, Shared-Risk Group, and Physician-Hospital Consortium Health Network Contracts Except those Affiliated with Kaiser Foundation Health Plan, Inc., and Ratification of the Delegation Agreements Related to Those Contracts
In addition to Chairman Do, Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Shivers did not participate in this item due to her affiliation with Optum Healthcare.

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network Health Maintenance Organization (HMO), Shared-Risk Group (SRG), and Physician-Hospital Consortium (PHC) Health Network contracts, except those Affiliated with Kaiser Foundation Health Plan, Inc. (Kaiser) to: a.) Extend the term through June 30, 2022; b.) Revise the Division of Financial Responsibility (DOFR) to transfer financial responsibility for Early and Periodic Screening,***

Diagnostic, and Treatment (EPSDT) Private Duty Nursing to CalOptima; c.) Reflect adjustments to the Health Networks' capitation rates for the DOFR change as well as changes in state funding effective July 1, 2021; and 2.) Ratified the Health Network Delegation Agreements, except Kaiser's Delegation Agreement, effective January 1, 2021. (Motion carried 6-0-1; Chairman Do abstained; Directors Schoeffel and Shivers absent)

Vice Chair Becerra passed the gavel back to Chairman Do to hear Agenda Item 32.

32. Authorize an Amendment Extending the Term of the Kaiser Foundation Health Plan, Inc. Health Maintenance Organization Health Network Contract and Current Rates, and Ratify the Delegation Agreement Related to that Contract
Director Schoeffel did not participate in this item due to potential conflicts of interest.

Chairman Do commented that staff has spent much time during the last year trying to negotiate mutually agreeable contract terms and had reached an impasse with Kaiser. He stated that he got involved and determined that the Center for Medicare & Medicaid Services (CMS) had concluded that Kaiser is different and because of this, it may have a different contractual arrangement that allows it to receive a percentage of the capitation CalOptima receives from the state without being held to rebased rates based on actual patient cost of care, which differs from CalOptima's other health network contracts. After considerable discussion, Chairman Do made an amended motion to extend the term of the Kaiser contract for two years.

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors approved the amended motion to: 1.) Continue the current alternative capitation rate methodology for Kaiser Foundation Health Plan, Inc. (Kaiser) through June 30, ~~2022~~ 2023; 2.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to Amend the Kaiser Medi-Cal, Full-Risk Health Maintenance Organization (HMO) contract to extend the term through June 30, ~~2022~~ 2023; and 3.) Ratified the Delegation Agreement. (Motion carried 8-0-0; Director Schoeffel absent)*** *Rev. 6/3/2021*

PUBLIC AFFAIRS
34. Consider Reallocating Intergovernmental Transfer (IGT) Funds and Approving a Grant Agreement for Whole-Person Care Housing Navigation and Supportive Services
Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Chau did not participate due to his role as Director of the Orange County Health Care Agency.

Action: ***On motion of Director Jordan, seconded and carried, the Board of Directors: 1.) Authorized reallocation of up to $640,000 in IGTs 1, 3, 4 and 6 to Orange County Health Care Agency's (OCHCA) Whole-Person Care (WPC) pilot for Housing Navigation and Supportive Services (HNSS) for CalOptima Medi-Cal members; and 2.) Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a Grant Agreement with OCHCA to provide $640,000 in grant funds for the County's WPC pilot for HNSS provided to CalOptima Medi-Cal members enrolled in WPC. (Motion carried 8-0-0;***

Back to Agenda

Director Schoeffel absent)

35. Consider Approving CalOptima's California Advancing and Innovating Medi-Cal (CalAIM) Model of Care Approach

Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors approved CalOptima's proposed California Advancing and Innovating Medi-Cal (CalAIM) Model of Care (MOC) approach, effective January 1, 2022, for submission to the Department of Health Care Services (DHCS), including utilizing CalOptima's health networks as Enhanced Care Management (ECM) Providers and the launch of four In Lieu of Services (ILOS), listed below. (Motion carried 8-0-0; Director Schoeffel absent)***

Chairman Do encouraged Board members to receive additional briefings regarding CalAIM with staff due to the complexities of the proposals.

As Chairman Do noted at the top of the meeting, Agenda Item 27 was considered at theend of the Report Items and before the Advisory Committee Updates.

ADMINISTRATION

27. Election of Officers of the Board of Directors for Fiscal Year 2021-22

Director Schoeffel made a motion to elect Chairman Do to continue to serve as Chairman and to elect Director Corwin to serve as Vice Chairman for the next fiscal year.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors elected Supervisor Andrew Do to serve as Board Chair and Director Clayton Corwin to serve as Vice Chair for terms effective July 1, 2021 through June 30, 2022, or until the election of a successor(s), unless the Board Chair or Vice Chair shall sooner resign or be removed from office. (Motion carried 9-0-0)***

ADVISORY COMMITTEE UPDATES

36. OneCare Connect Member Advisory Committee Update

Patty Mouton, Chair, OneCare Connect Member Advisory Committee (OCC MAC), provided an overview of the activities of the OCC MAC. Ms. Mouton reported that the OCC MAC has been working on its goals and accomplishments, noting that OCC MAC has contributed at total of 234 hours during its service to CalOptima this fiscal year.

37. Whole-Child Model Family Advisory Committee Update

Kristin Rogers, Chair, Whole-Child Model Family Advisory Committee (WCM FAC), provided an overview of the WCM FAC activities, noting contributions of 179 hours during its service to CalOptima this fiscal year.

38. Provider Advisory Committee Update

Dr. Junie Lazo-Pearson, Chair, Provider Advisory Committee (PAC), provided an overview of the PAC activities, noting contributions of 465 hours during its service to CalOptima this fiscal year.

Back to Agenda

39. Member Advisory Committee Update

Christine Tolbert, Chair, Member Advisory Committee (MAC), provided an overview of the MAC activities, noting contributions of 364 hours during its service to CalOptima this fiscal year. Ms. Tolbert also congratulated Director Corwin on his appointment as Vice Chair next fiscal year and thanked Vice Chair Becerra for service this fiscal year.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Vice Chair Corwin thanked the Board for their support.

Chairman Do thanked the Advisory Committees for their input.

Director Jordan announced that he is resigning from the CalOptima Board of Directors, noting that his last meeting will be August 5, 2021.

Hearing no further business, Chairman Do adjourned the meeting at 4:08 p.m.

ADJOURNMENT

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: August 5, 2021

Back to Agenda

MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE

April 22, 2021

A Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on April 22, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing requirements of the Brown Act.

CALL TO ORDER

Chair Patty Mouton called the meeting to order at 3:05 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Patty Mouton, Chair; Keiko Gamez, Vice Chair (3:30 PM); Meredith Chillemi; Gio Corzo; Josefina Diaz; Sandra Finestone; Eleni Hailemariam, M.D. (non-voting); Sara Lee; Mario Parada; Donald Stukes

Members Absent:

Others Present: Richard Sanchez, Interim Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Emily Fonda, M.D. Chief Medical Officer; Gary Crockett, Chief Counsel; Belinda Abeyta, Executive Director, Operations; Rachel Selleck, Executive Director, Public Affairs; Tracy Hitzeman, Executive Director Clinical Operations; Albert Cardenas, Director, Customer Service; Claudia Magee, Manager, Strategic Development; Bárbara Kidder García, Sr. Program/Policy Analyst, Strategic Development; Jackie Marks, Sr. Policy Advisor, Government Affairs; Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Lead Customer Service Representative, Customer Service.

MINUTES

Approve the Minutes of the March 11, 2020 Special Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC)

Action: ***On motion of Member Gio Corzo, seconded and carried, the Committee approved the minutes of the March 11, 2021 meeting by a roll call vote. (Motion carried 8-0-0; Voting Member Keiko Gamez absent)***

Back to Agenda

Approve the Minutes of the March 11, 2021 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and the Whole-Child Model Family Advisory Committee

Action: ***On motion of Member Gio Corzo, seconded and carried, the Committee approved the minutes of the March 11, 2021 meeting by a roll call vote. (Motion carried 8-0-0; Voting Member Keiko Gamez absent)***

PUBLIC COMMENT

There were no requests for public comment

REPORTS

Consider Approval of FY 2021-2022 OneCare Connect Member Advisory Committee Meeting Schedule

Action: ***On motion of Member Meredith Chillemi, seconded and carried, the Committee approved the FY 2021-2022 Meeting Schedule by a roll call vote. (Motion carried 8-0-0; Voting Member Keiko Gamez absent)***

Consider Recommendation of OneCare Connect Member Advisory Committee Slate of Candidates

Action: ***On motion of Member Mario Parada, seconded and carried, the Committee approved the Nominations Ad Hoc Recommendation on the OCC MAC Slate of Candidates by a roll call vote. (Motion carried 8-0-0; Voting Member Keiko Gamez absent)***

Chief Executive Officer Update

Richard Sanchez, Chief Executive Office announced that Dr. Fonda had been appointed as CalOptima's Chief Medical Officer. Mr. Sanchez also discussed how the strategic planning team lead by Rachel Selleck, Executive Director, Public Affairs would be reviewing the feedback received by strategic planning team from all the committees to allow OCC MAC another chance to provide additional feedback. Mr. Sanchez also noted that CalOptima and the Orange County Health Care Agency continue to work together to distribute vaccines to those most vulnerable in Orange County.

Chief Operating Officer Report

Ladan Khamseh, Chief Operating Officer updated the OCC MAC members on the current status of the draft policy intended to address health network model changes that was discussed at the August 2020 Board meeting. Ms. Khamseh noted that the policy included draft language that is intended to define the criteria and provided the process for health networks to submit requests for contract model changes. She also noted that staff plans to prepare and submit this policy for board consideration at the May 2021 Board meeting. Ms. Khamseh also updated the OCC MAC on the status of the Qualified

Back to Agenda

Medicare Beneficiary annual outreach to members. She noted that over 2,000 members had been contacted based on information received from the Social Services Agency.

INFORMATION ITEMS

OCC MAC Member Updates

Chair Patty Mouton notified the Committee that the committees accomplishments for FY 2020-21 were being compiled and would be ready for the June OCC MAC meeting. She requested that if the members had any accomplishments to add to please provide them to Cheryl Simmons. She noted that these accomplishments would be sent to the Board as an informational item. Chair Mouton also notified the committee that Jyothi Atluri had resigned her seat on the OCC MAC and staff was awaiting information on her replacement since her seat is appointed by the Orange County Social Services Agency.

COVID-19 Update

Emily Fonda, M.D., Chief Medical Officer, provided a COVID-19 update and discussed the on-going vaccine efforts that were currently in progress. Dr. Fonda noted that gift cards had also been distributed to CalOptima members as an incentive for getting their vaccine. Dr. Fonda also discussed the vaccine initiatives for those members who are homeless and addressed the myths that were circulating about the vaccines.

CalOptima 2020-2022 Strategic Plan Discussion

Rachel Selleck, Executive Director, Public Affairs, jointly presented with Claudia Magee, Manager, Strategic Development, and Bárbara Kidder García, Program/Policy Analyst, Sr., on the feedback they received for the FY 2020-2022 Strategic Plan that was presented at the advisory committees joint meeting March 11, 2021. OCC MAC provided additional feedback on Health Equity, Social Determinants of Health, Service Delivery Model and Behavioral Health as well as other service categories during the meeting.

California Advancing and Innovating Medi-Cal (CalAIM) Update

Pallavi Patel, Director, Process Excellence provided a California Advancing and Innovating Medi-Cal (CalAIM) presentation. Ms. Patel noted that this overview had been presented to the Board at their April meeting and staff begun presenting this item to all the advisory committees. A final plan will be presented to the Board at their June 3, 2021 meeting with submission of deliverables to the Department of Health Care Services (DHCS) on or before July 1, 2021.

Federal and State Legislative Update

Jackie Mark, Sr. Policy Advisor, Government Affairs provided an update on several legislative items of interest to the committee and referred the committee to the handout that they had received in their meeting materials including the CalOptima's Legislative Platform and Legislative Priorities.

Back to Agenda

ADJOURNMENT

Chair Mouton reminded the members that the next regular OCC MAC meeting is scheduled for June 24, 2021 at 3:00 p.m.

Hearing no further business, the meeting adjourned at 4:42 p.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the Advisory Committees

Approved: June 24, 2021

Back to Agenda

MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' PROVIDER ADVISORY COMMITTEE

May 13, 2021

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on May 13, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing requirements of the Brown Act.

CALL TO ORDER

PAC Chair Dr. Junie Lazo-Pearson, called the meeting to order at 8:03 a.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Junie Lazo-Pearson, Ph.D., Chair; John Nishimoto, O.D., Vice Chair; Amin Alpesh, M.D.; Anjan Batra, M.D.; Jennifer Birdsall, Ph.D; Tina Bloomer, MHNP ; Donald Bruhns; Andrew Inglis, M.D.; Jena Jensen; Teri Miranti; Loc Tran, PharmD.; Christy Ward

Members Absent: John Kelly, M.D.; Peter Korchin

Others Present: Richard Sanchez, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Emily Fonda, M.D., Chief Medical Officer; Michelle Laughlin, Executive Director, Network Operations; Tracy Hitzeman, Executive Director, Clinical Operations; Rachel Selleck, Executive Director, Public Affairs; Jackie Mark, Sr. Policy Advisor, Government Affairs; Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Lead Customer Service Representative, Customer Service

MINUTES

Approve the Minutes of the April 8, 2021 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Alex Rossel, seconded and carried, the Committee approved the minutes of the April 8, 2021 regular meeting. (Motion carried 13-0-0; Members Kelly, Korchin absent)***

Back to Agenda

REPORTS

Consider Approval of the FY 2021-2022 PAC Meeting Schedule

PAC members reviewed the proposed FY 2021-2022 meeting schedule. The PAC will continue to meet on a monthly basis on the second Thursday of every month with the exception of November 11, 2021 when they will meet on Wednesday, November 10, 2021 due to the Veteran's Day Holiday. PAC will not hold meetings in July 2021 and January 2022.

Action: ***On motion of Member Dr. Amin, seconded and carried, the Committee approved the PAC 2021-22 Meeting Schedule (Motion carried 13-0-0; Members Kelly, Korchin absent).***

Consider Recommendation of PAC Slate of Candidates

Vice Chair Dr. Nishimoto summarized the recommendations of the PAC Nominations Ad Hoc Committee, which consisted of Members Jennifer Birdsall, Teri Miranti, Christy Ward and Vice Chair Dr. Nishimoto. The ad hoc committee met on April 28, 2021 to review the five applications received from the recent recruitment to fill the four expiring PAC seats for Allied Health Services, Behavioral/Mental Health, Health Networks, and Nurse Representatives.

The ad hoc committee recommended the following candidates for the four expiring PAC seats: Gio Corzo (new appointment) as the Allied Health Services Representative, Junie Lazo-Pearson, Ph.D. (reappointment) as the Behavioral/Mental Health Representative; Jacob Sweidan, M.D. (new appointment) as the Health Network Representative and Tina Bloomer, NP (reappointment) as the Nurse Representative.

Action: ***On motion of Member Dr. Amin, seconded and carried, the Committee approved the Recommendation for the PAC Slate of Candidates (Motion carried 12-0-1; Members Kelly and Korchin absent, Chair Junie Lazo-Pearson abstained)***

PUBLIC COMMENTS

There were no public comments.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Report

Richard Sanchez, Chief Executive Officer, announced that Marie Jeannis had been named CalOptima's Executive Director, Quality and Population Health Management. Mr. Sanchez also discussed the Report to the Community that is posted on the CalOptima website and reflects on the past year as a way to honor the incredible work of our providers on behalf of CalOptima members. Mr. Sanchez also shared that CalOptima would be hosting a virtual CalAIM stakeholder meeting. He invited the PAC to share with their organizations that CalOptima would be hosting a vaccine event in the parking lot on May 15,2021 and that appointments were still available to obtain a vaccine.

Back to Agenda

Chief Operating Officer Report
Ladan Khamseh, Chief Operating Officer, updated the PAC members on the postponement of two draft health network policies to allow for more detailed information to be submitted on the health network reporting policy and review by the Board Ad Hoc of the new policy for health network model changes. Staff will make updates on the health network reporting policy and resubmit to the Board at their June 3, 2021 meeting.

Chief Medical Officer Report
Emily Fonda, M.D., Chief Medical Officer, provided a COVID-19 update and discussed the on-going vaccine efforts that were currently in process and noted that approximately 31,000 gift cards had been sent to members as an incentive for getting their vaccines. She also noted that 879 gift cards had been distributed to homeless individuals as part of the vaccine initiative. Dr. Fonda reviewed the vaccine event that was to be held at the CalOptima facility parking lot on May 15, 2021 and noted that over 200,000 test messages had been sent to CalOptima members in addition to messenger videos, clergy videos and a Public Broadcasting Service (PBS) information broadcast to spread the word to Orange County.

INFORMATION ITEMS

California Advancing and Innovating Medi-Cal (CalAIM)
Rachel Selleck, Executive Director, Public Affairs, provided a CalAIM presentation and noted that this overview had been presented to the Board in April 2021 with roll out to the Advisory Committees in April and May. She noted that a final plan will be presented to the Board at their June meeting with submission of deliverables to the Department of Health Care Services (DHCS) on or before July 1, 2021. Ms. Selleck indicated that a response from DHCS is anticipated late Summer on CalOptima's CalAIM submission.

Federal and State Legislative Update
Jackie Mark, Sr. Policy Advisor, Government Affairs also provided an update on several legislative items of interest to the committee and referred the committee to the handout that they had received in their meeting materials including a Behavioral Health report.

PAC Member Updates
Chair Lazo-Pearson noted that Alex Rossel's presentation on Families Together would be rescheduled for the June PAC meeting in order to allow time to troubleshoot the video issues that were encountered. Chair Lazo-Pearson also reminded the PAC members to submit any PAC accomplishments to Cheryl Simmons as she would be compiling the accomplishments for FY 2020-21.

Back to Agenda

ADJOURNMENT
Hearing no further business, Chair Lazo-Pearson adjourned the meeting at 8:55 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the Advisory Committees

Approved: June 10, 2021

Back to Agenda

MINUTES

SPECIAL MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE

May 13, 2021

A Special Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on May 13, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER

Chair Christine Tolbert called the meeting to order at 2:33 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Christine Tolbert, Chair; Pamela Pimentel, Vice Chair; Maura Byron; Sandra Finestone; Connie Gonzalez; Hai Hoang; Sally Molnar; Patty Mouton; Melisa Nicholson; Kate Polezhaev; Steve Thronson;

Members Absent: Linda Adair; Sister Mary Therese Sweeney; Mallory Vega

Others Present: Richard Sanchez, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Emily Fonda, M.D. Chief Medical Officer; Gary Crockett, Chief Counsel; Belinda Abeyta, Executive Director, Operations; Tracy Hitzeman, Executive Director Clinical Operations; Rachel Selleck, Executive Director, Public Affairs; Albert Cardenas, Director, Customer Service; Jackie Mark, Sr. Policy Advisor, Government Affairs; Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Lead Customer Service Representative, Customer Service.

MINUTES

Approve the Minutes of the April 8, 2021 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Member Maura Byron, seconded and carried, the MAC approved the minutes as submitted. (12-0-0, Members Adair, Sweeney and Vega absent)***

PUBLIC COMMENT

There were no public comments.

Back to Agenda

REPORTS

Consider Approval of the FY 2021-2022 MAC Meeting Schedule

MAC members reviewed the proposed FY 2021-2022 10 meeting schedule and after much discussion opted to increase their meeting frequency from bi-monthly to monthly basis for 90 minutes beginning at 3:00 p.m. on the second Thursday of every month with the exception of November 11, 2021 when they will meet on Wednesday, November 10, 2021 due to the Veteran's Day Holiday. MAC will not hold meetings in July 2021 and January 2022.

Action: ***On motion of Member Maura Byron, seconded and carried, the Committee approved the MAC 2021-22 Meeting Schedule (Motion carried 11-1-0; Members Adair, Sweeney and Vega absent).***

Consider Recommendation of MAC Slate of Candidates

Member Sally Molnar reviewed the recommendations of the MAC Nominations Ad Hoc Committee, which consisted of Chair Christine Tolbert and Members Sally Molnar, Patty Mouton and Steve Thronson. The ad hoc committee met on April 29, 2021 to review the five applications received from the recent recruitment to fill the four expiring MAC seats for Adult Beneficiaries, Family Support, Persons with Disabilities and Seniors Representatives.

The ad hoc committee recommended the following candidates for the four expiring MAC seats: Sandra Finestone (reappointment) as the Adult Beneficiaries Representative, Maura Byron (reappointment) as the Family Support Representative; Hai Hoang (reappointment) as the Persons with Disabilities Representative and Meredith Chillemi (new appointment) as the Seniors Representative.

Action: ***On motion of Member Sally Molnar, seconded and carried, the Committee approved the MAC Slate of Candidates (Motion carried 12-0-0; Members Adair, Sweeney and Vega absent).***

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Report

Richard Sanchez, Chief Executive Officer, announced that Marie Jeannis has been named CalOptima's Executive Director of Quality and Population Health Management. Mr. Sanchez also discussed the Report to the Community that is posted on the CalOptima website and reflects on the past year as a way to honor the incredible work of our providers on behalf of CalOptima members. Mr. Sanchez also shared that CalOptima would be hosting a virtual California Advancing and Innovating Medi-Cal (CalAIM) stakeholder meeting on May 14, 2021. Mr. Sanchez asked the MAC members to share with their organizations that CalOptima would be hosting a vaccine event on May 15, 2021. He noted that appointments were still available to receive the vaccine.

Back to Agenda

Chief Operating Officer Report
Ladan Khamseh, Chief Operating Officer, updated the MAC members on the postponement of two draft health network policies to allow for more detailed information to be submitted on the health network reporting policy and a review by the Board Ad Hoc of the new policy for health network model changes. Staff will make updates on the health network reporting policy and resubmit to the Board at their June 3, 2021 meeting.

Chief Medical Officer Report
Emily Fonda, M.D. Chief Medical Officer, provided a COVID-19 update and discussed COVID-19 vaccine efforts that were currently in progress. Dr. Fonda noted that over 31,000 gift cards have currently been sent to members as an incentive for getting vaccinated of which 900 of the gift cards had been given to homeless individuals for obtaining their vaccines. Dr. Fonda updated the MAC on the over 200,000 text messages that had been sent out to publicize the vaccine event at CalOptima on May 15, 2021 as well as messenger videos, clergy videos and a Public Broadcasting Service (PBS) broadcast to spread the word to Orange County.

INFORMATION ITEMS

MAC Member Updates
Chair Tolbert thanked the MAC for approving the 10 meeting schedule and asked that the members please send their MAC accomplishments for FY 2020-21 to Cheryl Simmons.

California Advancing and Innovating Medi-Care (CalAIM)
Rachel Selleck, Executive Director, Public Affairs, provided a California Advancing and Innovating Medi-Cal (CalAIM) presentation. She noted that this overview had been presented to the Board at their April meeting and staff have now completed presenting this item to all the advisory committees. A final plan will be presented to the Board at their June 3, 2021 meeting with submission of deliverables to the Department of Health Care Services (DHCS) on or before July 1, 2021. She also noted that CalOptima is anticipating a response from DHCS late Summer on this submission.

Federal & State Legislative Update
Jackie Mark, Sr. Policy Advisor, Government Affairs provided an update on several legislative items of interest to the MAC and referred the committee to the handout that they had received as part of their meeting materials including CalOptima's Behavioral Health Policy Landscape.

ADJOURNMENT
Hearing no further business, Chair Tolbert adjourned the meeting at 3:42 p.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the Advisory Committees

Approved: June 10, 2021

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Ratifying a Revised Amendment to Agreement 16-93274 with the California Department of Health Care Services in Order to Continue Operation of the OneCare Program

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Carmen Dobry, Executive Director, Compliance (657) 235-6997

Recommended Action

Ratify revised Amendment 05 to Agreement 16-93274 between CalOptima and the California Department of Health Care Services (DHCS), in order to continue operation of the OneCare program.

Background

As a County Organized Health System (COHS), CalOptima contracts with the DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year Primary Agreement with the DHCS. Amendments to the Primary Agreement are summarized in the attached appendix, including Amendment 49, which extends the agreement through December 31, 2021. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Until 2016, the Primary Agreement included language that incorporated provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs). In 2016, DHCS extracted the MIPPA-compliant language from the Primary Agreement and placed it in a standalone agreement, Agreement 16-93274. The Chairman executed that agreement, an action that was ratified during the August 2016 meeting of the Board. Subsequently, the Chairman of CalOptima's Board of Directors has executed five amendments to the agreement to extend the contract termination date, pursuant to Board authority, most recently during the June 2021 meeting of the Board.

Discussion

Amendment to Agreement 16-93274

In June 2021, Staff received authority from the CalOptima Board of Directors to execute an amendment to Agreement 16-93274 in order to continue operation of the OneCare program.

The Centers for Medicare & Medicaid Services (CMS) required that plans renewing their D-SNP programs submit evidence of a MIPPA-compliant Medicaid contract for the 2022 contract year no later than July 6, 2021. CalOptima received Amendment 05 (A-05) to Agreement 16-93274 for signature from DHCS on June 3, 2021, and subsequently procured the Board Chair's signature for the revised contract amendment and promptly returned the signed amendment to DHCS for countersignature. CalOptima received the fully executed agreement from DHCS on June 17, 2021, and completed its MIPPA filing with CMS on June 28, 2021, prior to the deadline.

Back to Agenda

The final amendment provided to CalOptima contained additional changes to the contract language when compared to the draft previously provided to CalOptima by DHCS. As Staff did not receive the revised language of the amendment from DHCS in time to bring it to the June 2021 Board of Directors Meeting, Staff is now returning to the Board to provide information on the additional revisions and seek retroactive authority for the Board Chair to have signed the revised Amendment 05 within the timeline established by DHCS that reflects these changes.

Following is a description of the changes contained within the amendment to Agreement 16-93274.

Section/Provision:	**Updates in Draft Amendment:**	**Updates in Final Amendment for Signature:**
Exhibit A - SCOPE OF WORK		
1. Care Coordination	• Clarifies care coordination procedures language.	• Language reworded and additional requirement included that Plan must notify members that Plan is responsible for coordination of Medi-Cal benefits.
2. All Plan and Policy Letters	• Clarifies that when there are inconsistencies in DHCS Medi-Cal Program All Plan and Policies Letter with Medicare requirements, Medicare takes precedence.	• Language reworded and it is clarified that a conflict between Medi-Cal and Medicare guidance only exists when an APL or PL "requires conduct that would violate Medicare requirements or regulations."
3. Coverage Area and Eligible Beneficiaries	• Updates language to further clarify that dual eligible beneficiaries with a share of cost who reside in long term care facilities and are continuously certified are eligible for coverage under the D-SNP.	• This language change is removed, and there are now no changes to this section.
5. Member Billing Prohibitions	• Adds language to strengthen balance billing protections for members and plan's delegates.	• Reference to Social Security Act is removed from beginning of section A.5.B. • A new requirement has been added stating that provider contracts shall require a contracted Medicare provider to comply with Welfare and Institutions Code section 14019.4, which states that a provider who obtains a Medi-Cal card or other proof of eligibility from an eligible applicant or recipient, shall neither seek reimbursement nor attempt to

Section/Provision:	Updates in Draft Amendment:	Updates in Final Amendment for Signature:
		obtain payment for the cost of covered services from the eligible applicant or recipient.
7. Medi-Cal and Medicare Eligibility Verification	• Deletes the D-SNP's responsibility to confirm all applicable Medicare Advantage *special needs criteria* are met, based on D-SNP type. • Adds requirement to ensure appropriate training of Plan staff to use Medi-Cal eligibility verification systems.	• No significant difference between draft and final.
8. Contract Term	• Extends the contract term through December 31, 2023.	• Extends the contract term through December 31, **2022**
11. CMS Documentation	• Updates the type of CMS documentation that is required to be submitted to DHCS to include the D-SNP's Model of Care and a list of approved Supplemental Benefits.	• This section is included but expanded upon. An additional provision requiring the member to exhaust supplemental benefits prior to using any Medi-Cal benefits, including In Lieu of Services was added.
Exhibit D(F) SPECIAL TERMS AND CONDITIONS		
9. Federal Contract Funds	• Removes outdated Federal Contract Funds language.	• No significant difference between draft and final.
Exhibit E, Attachment 2 PROGRAM TERMS AND CONDITIONS		
1. Governing Law	• Removes outdated Balanced Budget Act language.	• No significant difference between draft and final.
9. Prohibition Against Subcontracts	• Removes Prohibition Against Subcontracts language.	• No significant difference between draft and final.
27. Untitled Section	• Updates the Discrimination grievance processing requirement references.	• Changes are included and expanded upon further. New requirement to report discrimination grievances in accordance with APL 21-004. New sections "27. Discrimination Grievances" and "28. Nondiscrimination Notice and Language Taglines" created to describe mostly existing language. Adds another reference to follow APL 21-004.

Back to Agenda

Fiscal Impact
The recommended action to ratify revised Amendment 05 to Agreement 16-93274 between CalOptima and DHCS is projected to be budget neutral.

Rationale for Recommendation
CalOptima's execution of Amendment 05 (A-05) to the Agreement 16-93274 with the DHCS was necessary to ensure that CalOptima meets CMS requirements in order for CalOptima to operate the OneCare program during 2022. This ratification item informs the Board of additional language changes to the final version of A-05.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Appendix summary of amendments to Agreements with DHCS
2. 2022 Final Amendment to Agreement 16-93274
3. Previous Board Action dated June 3, 2021: Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to Agreement 16-93274 with the California Department of Health Care Services (DHCS) in Order to Continue Operation of the OneCare Program

/s/ Richard Sanchez — **Authorized Signature**

07/28/2021 — **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 5

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

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

Back to Agenda Back To Item

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

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
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

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020

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

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

A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2023.	June 3, 2021

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

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

Exhibit A
SCOPE OF WORK

D-SNP in Coordinated Care Initiative County

1. Service Overview

This contract is being executed with this Contractor that is a Dual Eligible Special Needs Plan (D-SNP).

D-SNP Contractor agrees to provide to the Department of Health Care Services (DHCS) the services described herein:

Care coordination of the Medi-Cal benefits and services provided to eligible Medi-Cal beneficiaries but which are not covered by the Medicare Advantage health plan under whose authority the D-SNP Contractor operates. These Medi-Cal benefits and services are defined in the contents of this D-SNP Contract.

2. Project Representatives

A. The project representatives during the term of this D-SNP Contract will be:

Department of Health Care Services	**D-SNP Contractor**
Managed Care Operations Division (MCOD) Attn: Chief, Managed Care Systems and Support Services Branch	Orange County Organized Health System dba: CalOPTIMA Attn: Richard Sanchez, Chief Executive Officer
Telephone: (916) 449-5000 Fax: (916) 449-5090	Telephone: (657) 900-1481 Email: Richard.Sanchez@caloptima.org

B. Direct all inquiries to:

Department of Health Care Services	**D-SNP Contractor**
Managed Care Operations Division Attn: Contracting Officer	Orange County Organized Health System dba: CalOPTIMA Attn: Richard Sanchez, Chief Executive Officer
MS 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: (657) 900-1481

Back to Agenda Back To Item

Exhibit A
SCOPE OF WORK

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 D-SNP Contract.

3. See the following attachments for a detailed description of the services to be performed

Exhibit A, Attachment 1
COORDINATION OF CARE

1. Care Coordination

This D-SNP Contract is a care coordination agreement. D-SNP Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including when Medi-Cal benefits are delivered via Medi-Cal Fee-For-Service (FFS), managed care, or other Medi-Cal delivery systems. Without limitation, D-SNP shall coordinate care with providers and other entities for the Medi-Cal benefits included in Exhibit A, Provision 1, Care Coordination, Paragraph A, below, and outlined in Exhibit H, when Medically Necessary for the Member. D-SNP Contractor is responsible for coordinating the Member's Medicare and Medi-Cal benefits including, but not limited to, discharge planning, disease management, and care management. D-SNP Contractor must notify Members that D-SNP Contractor, and not the Member, is responsible for coordination of the Member's Medi-Cal benefits. D-SNP Contractor shall:

A. Develop and implement care coordination procedures that are submitted to and approved by DHCS for referral and coordination of care for Members who receive benefits and services through either the Medi-Cal managed care or FFS programs. Medi-Cal benefits and services requiring referral and coordination of care by D-SNP Contractor are outlined in Exhibit H.

   1) For Medi-Cal managed care Members, Contractor's D-SNP will contact the Member's Medi-Cal managed care plan (MCP) for provider information and for the coordination of Medi-Cal managed care covered benefits. Managed care health plan contact information can be found at the following link: http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx;

   2) For Medi-Cal FFS Members, Contractor's D-SNP will contact Medi-Cal for provider information and the coordination of Medi-Cal FFS benefits. Medi-Cal contact information can be found at the following link: https://www.dhcs.ca.gov/Pages/dhcs_contact.aspx;

   3) For coordination of behavioral health services, Contractor's D-SNP will contact the Member's Medi-Cal managed care health plan and/or the county mental health plans for provider information and the coordination of behavioral health services. County mental health plan contact information can be found at the following link: http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx;

   4) For coordination of In-Home Supportive Services (IHSS) benefits, Contractor's D-SNP will contact the County IHSS Office. County IHSS Office contact information can be found at

https://www.cdss.ca.gov/inforesources/county-ihss-offices; and

5) For coordination of Medi-Cal Dental benefits, Contractor's D-SNP will contact the DHCS Dental Administrative Service Organization (ASO) for provider information and the coordination of dental benefits. ASO contact information can be found at the following link: https://smilecalifornia.org/contact-us/.

B. Make a referral to the Member's Medi-Cal MCP, or county or state office listed in Section A above, for follow-up and possible provision of Medi-Cal benefits or services, when a Member requests or D-SNP Contractor determines a Member may need a Medi-Cal benefit or service that is not covered by D-SNP Contractor.

C. D-SNP Contractor is not responsible for the provision of, or paying reimbursement for, any Medi-Cal benefits. D-SNP Contractor shall maintain a current knowledge and familiarity of Medi-Cal benefits through ongoing reviews of California laws, rules, policies, and further guidance as posted on the DHCS website. D-SNP Contractor shall timely coordinate Medi-Cal benefits and services requiring referral and coordination of care as outlined in Exhibit H for its Enrolled Dual Eligible Members under this Contract.

This Provision details D-SNP Contractor's specific Medicare-Medi-Cal care coordination requirements. Medi-Cal Covered Services are described in Title XIX of the Social Security Act, 42 CFR sections 440 and 441, the California Medicaid State Plan, Section 3.2, Provision 1 of this Attachment, the DHCS and Medi-Cal websites, and other relevant materials.

D. D-SNP Contractor will provide a report via SFTP in Excel format to DHCS on a monthly basis by the close of business on the sixth business day after the end of the reporting month. The report will contain all Dual Eligible Member admissions to a hospital or Skilled Nursing Facility (SNF) for any reason. Reports will include:

1) Beneficiary Demographic Information

a) First Name, Last Name

b) Medicare Beneficiary Identifier (MBI)

c) Date of Birth

d) Client Index Number (CIN) – if available

2) Inpatient Admissions

a) Date of Notification

b) Date of Admission

c) Admitting Facility – if available

d) Admitting Cause/Diagnosis – if available

e) Type of Admission (e.g., emergency versus directed)

f) Care Manager (provider, social worker, caseworker – if available)

3) Skilled Nursing Facility (SNF) Admissions

a) Date of Notification

b) Date of Admission

c) Admitting Facility – if available

d) Admitting Cause/Diagnosis – if available

e) Type of Admission (e.g., emergency versus directed)

f) Care Manager (provider, social worker, caseworker – if available)

4) Discharge Planning Documents (if available)

a) Discharge date and time

b) Discharge disposition

c) Discharging Facility

d) Discharge diagnosis

e) Discharge instructions

E. D-SNP Contractor will provide a summary report via SFTP to DHCS on a semi-annually basis, due July 31 and January 31 for the previous six-month period, to DHCS for Dual Eligible Members hospitalized or in a skilled nursing facility. D-SNP Contractor's report shall include the following:

1) Number and percentage of population hospitalized;

2) Percentage of population having care coordination prior to hospitalization;

3) Number and percentage of populations offered care coordination following hospitalization;

4) Number and percentage of population accepting care coordination;

5) Number and percentage of populations readmitted from the prior year;

6) Average length of stay;

7) Number discharged from hospital to community;

8) Number discharged from hospital to SNF;

9) Number discharged from hospital to other Facility:

10) Number discharged from SNF to community;

11) Number discharged from SNF to other Facility:

In the event that D-SNP Contractor authorizes another entity or entities to perform this notification, D-SNP Contractor must retain responsibility for complying with this requirement.

2. All Plan and Policy Letters

In addition to the terms and conditions of this Contract. D-SNP Contractor shall comply with All Plan Letters (APLs) and Policy Letters (PLs), including but not limited to APL 12-001, 13-003, 13-008 and 14-007 as well as any subsequent APLs, PLs, or updates, departmental updates regarding D-SNP policies for the duration of the Duals Demonstration Project in connection with Coordinated Care Initiative (CCI) counties, all of which are incorporated by reference into this D-SNP Contract.

To the extent that an APL or PL conflicts with Medicare requirements or regulations, the D-SNP Contractor shall comply with Medicare requirements and regulations. For purposes of this Provision, an APL or PL shall conflict with Medicare requirements or regulations only to the extent that the APL or PL requires conduct that would violate Medicare requirements or regulations.

3. Coverage Area and Eligible Beneficiaries

A. Contractor's D-SNP in the following CCI county may enroll the Dual

Eligible Beneficiaries identified in Paragraphs B and C, subject to the eligibility limitations applicable to the CCI county:

Orange County

B. In CCI counties, beneficiaries eligible for coverage under this D-SNP Contract shall be limited to the following:

1) Dual Eligible Beneficiaries who are eligible for enrollment in a Full Benefit D-SNP and who are enrolled in the Contractor's D-SNP as of December 31, 2014;

2) Dual Eligible Beneficiaries who are eligible for enrollment in a Full Benefit D-SNP and who are excluded from enrollment into Cal MediConnect as follows:

a) Individuals under the age of 21;

b) Individuals with other private or public health insurance;

c) Developmentally Disabled (DD) beneficiaries receiving services through a Department of Developmental Services 1915(c) waiver, regional center, or state developmental center;

d) Individuals with a share of cost - in community and not continuously certified;

e) Individuals residing in one of the Veterans' Homes of California;

f) Individuals residing in an excluded zip code per the Memorandum of Understanding (MOU) between the State and the Centers for Medicare and Medicaid Services (CMS); and

g) Beneficiaries in the following 1915(c) waivers:

i. Home and Community Based Alternative Waiver;

ii. HIV/AIDS Waiver;

iii. Assisted Living Waiver.

h) Intermediate Care Facility - DD Residents.

3) Dual Eligible Beneficiaries who were Members in Contractor's D-SNP as of December 31, 2014, who enroll in Cal MediConnect after

December 31, 2014 and choose to disenroll from Cal MediConnect, may return to Contractor's D-SNP.

4) A Member enrolled in Contractor's D-SNP in a non-CCI county, regardless of enrollment date, who moves during the duration of the CCI Demonstration to a CCI county also covered by Contractor's D-SNP, may remain enrolled in Contractor's D-SNP.

C. In non-CCI counties, all Dual Eligible Beneficiaries eligible for enrollment in a Full Benefit D-SNP may enroll in Contractor's D-SNP.

4. Certification and Enrollment Reporting

A. D-SNP Contractor shall submit to DHCS a certification, signed by the Chief Operations Officer or similar executive officer, that attests to the number of Members enrolled in Contractor's D-SNP as of the effective date of this Contract.

B. By the fifth working day of each month during the term of the D-SNP Contract, D-SNP Contractor shall submit a report, signed by the Chief Operations Officer or similar executive officer, to DHCS summarizing the previous month's Enrollment numbers.

5. Member Billing Prohibitions

A. D-SNP Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on Dual Eligible Members that would exceed the amounts permitted under the California Medicaid State Plan, Section 1852(a)(7) of the Act, and 42 CFR section 422.504(g)(1)(iii). D-SNP Contractor shall not bill a Dual Eligible Member with QMB benefits for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments, in accordance with Section 1902(n)(3)(B) of the Social Security Act. Section 1902(n)(3)(B) of the Social Security Act prohibits a Medicare provider from billing a Dual Eligible Member with QMB benefits for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments.

B. A Dual Eligible Member with QMB benefits has no legal obligation to make further payment to a provider or to D-SNP Contractor for Medicare Part A or Part B cost sharing amounts. D-SNP Contractor's provider agreements shall specify that a contracted Medicare provider agrees to accept D-SNP Contractor's Medicare reimbursement as payments in full for services rendered to Dual Eligible Members, or to bill Medi-Cal or the Member's Medi-Cal MCP as applicable for any additional Medicare

payments that may be reimbursed by Medi-Cal. D-SNP Contractor's provider agreements shall require a contracted Medicare provider to comply with Welfare and Institutions Code Section 14019.4.

6. Provider Network Reporting Requirements

Upon execution of this D-SNP Contract, D-SNP Contractor shall submit to DHCS an initial report that outlines D-SNP Contractor's full Medi-Cal provider network within the defined Service Area.

A. D-SNP Contractor can obtain Medi-Cal participating providers by reviewing the California Health and Human Services Open Data Portal. The California Health and Human Services Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers. Any D-SNPs affiliated with a companion Medi-Cal MCP can obtain the file from the affiliated Medi-Cal plan.

B. D-SNP Contractor will identify in its provider directory those providers that accept both Medicare and Medicaid (providers that are currently registered providers under Medi-Cal and are also within D-SNP Contractor's network).

C. The report, at a minimum, shall include the following:

1) NPI (National Provider Identifier);

2) First and last name;

3) Specialty type;

4) Group association;

5) Full address;

6) Telephone number;

7) Cultural and linguistic services, including provider and provider staff language capability;

8) Hospital admitting privileges; and

9) Provider capacity, including current capacity.

D. After the initial submission of a Medi-Cal provider network report, D-SNP Contractor shall submit an updated report at least:

1) Quarterly; and

2) Whenever a significant change to the network affects provider capacity and services, including changes in:

a) Services or benefits;

b) Geographic Service Area or payments; or

c) Enrollment of a new population.

E. The quarterly report shall include, at a minimum, the following:

1) Network provider deletions:

2) The number of Members assigned to each primary care provider that has been deleted from the network;

3) Network providers who are not accepting new patients; and

4) Provider additions: Each provider addition must include the information prescribed in the initial Medi-Cal provider network report.

7. Medi-Cal and Medicare Eligibility Verification

A. It is D-SNP Contractor's responsibility to:

1) Confirm Medicare Advantage and Medi-Cal eligibility;

2) Verify Medi-Cal eligibility of a Member, Medi-Cal agrees to provide D-SNP Contractor with real-time access to the Medi-Cal's eligibility verification system;

B. D-SNP Contractor must validate Medicare Advantage and Medi-Cal eligibility through its existing on-line and/or batch Medicare and Medi-Cal eligibility user interfaces.

1) Medicare and/or Medi-Cal eligibility systems will indicate whether a beneficiary is currently enrolled or is pending enrollment in a Cal MediConnect plan or Medi-Cal MCP at the time of the inquiry.

2) If neither the Medicare and/or Medi-Cal eligibility systems indicate current or pending Cal MediConnect enrollment, and the beneficiary meets the criteria for enrollment listed in Section 3, the beneficiary may be enrolled in the Contractor's D-SNP.

C. D-SNP Contractor shall ensure appropriate training of plan personnel and contracted providers regarding the use of the Medi-

Cal eligibility verification system interface and the interpretation of its eligibility results.

8. Contract Term

This D-SNP Contract shall be effective from January 1, 2017 through December 31, 2022.

9. Termination

DHCS retains the right to terminate this D-SNP Contract at any time for cause or no cause.

10. Compensation

The State of California and DHCS shall not provide any remuneration or other form of compensation for the performance of any duties or obligations provided under this D-SNP Contract.

11. Centers for Medicare ~~and~~ & Medicaid Services Documentation

D-SNP Contractor shall submit to DHCS a complete and accurate copy of the Medicare Advantage bid as approved by CMS.

If not included in the approved bid, the D-SNP Contractor shall also provide to DHCS the following information, in a format as specified by DHCS, upon execution of this contract, no later than June 30, 2021, and annually thereafter on the last day of June to the Contract Manager:

1) The current approved Model of Care;

2) A list of the Supplemental Benefits included in the initial annual Medicare Advantage bid submission to CMS;

3) A list of approved Supplemental Benefits.

If D-SNP Contractor offers Supplemental Benefits, those services should be coordinated with the MCP to ensure the D-SNP tracks enrollee use of Supplemental Benefits and exhausts Supplemental Benefits prior to authorization of or referral for Medi-Cal benefits, including any In Lieu of Services that the MCP is approved to offer.

GTC 307 **Exhibit C**

GENERAL TERMS AND CONDITIONS

1. APPROVAL: This Agreement is of no force or effect until signed by both parties and approved by the Department of General Services, if required. D-SNP Contractor may not commence performance until such approval has been obtained.

2. AMENDMENT: No amendment or variation of the terms of this Agreement shall be valid unless made in writing, signed by the parties and approved as required. No oral understanding or Agreement not incorporated in the Agreement is binding on any of the parties.

3. ASSIGNMENT: This Agreement is not assignable by the D-SNP Contractor, either in whole or in part, without the consent of the State in the form of a formal written amendment.

4. AUDIT: D-SNP Contractor agrees that the awarding department, the Department of General Services, the Bureau of State Audits, or their designated representative shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. D-SNP Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. D-SNP 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. (Government Code Section 8546.7, Public Contract Code Section 10115 et seq., Title 2 CCR Section 1896).

5. INDEMNIFICATION: D-SNP Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, suppliers, laborers, and any other person, firm or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Agreement, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by D-SNP Contractor in the performance of this Agreement.

6. DISPUTES: D-SNP Contractor shall continue with the responsibilities under this Agreement during any dispute.

GTC 307 **Exhibit C**
GENERAL TERMS AND CONDITIONS

7. TERMINATION FOR CAUSE: The State may terminate this Agreement and be relieved of any payments should D-SNP 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 shall be deducted from any sum due D-SNP Contractor under this Agreement and the balance, if any, shall be paid to D-SNP Contractor upon demand.

8. INDEPENDENT CONTRACTOR*:* D-SNP Contractor, and the agents and employees of D-SNP Contractor, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State.

9. RECYCLING CERTIFICATION: D-SNP Contractor shall certify in writing under penalty of perjury, the minimum, if not exact, percentage of post- consumer 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 the product meets the requirements of Public Contract Code Section 12209. With respect to printer or duplication cartridges that comply with the requirements of Section 12156(e), the certification required by this subdivision shall specify that the cartridges so comply (Public Contract Code Section12205).

10. NON-DISCRIMINATION CLAUSE: During the performance of this Agreement, D-SNP Contractor shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40*),* marital status, and denial of family care leave. D-SNP Contractor shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. D-SNP Contractor shall comply with the provision*s* of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (Title 2 CCR Section 7285 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Title 2 CCR Chapter 5 of Division 4, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. D-SNP Contractor shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

GTC 307 **Exhibit C**
GENERAL TERMS AND CONDITIONS

11. CERTIFICATION CLAUSES: The CONTRACTOR CERTIFICATION CLAUSES contained in the document CCC 307 are hereby incorporated by reference and made a part of this Agreement by this reference as if attached hereto.

12. TIMELINESS: Time is of the essence in this Agreement.

13. COMPENSATION:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

14. GOVERNING LAW: This D-SNP Contract is governed by and shall be interpreted in accordance with the laws of the State of California.

15. ANTITRUST CLAIMS:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

16. CHILD SUPPORT COMPLIANCE ACT:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

17. UNENFORCEABLE PROVISION: In the event that any provision of this Agreement is unenforceable or held to be unenforceable, then the parties agree that all other provisions of this Agreement have force and effect and shall not be affected thereby.

18. PRIORITY HIRING CONSIDERATIONS: If this D-SNP Contract includes services in excess of $200,000, D-SNP Contractor shall give priority consideration in filling vacancies in positions funded by the D-SNP Contract to qualified recipients of aid under Welfare and Institutions Code Section 11200 in accordance with Public Contract Code Section 10353.

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

1. Federal Equal Opportunity Requirements

A. D-SNP 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. D-SNP 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 shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. D-SNP 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 USC 4212). Such notices shall state D-SNP 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. D-SNP Contractor will, in all solicitations or advancements for employees placed by or on behalf of D-SNP 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. D-SNP 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 g overnment or the State, advising the labor union or workers' representative of D-SNP Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

D. D-SNP 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 USC 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 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. D-SNP 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 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

F. In the event of D-SNP Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this D-SNP Contract may be cancelled, terminated, or suspended in whole or in part and D-SNP 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 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

G. D-SNP Contractor will include the Provisions of Paragraphs A through G in every 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 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each vendor. D-SNP Contractor will take such action with respect to any 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 D-SNP Contractor becomes involved in, or is

threatened with litigation by a vendor as a result of such direction by DHCS, D-SNP 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

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

3. Procurement Rules

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

4. Equipment Ownership / Inventory / Disposition

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

5. Subcontract Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

6. Income Restrictions

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

7. Audit and Record Retention

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

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 and the premises in which it is being performed. If any inspection or evaluation is made of the premises of D-SNP Contractor, D-SNP Contractor shall 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 shall be performed in such a manner as will not unduly delay the work.

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

9. Federal Contract Funds

It is mutually understood between the parties that this D-SNP Contract 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 D-SNP Contract were executed after that determination was made.

10. Intellectual Property Rights

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

11. Air or Water Pollution Requirements

Any federally funded agreement in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5:

A. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act [42 USC 1857(h)], section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).

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 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

13. Confidentiality of Information

A. D-SNP Contractor and its employees, agents shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this D-SNP Contract or persons whose names or identifying information become available or are disclosed to D-SNP Contractor, its employees or agents as a result of services performed under this D-SNP Contract, except for statistical information not identifying any such person.

B. D-SNP Contractor and its employees or agents shall not use such identifying information for any purpose other than carrying out D-SNP Contractor's obligations under this D-SNP Contract.

C. D-SNP Contractor and its employees, or agents shall promptly transmit to the DHCS program contract manager all requests for disclosure of such identifying information not emanating from the client or person.

D. D-SNP Contractor shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS program contract manager.

E. For purposes of this Provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

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 D-SNP Contract or incorporated into this D-SNP Contract by reference.

14. Documents, Publications and Written Reports

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

15. Dispute Resolution Process

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

16. Financial and Compliance Audit Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

17. Human Subjects Use Requirements

By signing this D-SNP Contract, D-SNP Contractor agrees that if any performance under this D-SNP Contract includes any tests or examination of materials derived from the human body for the purpose of providing information,

diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC 263a (CLIA) and the regulations thereto.

18. Novation Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

19. Debarment and Suspension Certification

A. By signing this D-SNP Contract, D-SNP Contractor agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

B. By signing this D-SNP Contract, D-SNP 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 (3) year period preceding this D-SNP Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Subprovision B.(2) herein; and

4) Have not within a three (3) year period preceding this D-SNP Contract had one or more public transactions (federal, State or local) terminated for cause or default.

5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

6) Will include a clause entitled, “Debarment and Suspension Certification’’ that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

C. If D-SNP Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS program funding this D-SNP Contract.

D. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

E. If D-SNP Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this D-SNP Contract for cause or default.

20. Smoke-Free Workplace Certification

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 Women, Infants, and Children (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 D-SNP Contract, D-SNP Contractor 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.

21. Covenant Against Contingent Fees

D-SNP Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this D-SNP Contract 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 D-SNP Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS shall have the right to annul this D-SNP Contract without liability or in its discretion to deduct from the D-SNP Contract price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

22. Payment Withholds

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

23. Performance Evaluation

DHCS may, at its discretion, evaluate the performance of D-SNP Contractor at the conclusion of this D-SNP Contract. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

24. 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 D-SNP Contract, or to any benefit that may arise therefrom. This Provision shall not be construed to extend to this D-SNP Contract if made with a corporation for its general benefits.

25. Four-Digit Date Compliance

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

26. Prohibited Use of State Funds for Software

D-SNP 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 D-SNP Contract for the acquisition, operation or maintenance of computer software in violation of copyright laws.

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

27. Use of Small, Minority Owned and Women's Businesses

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

28. Alien Ineligibility Certification

By signing this D-SNP Contract, D-SNP 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 USC 1601, et seq.)

29. Union Organizing

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

30. Contract Uniformity (Fringe Benefit Allowability)

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

31. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded contracts in excess of $100,000 per 31 USC Section 1352)

A. Certification and Disclosure Requirements

1) Each person (or recipient) who requests or receives a contract, grant, or sub-grant, which is subject to 31 USC Section 1352, and which exceeds $100,000 at any tier, shall 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 shall 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 non appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 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, grant or sub-grant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

B. Prohibition

Title 31 USC Section 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

Exhibit E, Attachment 1
DEFINITIONS

As used in this D-SNP Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this D-SNP Contract:

1. **Care Coordination or Coordination of Care** means the identification of a Medical condition that requires referral for Medi-Cal benefits or services that are not covered by the Medicare Advantage health plan under whose authority the D-SNP Contractor operates.

2. **Confidential Information** means specific facts or documents identified as “confidential" by any law, regulations or contractual language.

3. **Coordinated Care Initiative (CCI)** means an initiative that includes a three-year Duals Demonstration project (Cal MediConnect) for beneficiaries who are dually eligible for Medicare and Medi-Cal (Duals) to combine the full continuum of acute, primary, institutional, and home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system. CCI was enacted through SB 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012) and SB 94 (Chapter 34, Statutes of 2013), and includes a mandatory Medi-Cal managed care enrollment for Duals, and the inclusion of long-term services and supports (LTSS) as Medi-Cal managed care benefits for Seniors and Persons with Disabilities (SPD) beneficiaries who are eligible for Medi-Cal only, and for Dual SPD beneficiaries. CCI counties include Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

4. **Covered Service(s) or covered service(s)**, as used in this contract, means care coordination or coordination of care. This is the only service covered under this contract.

5. **California Department of Health Care Services (DHCS)** means the single State Department responsible for administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

6. **D-SNP Contract** means this written agreement between DHCS and the D-SNP Contractor.

7. **Department of Health and Human Services (DHHS)** means the Federal agency responsible for management of the Medicare and Medicaid programs.

8. **Director** means the Director of the California Department of Health Care Services.

Exhibit E, Attachment 1
DEFINITIONS

9. **Dual-Eligible Beneficiary (or Enrollee)** means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and/or Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan.

10. **Enrollment** means the process by which a beneficiary eligible for enrollment as contained in Exhibit A, Attachment 1, Provision 3 becomes a Member of the Contractor's D-SNP.

11. **Facility** means any premise that is:

    A. Owned, leased, used or operated directly or indirectly by or for Contractor or its affiliates for purposes related to this Contract, or

    B. Maintained by a Provider to provide services on behalf of Contractor.

12. **Medi-Cal Managed Care Health Plan** means a managed care health plan that contracts with the Department of Health Care Services for provision or arrangement of Medi-Cal benefits and services.

13. **Member** means any beneficiary who is enrolled in the Contractor's D-SNP.

14. **Service Area** means the geographic area in which Members or potential Members reside and for whom D-SNP Contractor is approved to provide services by CMS.

15. **State** means the State of California.

16. **Working day(s)** mean State calendar (State Appointment Calendar, Standard101) working day(s).

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

1. Governing Law

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

A. If it is necessary to interpret this D-SNP Contract, all applicable laws may be used as aids in interpreting the D-SNP Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHCS or D-SNP Contractor, unless such applicable laws are expressly incorporated into this D-SNP Contract in some section other than this provision, Governing Law. The parties agree that any remedies for DHCS' or D-SNP Contractor's non-compliance with laws not expressly incorporated into this D-SNP Contract, or any covenants implied to be part of this D-SNP Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This D-SNP Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this D-SNP Contract, both parties shall be deemed authors of this D-SNP Contract.

   Any provision of this D-SNP Contract which 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 D-SNP 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.

B. Such amendment shall constitute grounds for termination of this D-SNP Contract in accordance with the procedures and provisions of Provision 18, Paragraph C, Termination – D-SNP Contractor below. The parties shall be bound by the terms of the amendment until the effective date of the termination.

C. All existing final Policy Letters issued by MMCD or the current Managed Care Operations Division (MCOD) can be viewed at https://www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx and shall be complied with by D-SNP Contractor. All Policy Letters issued by MMCD subsequent to the effective date of this D-SNP Contract shall provide clarification of D-SNP Contractor's obligations pursuant to this D-SNP Contract, and may include instructions to D-SNP Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial

interpretation. In the event DHCS determines that there is an inconsistency between this D-SNP Contract and a MMCD or MCOD Policy Letter or All Plan Letter, the D-SNP Contract shall prevail.

2. Entire Agreement

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

3. Amendment Process

In addition to Exhibit C, Provision 2, Amendment, D-SNP Contractor also agrees to the following:

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

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this D-SNP Contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the D-SNP Contract. The parties agree that the development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. D-SNP Contractor's Obligation to Implement

D-SNP Contractor will make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, federal guidelines, or judicial interpretation, DHCS may direct D-SNP Contractor to immediately begin implementation of any change by issuing a change order. If DHCS issues a change order, D-SNP Contractor will be obligated to implement the required changes while discussions are taking place. DHCS may, at any time, within the general scope of the D-SNP Contract, by written notice, issue change orders to the D-SNP Contract.

5. Delegation of Authority

DHCS intends to implement this D-SNP Contract through a single administrator, called the "Contracting Officer". The Director of DHCS will appoint the Contracting Officer. The Contracting Officer, on behalf of DHCS, will make all determinations and take all actions as are appropriate under this D-SNP Contract, subject to the limitations of applicable Federal and State laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to D-SNP Contractor.

D-SNP Contractor will designate a single administrator; hereafter called the "Contractor's Representative". The Contractor's Representative, on behalf of D-SNP Contractor, will make all determinations and take all actions as are appropriate to implement this D-SNP Contract, subject to the limitations of Contract, Federal and State laws and regulations. The Contractor's Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind D-SNP Contractor to all agreements reached with DHCS. D-SNP Contractor shall designate Contractor’s Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, Provision 14, Notices.

6. Authority of the State

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered services under the Medi-Cal program administered in this D-SNP Contract or coverage for such services, or the eligibility of the beneficiaries or providers to participate in the Medi-Cal Program reside with DHCS. Sole authority to establish or interpret policy and its application related to the above areas will reside with DHCS.

D-SNP Contractor may not make any limitations, exclusions, or changes in covered services; any changes in definition or interpretation of covered services; or any changes in the administration of the D-SNP Contract related to the scope of covered services, allowable coverage for those covered services, or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

7. Fulfillment of Obligations

No covenant, condition, duty, obligation, or undertaking continued or made a part of this D-SNP Contract will be waived except by written agreement of the parties hereto, and 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; and, 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 D-SNP Contract, or under law, notwithstanding such forbearance or indulgence.

8. Prohibition Against Assignments or Delegation of Contractor's Duties and Obligations Under this D-SNP Contract

D-SNP Contractor shall not negotiate or enter into any agreement to assign or delegate the duties and obligations under this D-SNP Contract. If D-SNP Contractor fails to comply with this Provision, DHCS may terminate the D-SNP Contract for cause in compliance with Exhibit E, Attachment 2, Provision 18.

9. Prohibition Against Novations

D-SNP Contractor and DHCS shall not enter any novation agreements. Contractor shall not propose any novation agreements nor shall DHCS agree to or act upon any proposal.

10. Obtaining DHCS Approval

D-SNP Contractor shall obtain written approval from DHCS prior to commencement of operation under this D-SNP Contract:

A. Within five (5) working days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS pursuant to this Provision.

B. Within 60 calendar days of receipt, DHCS shall make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to this Provision to provide D-SNP Contractor with a written explanation why its use is not approved, or provide a written estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, D-SNP Contractor may elect to implement or use the material at D-SNP Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Provision shall not be construed to imply DHCS approval of any material that has not received written DHCS approval.

11. Program

DHCS reserves the right to review and approve any changes to D-SNP Contractor's protocols, policies, and procedures as specified in this D-SNP Contract.

12. Certifications

D-SNP Contractor shall comply with certification requirements set forth in 42 CFR 438.604 and 42 CFR 438.606.

In addition to Exhibit C, Provision 11, Certification Clauses, Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this D-SNP Contract, the Contractor's Representative or his/her designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by DHCS in writing.

13. Notices

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

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

Orange County Organized Health System dba CalOptima
Attn: Richard Sanchez, CEO
505 City Parkway West
Orange, CA 92868

14. Term

The D-SNP Contract will become effective January 1, 2017, and will continue in full force and effect through December 31, 2022.

15. Service Area

The Service Area covered under this D-SNP Contract includes:
Orange County

All D-SNP Contract provisions apply separately to each Service Area.

16. D-SNP Contract Extension

DHCS may extend this D-SNP Contract for any reason.

17. Termination for Cause and Other Terminations

In addition to Exhibit C, Provision 7, Termination for Cause, D-SNP Contractor also agrees to the following:

A. Termination - State or Director

1) DHCS may terminate performance of work under this D-SNP Contract in whole, or in part, whenever for any reason DHCS determines that the termination is in the best interest of the State.

2) Notification shall be given at least 60 days prior to the effective date of termination, except in cases described below in Paragraph B, Termination for Cause.

B. Termination for Cause

1) DHCS shall terminate this D-SNP Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22 CCR Section 53873.

2) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the D-SNP Contract, the D-SNP Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination. Except for termination pursuant to this Paragraph B, item 3) below, D-SNP Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 19, Disputes. Termination of the D-SNP Contract shall be effective on the last day of the month in which the Secretary, DHHS, or the DMHC makes such determination, provided that DHCS provides D-SNP Contractor with at least 60 calendar days' notice of termination. The termination of this D-SNP Contract shall be effective on the last day of the second full month from the date of the notice of termination. D-SNP Contractor agrees that 60 calendar days' notice is reasonable.

3) DHCS may terminate this D-SNP Contract in the event that D-SNP Contractor enters negotiations to change ownership or actually changes ownership, enters negotiations to assign or delegate its duties and obligations under the contract to another party or actually assigns or delegates its duties or obligations under the D-SNP Contract.

C. Termination - D-SNP Contractor

Grounds under which D-SNP Contractor may terminate this D-SNP Contract are limited to 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 conditions under which D-SNP Contractor entered into this D-SNP Contract, such that D-SNP Contractor can demonstrate to the satisfaction of DHCS.

D. Termination of Obligations

All obligations to provide services under this D-SNP Contract will automatically terminate on the date the operations period ends.

18. Disputes

In addition to Exhibit C, Provision 6, Disputes, D-SNP Contractor also agrees to the following:

This Disputes section will be used by D-SNP Contractor as the means of seeking resolution of disputes on contractual issues.

A. Disputes Resolution by Negotiation

DHCS and D-SNP Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

B. Notification of Dispute

1) Within 15 calendar days of the date the dispute concerning performance of this D-SNP Contract arises or otherwise becomes known to D-SNP Contractor, D-SNP Contractor will notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.

2) D-SNP Contractor's notification will state, on the basis of the most accurate information then available to D-SNP Contractor, the following:

a) That it is a dispute pursuant to this section.

b) The date, nature, and circumstances of the conduct which is subject of the dispute.

c) The names, phone numbers, function, and activity of each D-SNP Contractor, DHCS/State official or employee involved in or knowledgeable about the conduct.

d) The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.

e) The reason D-SNP Contractor is disputing the conduct.

f) The cost impact to D-SNP Contractor directly attributable to the alleged conduct, if any.

g) D-SNP Contractor's desired remedy.

3) The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by D-SNP Contractor. This documentation will serve as the basis for any subsequent appeal.

4) Following submission of the required notification, with supporting documentation, the D-SNP Contractor will comply with the requirements of Title 22, CCR, Section 53851(d) and diligently continue performance of this D-SNP Contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

5) Contracting Officer's or Alternate Dispute Officer's Decision
Pursuant to a request by D-SNP Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by DHCS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program. Any disputes concerning performance of this D-SNP Contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within 30 calendar days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer shall either:

a. Find in favor of D-SNP Contractor, in which case the Contracting Officer or alternate dispute officer may countermand the earlier conduct which caused D-SNP Contractor to file a dispute; or

b. Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

c. Request additional substantiating documentation in the event the information in D-SNP Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise D-SNP Contractor as to what additional information is required, and establish how that information shall be furnished. D-SNP Contractor shall have 30 calendar days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the Contracting Officer or alternate dispute officer within the time period specified above shall constitute waiver by D-SNP

Contractor of all claims in accordance with Paragraph F, Waiver of Claims, below.

A copy of the decision shall be served on D-SNP Contractor.

i) Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

D-SNP Contractor shall have 30 calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include D-SNP Contractor's contentions as to those issues. However, D-SNP Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B, Notification of Dispute above. Failure to timely appeal the decision shall constitute a waiver by D-SNP Contractor of all claims arising out of that conduct, in accordance with Paragraph F, Waiver of Claims below, D-SNP Contractor shall exhaust all procedures provided for in this Provision 19, Disputes, prior to initiating any other action to enforce this D-SNP Contract.

j) D-SNP Contractor Duty to Perform

Pending final determination of any dispute hereunder, D-SNP Contractor shall comply with the requirements of Title 22, CCR, Section 53851(d) and proceed diligently with the performance of this D-SNP Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision. If pursuant to an appeal under Paragraph D, Appeal of Contracting Officer’s or Alternate Dispute Officer’s Decision above, the Contracting Officer’s or alternate dispute officer’s decision is reversed, the effect of the decision pursuant to Paragraph D, shall be retroactive to the date of the Contracting Officer’s or alternate dispute officer’s decision, and D-SNP Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a Contracting Officer’s or alternate dispute officer’s decision or any appeal of such decision.

k) Waiver of Claims

If D-SNP Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required

information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this Provision 19, Disputes, that failure shall constitute a waiver by D-SNP Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

19. Audit

In addition to Exhibit C, Provision 4, Audit, D-SNP Contractor also agrees to the following:

The D-SNP Contractor will maintain such books and records necessary to disclose how D-SNP Contractor discharged its obligations under this D-SNP Contract. These books and records will disclose the quantity of Covered Services provided under this D-SNP Contract, the quality of those services, the manner for those services, the persons eligible to receive Covered Services, and the manner in which Contractor administered its daily business.

A. Books and Records

These books and records will include, but are not limited to, all physical records originated or prepared pursuant to the performance under this D-SNP Contract including working papers; reports submitted to DHCS; all medical records, medical charts and prescription files; and other documentation pertaining Covered Services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this D-SNP Contract, these books and records will be maintained for a minimum of five years from the end of the current Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created or the D-SNP Contract is terminated, or, in the event D-SNP Contractor has been duly notified that DHCS, DHHS, Department of Justice (DOJ) or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the D-SNP Contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

20. Inspection Rights

In addition to Exhibit D(F), Provision 8, Site Inspection, D-SNP Contractor also agrees to the following:

Through the end of the records retention period specified in Provision 20, Audit, Paragraph B, Records Retention above, D-SNP Contractor shall allow the DHCS, DHHS, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives, including DHCS' external quality review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this D-SNP Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, contracts, computers or other electronic systems and facilities maintained by D-SNP Contractor pertaining to these services at any time during normal business hours.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, and books of account, medical records, prescription files, laboratory results, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 20, Audit, Paragraph B, Records Retention above, D-SNP Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at D-SNP Contractor's sole expense.

A. Facility Inspections

DHCS shall conduct unannounced validation reviews on a number of D-SNP Contractor's primary care sites, selected at DHCS' discretion, to verify compliance of these sites with DHCS requirements.

B. Access Requirements and State's Right to Monitor

Authorized State and federal agencies will have the right to monitor all aspects of D-SNP Contractor's operation for compliance with the provisions of this D-SNP Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of D-SNP Contractor and provider facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time during D-SNP Contractor's or other facility's normal business hours. The monitoring activities will be either announced or unannounced.

To assure compliance with the D-SNP Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to D-SNP Contractor. This will include the Management Information System operations site or such other place where duties under the D-SNP Contract

are being performed.

Staff designated by authorized State agencies will have access to all security areas and D-SNP Contractor will provide reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of D-SNP Contractor.

21. Confidentiality of Information

In addition to Exhibit D(F), Provision 13, Confidentiality of Information, D-SNP Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this D-SNP Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR 431.300 et seq., Welfare and Institutions Code, Section 14100.2, and regulations adopted thereunder. For the purpose of this D-SNP Contract, all information, records, data, and data elements collected and maintained for the operation of the D-SNP Contract and pertaining to Members shall be protected by D-SNP Contractor from unauthorized disclosure.

   D-SNP Contractor may release medical records in accordance with applicable law pertaining to the release of this type of information. D-SNP Contractor is not required to report requests for Medical Records made in accordance with applicable law. Exhibit G is hereby incorporated into this contract by reference.

B. With respect to any identifiable information concerning a Member under this D-SNP Contract that is obtained by D-SNP Contractor, D-SNP Contractor:

   1) Will not use any such information for any purpose other than carrying out the express terms of this D-SNP Contract;

   2) Will promptly transmit to DHCS all requests for disclosure of such information, except requests for Medical records in accordance with applicable law;

   3) Will not disclose except as otherwise specifically permitted by this D-SNP Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR 431.300 et seq., Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder; and

4) Will, at the termination of this D-SNP Contract, return all such information to DHCS or maintain such information according to written procedures sent to D-SNP Contractor by DHCS for this purpose.

22. Third-Party Tort and Workers' Compensation Liability

D-SNP Contractor shall identify and notify DHCS' Third Party Liability and Recovery Branch of all instances or cases in which D-SNP Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under Welfare and Institutions Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, D-SNP Contractor shall make no claim for recovery of the value of case management rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability and Recovery Branch within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, D-SNP Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of reports for Covered Services to an individual Member, D-SNP Contractor shall deliver the requested information within 30 calendar days of the request.

B. Information to be delivered shall contain the following data items:

1) Member name.

2) Full 14-digit Medi-Cal number.

3) Social Security Number.

4) Date of birth.

5) Diagnosis code and description of illness/injury (if known).

6) Procedure code and/or description of services rendered (if known).

C. D-SNP Contractor shall identify to DHCS' Third Party Liability and Recovery Branch the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If D-SNP Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of referrals, D-SNP Contractor shall refer the request to the Third Party Liability and Recovery Branch with the

information contained in Paragraph B above, and shall provide the name, address and telephone number of the requesting party.

E. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding D-SNP Contractor's service and utilization information, and paid invoices and claims submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the secure file transfer protocol folders.

23. Records Related To Recovery for Litigation

A. Upon request by DHCS, D-SNP Contractor shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in D-SNP Contractor's possession, relating to threatened or pending litigation by or against DHCS.

B. If D-SNP Contractor asserts that any requested documents are covered by a privilege, D-SNP Contractor shall:

1) Identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and

2) State the privilege being claimed that supports withholding production of the document.

C. Such request shall include, but is not limited to a response to a request for documents submitted by any party in any litigation by or against DHCS D-SNP Contractor acknowledges that time may be of the essence in responding to such request. D-SNP Contractor shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by D-SNP Contractor related to this D-SNP Contract entered into under this D-SNP Contract.

24. Equal Opportunity Employer

D-SNP Contractor must comply with all applicable federal and State employment discrimination laws. D-SNP Contractor will, in all solicitations or advertisements for employees placed by or on behalf of D-SNP Contractor, state that it is an equal opportunity employer, and 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 DHCS, advising the labor union or workers' representative of D-SNP Contractor's commitment as an equal opportunity employer and will post

copies of the notice in conspicuous places available to employees and applicants for employment.

25. Discrimination Prohibitions

A. Member Discrimination Prohibition

D-SNP Contractor shall not unlawfully discriminate against Members or beneficiaries eligible for enrollment into Contractor's D-SNP on the basis of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56 in accordance with the statues identified in Exhibit E, Attachment 2, Provision 26 below, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this D-SNP Contract, discrimination may include, but is not limited to, the following:

1) Denying any Member any Covered Services;

2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;

4) Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or a beneficiary eligible for enrollment into the Contractor's D-SNP differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;

5) The assignment of times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.

6) 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.

7) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and Potential Enrollees.

D-SNP Contractor shall 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 422.56, except as needed to provide equal access to Limited English Proficient (LEP) Members or Members with disabilities, or as medically indicated.

For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related To Health Status

D-SNP Contractor shall not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during enrollment, re-enrollment or disenrollment. D-SNP Contractor will not terminate the enrollment of an eligible individual based on an adverse change in the Member’s health.

26. Federal and State Nondiscrimination Requirements

D-SNP Contractor shall comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; Titles I and II 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 issued under the above-listed statutes. D-SNP Contractor shall also comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Sections 7405 and 11135 of the Government Code, Section 14029.91 of the Welfare and Institutions Code, and state implementing regulations.

27. Discrimination Grievances

D-SNP Contractor shall process a grievance for discrimination as required by APL 21-004, and in accordance with federal and State nondiscrimination law as stated in 45 CFR sections 84.7; 34 CFR section 106.8; 28 CFR section 35.107; and W&I Code section 14029.91(e)(4).

A. D-SNP Contractor shall 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. D-SNP Contractor shall adopt procedures to ensure the prompt and equitable resolution of discrimination grievances by D-SNP Contractor. D-SNP Contractor shall not require a Member or potential enrollee to file a discrimination Grievance with D-SNP Contractor before filing with the DHCS Office of Civil Rights or the U.S. Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a discrimination grievance resolution letter, D-SNP Contractor shall submit the following information regarding the discrimination grievance in a secure format to the DHCS Office of Civil Rights:

1) The original discrimination grievance;

2) The provider's or other accused party's response to the discrimination grievance;

3) Contact information for the personnel primarily responsible for investigating and responding to the discrimination grievance on behalf of D-SNP Contractor;

4) Contact information for the person filing the discrimination grievance, and for the provider or other accused party that is the subject of the discrimination grievance;

5) All correspondence with the person filing the discrimination grievance regarding the discrimination grievance, including, but not limited to, the discrimination grievance acknowledgment letter and resolution letter; and

6) The results of D-SNP Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

28. Nondiscrimination Notice and Language Taglines

A. D-SNP Contractor shall post (1) a DHCS-approved nondiscrimination notice, and (2) language taglines in a conspicuously visible font size in English, the threshold languages, and 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 taglines shall include D-SNP Contractor's toll-free and TTY/TDD telephone number for obtaining these services, and shall be posted as required in APL 21-004 and in accordance with 42 CFR section 438.10(d)(2)-(3) and W&I Code sections 14029.91(f) and 14029.92(c).

B. D-SNP Contractor's nondiscrimination notice shall include all information required by W&I Code section 14029.91(e) and APL 21-004, any additional information required by DHCS, and shall provide information on how to file a discrimination grievance with:

1) Both D-SNP Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination in the Medi-Cal program based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation or identification with any other persons or groups defined in Penal Code 422.56. (W&I Code section 14029.91(e); H&S Code section 11135).

2) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (W&I Code section 14029.91(e)).

29. Disabled Veteran Business Enterprises (DVBE)

D-SNP Contractor shall comply with applicable requirements of California law relating to DVBE commencing at Section 10115 of the Public Contract Code.

30. Word Usage

Unless the context of this D-SNP Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall 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.

31. Federal False Claims Act Compliance

Effective January 1, 2007, D-SNP Contractor shall comply with 42 USC Section 1396a (a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this D-SNP Contract. Upon request by DHCS, D-SNP Contractor shall demonstrate compliance with this provision, which may include providing DHCS with copies of Contactor's applicable written policies and procedures and any relevant employee handbook excerpts.

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 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. D-SNP Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's 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. 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 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 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, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

9.1 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.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 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

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall maintain, at a minimum, industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a

confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, 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 shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible,

Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

18.1.2 Business Associate shall notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of:

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 data affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS

Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at http://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incident-Report-PIR.pdf.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or confidential breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request

approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, 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, D-SNP Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

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 shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 **Termination for Cause**. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 **Judicial or Administrative Proceedings.** DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 **Disclaimer**. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. **Amendment**.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 **Assistance in Litigation or Administrative Proceedings**. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Authorizing and Directing Execution of an Amendment to Agreement 16-93274 with the California Department of Health Care Services in Order to Continue Operation of the OneCare Program

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
TC Roady, Interim Executive Director of Compliance, (714) 796-6122

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Chairman) to execute an Amendment to Agreement 16-93274 between CalOptima and the California Department of Health Care Services (DHCS) in order to continue operation of the OneCare program.

Background

As a County Organized Health System (COHS), CalOptima contracts with the DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year Primary Agreement with the DHCS. Amendments to the Primary Agreement are summarized in the attached appendix, including Amendment 49, which extends the agreement through December 31, 2021. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services. Until 2016, the Primary Agreement included language that incorporated provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs).

In 2016, DHCS extracted the MIPPA-compliant language from the Primary Agreement and placed it in a standalone agreement, Agreement 16-93274. The Chairman executed that agreement, an action that was ratified during the August 2016 meeting of the Board.

Subsequently, the Chairman has executed four amendments to the agreement pursuant to Board authority. Agreement 16-93274 is set to terminate on December 31, 2021. The agreement contains no rates of payment.

Discussion

Amendment to Agreement 16-93274

On April 1, 2021, DHCS provided managed care plans (MCPs), including CalOptima, with a draft amendment to extend Agreement 16-93274 through December 31, 2023.

The Centers for Medicare & Medicaid Services (CMS) requires that plans renewing their D-SNP programs must submit evidence of a MIPPA-compliant Medicaid contract for the 2022 contract year no later than July 1, 2021. Executing Amendment 05 (A-05) to Agreement 16-93274 is required in order

for CalOptima to meet CMS's filing requirements, and to continue to operate CalOptima's D-SNP (OneCare) in contract year 2022. CalOptima has requested that DHCS send the final amendment to CalOptima as soon as possible in order to allow for immediate signature by CalOptima and prompt return to DHCS for counter-signature.

The amendment contains language changes in addition to the extension of the expiration date. DHCS has only shared boilerplate contract amendments with CalOptima at this time. If the final contract amendment is not consistent with staff's understanding as presented in this document, or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for further consideration.

What follows is a description of the changes contained within Agreement 16-93274.

Section/Provision:	Updates to Provision:
Exhibit A - SCOPE OF WORK	
1. Care Coordination	• Clarifies care coordination procedures language.
2. All Plan and Policy Letters	• Clarifies that when there are inconsistencies in DHCS Medi-Cal Program All Plan and Policies Letter with Medicare requirements, Medicare takes precedence.
3. Coverage Area and Eligible Beneficiaries	• Updates language to further clarify that dual eligible beneficiaries with a share of cost who reside in long term care facilities and are continuously certified are eligible for coverage under the D-SNP.
5. Member Billing Prohibitions	• Adds language to strengthen balance billing protections for members and plan's delegates.
7. Medi-Cal and Medicare Eligibility Verification	• Deletes the D-SNP's responsibility to confirm all applicable Medicare Advantage *special needs criteria* are met, based on D-SNP type. • Adds requirement to ensure appropriate training of Plan staff to use Medi-Cal eligibility verification systems.
8. Contract Term	• Extends the contract term through December 31, 2023.
11. CMS Documentation	• Updates the type of CMS documentation that is required to be submitted to DHCS to include the D-SNP's Model of Care and a list of approved Supplemental Benefits.
Exhibit D(F) SPECIAL TERMS AND CONDITIONS	
9. Federal Contract Funds	• Removes outdated Federal Contract Funds language.
Exhibit E, Attachment 2 PROGRAM TERMS AND CONDITIONS	
1. Governing Law	• Removes outdated Balanced Budget Act language.
9. Prohibition Against Subcontracts	• Removes Prohibition Against Subcontracts language.
27. Untitled Section	• Updates the Discrimination grievance processing requirement references.

Fiscal Impact
The recommended action to execute Amendment 05 to Agreement 16-93274 between CalOptima and DHCS is projected to be budget neutral.

Rationale for Recommendation
CalOptima's execution of Amendment 05 (A-05) to the Agreement 16-93274 with the DHCS is necessary to ensure that CalOptima meets CMS requirements in order for CalOptima to operate the OneCare program during 2022 and 2023.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Appendix summary of amendments to Agreements with DHCS
2. 2022 Draft Amendment to Agreement 16-93274

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

APPENDIX TO AGENDA ITEM 5

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

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

Back to Agenda Back To Item Back to Item

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 Agenda Back To Item Back to Item

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-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020

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

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

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

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

Exhibit A
SCOPE OF WORK

CCI Non-Cal MediConnect D-SNPs

1. Service Overview

This contract is being executed with this Contractor that is a Dual Eligible Special Needs Plan (D-SNP).

D-SNP Contractor agrees to provide to the Department of Health Care Services (DHCS) the services described herein:

Care coordination of the Medi-Cal benefits and services provided to eligible Medi-Cal beneficiaries but which are not covered by the Medicare Advantage health plan under whose authority the D-SNP Contractor operates. These Medi-Cal benefits and services are defined in the contents of this D-SNP Contract.

2. Project Representatives

A. The project representatives during the term of this D-SNP Contract will be:

Department of Health Care Services	**D-SNP Contractor**
Managed Care Operations Division (MCOD) Attn: Chief, Managed Care Systems and Support Services Branch	California Attn:, President
Telephone: (916) 449-5000 Fax: (916) 449-5090	Telephone: Email:

B. Direct all inquiries to:

Department of Health Care Services	**D-SNP Contractor**
Managed Care Operations Division Attn: Contracting Officer	California Attn: President
MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413	
Telephone: (916) 449-5000 Fax: (916) 449-5090	Telephone: Email:

Back to Agenda
Back To Item
Back to Item

Exhibit A
SCOPE OF WORK

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 D-SNP Contract.

3. See the following attachments for a detailed description of the services to be performed

Exhibit A
SCOPE OF WORK

1. Care Coordination

This D-SNP Contract is a care coordination agreement. D-SNP Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including when Medi-Cal benefits are delivered via Medi-Cal Fee-For-Service (FFS), managed care, or other Medi-Cal delivery systems. **The D-SNP shall coordinate Medi-Cal benefits with Medi-Cal payers responsible for specialized Medi-Cal benefit provision to enrollees, including services listed below. Coordination of these benefits shall occur when necessary and appropriate.** D-SNP Contractor is responsible for coordinating the Member's Medicare and Medi-Cal benefits including, but not limited to, discharge planning, disease management, and care management. **Coordination of Medicaid benefits is not the enrollee's responsibility.** D-SNP Contractor shall:

A. Develop and implement care coordination procedures that are submitted to and approved by DHCS for referral and coordination of care for Members who receive benefits and services through either the Medi-Cal managed care or FFS programs. Medi-Cal benefits and services requiring referral and coordination of care by D-SNP Contractor are outlined in Exhibit H.

   1) For Medi-Cal managed care Members, Contractor's D-SNP will contact the Member's Medi-Cal managed care plan for provider information and for the coordination of Medi-Cal managed care covered benefits. Managed care health plan contact information can be found at the following link: http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx;

   2) For Medi-Cal FFS Members, Contractor's D-SNP will contact Medi-Cal for provider information and the coordination of Medi-Cal FFS benefits. Medi-Cal contact information can be found at the following link: http://www.medi-cal.ca.gov/contact.asp;

   3) For coordination of behavioral health services, Contractor's D-SNP will contact the Member's Medi-Cal managed care health plan and/or the county mental health plans for provider information and the coordination of behavioral health services. County mental health plan contact information can be found at the following link: http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx;

   4) For coordination of In-Home Supportive Services (IHSS) benefits, Contractor's D-SNP will contact the County IHSS Office. County IHSS Office contact information can be found at https://www.cdss.ca.gov/inforesources/county-ihss-offices; and

Back to Agenda Back To Item Back to Item

Exhibit A
SCOPE OF WORK

5) For coordination of Medi-Cal Dental benefits, Contractor's D-SNP will contact the DHCS Dental Administrative Service Organization (ASO) for provider information and the coordination of dental benefits. ASO contact information can be found at the following link: http://www.denti-cal.ca.gov/WSI/contact.jsp?fname=ContactInfo.

B. Make a referral to DHCS for follow-up and possible provision of Medi-Cal benefits or services, when a Member requests or D-SNP Contractor determines a Member may need a Medi-Cal benefit or service that is not covered by D-SNP Contractor.

C. D-SNP Contractor is not responsible for the provision of, or paying reimbursement for, any Medi-Cal benefits. D-SNP Contractor shall maintain a current knowledge and familiarity of Medi-Cal benefits through ongoing reviews of California laws, rules, policies, and further guidance as posted on the ~~California Department of Health Care Services (~~DHCS~~)~~ website. D-SNP Contractor shall timely coordinate Medi-Cal benefits and services requiring referral and coordination of care as outlined in Exhibit H for its Enrolled Dual Eligible Members under this Contract.

This Provision details D-SNP Contractor's specific Medicare-Medi-Cal care coordination requirements. Medi-Cal Covered Services are described in Title XIX of the Social Security Act, 42 CFR sections 440 and 441, the California Medicaid State Plan, Section 3.2, Provision 1 of this Attachment, the DHCS and Medi-Cal websites, and other relevant materials.

D. D-SNP Contractor will provide a report via SFTP in Excel format to DHCS on a monthly basis by the close of business on the sixth business day after the end of the reporting month. The report will contain all Dual Eligible Member admissions to a hospital or Skilled Nursing Facility (SNF) for any reason. Reports will include:

1) Beneficiary Demographic Information

a) First Name, Last Name

b) Medicare Beneficiary Identifier (MBI)

c) Date of Birth

d) Client Index Number (CIN) – if available

Back to Agenda Back To Item Back to Item

Exhibit A
SCOPE OF WORK

2) Inpatient Admissions

a) Date of Notification

b) Date of Admission

c) Admitting Facility – if available

d) Admitting Cause/Diagnosis – if available

e) Type of Admission (e.g., emergency versus directed)

f) Care Manager (provider, social worker, caseworker – if available)

3) Skilled Nursing Facility (SNF) Admissions

a) Date of Notification

b) Date of Admission

c) Admitting Facility – if available

d) Admitting Cause/Diagnosis – if available

e) Type of Admission (e.g., emergency versus directed)

f) Care Manager (provider, social worker, caseworker – if available)

4) Discharge Planning Documents (if available)

a) Discharge date and time

b) Discharge disposition

c) Discharging Facility

d) Discharge diagnosis

e) Discharge instructions

E. D-SNP Contractor will provide a summary report via SFTP to DHCS on a semi-annually basis, due July 31 and January 31 for the previous six-month period, to DHCS for Dual Eligible Members hospitalized or in a skilled nursing facility. D-SNP Contractor's report shall include the following:

Back to Agenda Back To Item Back to Item

Exhibit A
SCOPE OF WORK

1) Number and percentage of population hospitalized;

2) Percentage of population having care coordination prior to hospitalization;

3) Number and percentage of populations offered care coordination following hospitalization;

4) Number and percentage of population accepting care coordination;

5) Number and percentage of populations readmitted from the prior year;

6) Average length of stay;

7) Number discharged from hospital to community;

8) Number discharged from hospital to SNF;

9) Number discharged from hospital to other Facility:

10) Number discharged from SNF to community;

11) Number discharged from SNF to other Facility:

In the event that D-SNP Contractor authorizes another entity or entities to perform this notification, D-SNP Contractor must retain responsibility for complying with this requirement.

2. All Plan and Policy Letters

In addition to the terms and conditions of this Contract. D-SNP Contractor shall comply with All Plan Letters (APLs) and Policy Letters (PLs), including but not limited to APL 12-001 and 13-003, as well as any subsequent APLs, PLs, or updates, departmental updates regarding D-SNP policies for the duration of the Duals Demonstration Project in connection with Coordinated Care Initiative (CCI) counties, all of which are incorporated by reference into this D-SNP Contract.

In the event that an APL conflicts with Medicare requirements or regulations, the Medicare requirements and regulations take precedence.

3. Coverage Area and Eligible Beneficiaries

A. Contractor's D-SNP in the following CCI county may enroll the Dual

Back to Agenda Back To Item Back to Item

Exhibit A
SCOPE OF WORK

Eligible Beneficiaries identified in Paragraphs B and C, subject to the eligibility limitations applicable to the CCI county:

Los Angeles County

B. In CCI counties, beneficiaries eligible for coverage under this D-SNP Contract shall be limited to the following:

1) Dual Eligible Beneficiaries who are eligible for enrollment in a Full Benefit D-SNP or who are enrolled in the Contractor's D-SNP as of December 31, 2014;

2) Dual Eligible Beneficiaries who are eligible for enrollment in a Full Benefit D-SNP or who are excluded from enrollment into Cal MediConnect as follows:

a) Individuals under the age of 21;

b) Individuals with other private or public health insurance;

c) Developmentally Disabled (DD) beneficiaries receiving services through a Department of Developmental Services 1915(c) waiver, regional center, or state developmental center;

d) Individuals with a share of cost ~~- in community and not~~ **who reside in a long term care facility and are** continuously certified;

e) Individuals residing in one of the Veterans' Homes of California;

f) Individuals residing in an excluded zip code per the Memorandum of Understanding (MOU) between the State and the Centers for Medicare and Medicaid Services (CMS); and

g) Beneficiaries in the following 1915(c) waiver:

i. Nursing Facility/Acute Hospital Waiver;

ii. HIV/AIDS Waiver;

iii. Assisted Living Waiver; and

iv. In-Home Operations Waiver.

h) Intermediate Care Facility - DD Residents.

Back to Agenda Back To Item Back to Item

3) Dual Eligible Beneficiaries who were Members in Contractor's D-SNP as of December 31, 2014, who enroll in Cal MediConnect after December 31, 2014 and choose to disenroll from Cal MediConnect, may return to Contractor's D-SNP.

4) A Member enrolled in Contractor's D-SNP in a non-CCI county, regardless of enrollment date, who moves during the duration of the CCI Demonstration to a CCI county also covered by Contractor's D-SNP, may remain enrolled in Contractor's D-SNP.

C. In non-CCI counties, all Dual Eligible Beneficiaries eligible for enrollment in a Full Benefit D-SNP may enroll in Contractor's D-SNP.

4. Certification and Enrollment Reporting

A. D-SNP Contractor shall submit to DHCS a certification, signed by the Chief Operations Officer or similar executive officer, that attests to the number of Members enrolled in Contractor's D-SNP as of January 1, 2017.

B. By the fifth working day of each month during the term of the D-SNP Contract, D-SNP Contractor shall submit a report, signed by the Chief Operations Officer or similar executive officer, to DHCS summarizing the previous month's Enrollment numbers.

5. Member Billing Prohibitions

A. D-SNP Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on Dual Eligible Members that would exceed the amounts permitted under the California Medicaid State Plan, Section 1852(a)(7) of the Act, and 42 CFR section 422.504(g)(1)(iii). D-SNP Contractor shall not bill a Dual Eligible Member with QMB benefits for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments, in accordance with Section 1902(n)(3)(B) of the Social Security Act.

B. **Section 1902(n)(3)(B) of the Social Security Act prohibits a Medicare provider from billing a Dual Eligible Member with QMB benefits for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments.** A Dual Eligible Member with QMB benefits has no legal obligation to make further payment to a provider or to D-SNP Contractor for Medicare Part A or Part B cost sharing amounts. D-SNP Contractor's provider agreements shall specify that a contracted Medicare provider agrees to accept D-SNP Contractor's Medicare reimbursement as payments in full for services rendered to Dual Eligible Members, or to bill Medi-Cal or the Member's Medi-Cal

managed care plan as applicable for any additional Medicare payments that may be reimbursed by Medi-Cal.

6. Provider Network Reporting Requirements

Upon execution of this D-SNP Contract, D-SNP Contractor shall submit to DHCS an initial report that outlines D-SNP Contractor's full Medi-Cal provider network within the defined Service Area.

A. D-SNP contractor can obtain Medi-Cal participating providers by reviewing the California Health and Human Services Open Data Portal. The California Health and Human Services Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers. Any D-SNPs affiliated with a companion Medi-Cal managed care plan can obtain the file from the affiliated Medi-Cal plan.

B. Contractor will identify in its provider directory those providers that accept both Medicare and Medicaid (providers that are currently registered providers under Medi-Cal and are also within D-SNP Contractor's network).

C. The report, at a minimum, shall include the following:

1) NPI (National Provider Identifier);

2) First and last name;

3) Specialty type;

4) Group association;

5) Full address;

6) Telephone number;

7) Cultural and linguistic services, including provider and provider staff language capability;

8) Hospital admitting privileges; and

9) Provider capacity, including current capacity.

D. After the initial submission of a Medi-Cal provider network report, D-SNP Contractor shall submit an updated report at least:

1) Quarterly; and

2) Whenever a significant change to the network affects provider capacity and services, including changes in:

   a) Services or benefits;

   b) Geographic Service Area or payments; or

   c) Enrollment of a new population.

E. The quarterly report shall include, at a minimum, the following:

1) Network provider deletions:

2) The number of Members assigned to each primary care provider that has been deleted from the network;

3) Network providers who are not accepting new patients; and

4) Provider additions: Each provider addition must include the information prescribed in the initial Medi-Cal provider network report.

7. Medi-Cal and Medicare Eligibility Verification

A. It is D-SNP Contractor's responsibility to:

1) Confirm Medicare Advantage and Medi-Cal eligibility;

2) Verify Medi-Cal eligibility of a Member, Medi-Cal agrees to provide D-SNP Contractor with real-time ac**c**ess to the Medi-Cal's eligibility verification system;

~~3) Confirm all applicable Medicare Advantage special needs criteria are met, based on D-SNP type.~~

B. Contractor must validate Medicare Advantage and Medi-Cal eligibility through its existing on-line and/or batch Medicare and Medi-Cal eligibility user interfaces.

1) Medicare and/or Medi-Cal eligibility systems will indicate whether a beneficiary is currently enrolled or is pending enrollment in a Cal MediConnect plan or Medi-Cal MCP at the time of the inquiry.

2) If neither the Medicare and/or Medi-Cal eligibility systems indicate current or pending Cal MediConnect or MCP enrollment, the beneficiary may be enrolled in the Contractor's D-SNP.

Exhibit A
SCOPE OF WORK

C. **D-SNP Contractor shall ensure appropriate training of plan personnel and providers regarding the use of the Medi-Cal eligibility verification system interface and the appropriate interpretation of its eligibility results.**

8. Contract Term

This D-SNP Contract shall be effective from January 1, 2017 through December 31, 2021~~4~~**3**.

9. Termination

DHCS retains the right to terminate this D-SNP Contract at any time for cause or no cause.

10. Compensation

The State of California and DHCS shall not provide any remuneration or other form of compensation for the performance of any duties or obligations provided under this D-SNP Contract.

11. Centers for Medicare ~~and~~ & Medicaid Services Documentation

Contractor shall submit to DHCS a complete and accurate copy of the bid ~~submitted to~~ **as approved by** CMS.

If not included in the approved bid, the D-SNP Contractor also will provide to DHCS the following information, in a format as specified by DHCS, upon execution of this contract and annually thereafter on the last day of June:

1) The current approved Model of Care.

2) A list of approved Supplemental Benefits.

GTC 307 **Exhibit C**

GENERAL TERMS AND CONDITIONS

1. APPROVAL: This Agreement is of no force or effect until signed by both parties and approved by the Department of General Services, if required. Contractor may not commence performance until such approval has been obtained.

2. AMENDMENT: No amendment or variation of the terms of this Agreement shall be valid unless made in writing, signed by the parties and approved as required. No oral understanding or Agreement not incorporated in the Agreement is binding on any of the parties.

3. ASSIGNMENT: This Agreement is not assignable by the Contractor, either in whole or in part, without the consent of the State in the form of a formal written amendment.

4. AUDIT: D-SNP Contractor agrees that the awarding department, the Department of General Services, the Bureau of State Audits, or their designated representative shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. 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. (Government Code Section 8546.7, Public Contract Code Section 10115 et seq., Title 2 CCR Section 1896).

5. INDEMNIFICATION: Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, suppliers, laborers, and any other person, firm or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Agreement, 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 Agreement.

6. DISPUTES: Contractor shall continue with the responsibilities under this Agreement during any dispute.

GTC 307 **Exhibit C**
GENERAL TERMS AND CONDITIONS

7. TERMINATION FOR CAUSE: The State may terminate this Agreement 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 shall be deducted from any sum due the Contractor under this Agreement and the balance, if any, shall be paid to the Contractor upon demand.

8. INDEPENDENT CONTRACTOR: Contractor, and the agents and employees of Contractor, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State.

9. RECYCLING CERTIFICATION: Contractor shall certify in writing under penalty of perjury, the minimum, if not exact, percentage of post- consumer 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 the product meets the requirements of Public Contract Code Section 12209. With respect to printer or duplication cartridges that comply with the requirements of Section 12156(e), the certification required by this subdivision shall specify that the cartridges so comply (Public Contract Code Section12205).

10. NON-DISCRIMINATION CLAUSE: During the performance of this Agreement, Contractor shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, and denial of family care leave. Contractor shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. D-SNP Contractor shall comply with the provisions of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (Title 2 CCR Section 7285 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Title 2 CCR Chapter 5 of Division 4, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

GTC 307 **Exhibit C**
GENERAL TERMS AND CONDITIONS

11. CERTIFICATION CLAUSES: The CONTRACTOR CERTIFICATION CLAUSES contained in the document CCC 307 are hereby incorporated by reference and made a part of this Agreement by this reference as if attached hereto.

12. TIMELINESS: Time is of the essence in this Agreement.

13. COMPENSATION:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

14. GOVERNING LAW: This D-SNP Contract is governed by and shall be interpreted in accordance with the laws of the State of California.

15. ANTITRUST CLAIMS:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

16. CHILD SUPPORT COMPLIANCE ACT:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

17. UNENFORCEABLE PROVISION: In the event that any provision of this Agreement is unenforceable or held to be unenforceable, then the parties agree that all other provisions of this Agreement have force and effect and shall not be affected thereby.

18. PRIORITY HIRING CONSIDERATIONS: If this D-SNP Contract includes services in excess of $200,000, the Contractor shall give priority consideration in filling vacancies in positions funded by the D-SNP Contract to qualified recipients of aid under Welfare and Institutions Code Section 11200 in accordance with Public Contract Code Section 10353.

Back to Agenda Back To Item Back to Item

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

1. Federal Equal Opportunity Requirements

A. 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. 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 shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. 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 USC 4212). Such notices shall state 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. Contractor will, in all solicitations or advancements for employees placed by or on behalf of 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. 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 g overnment or the State, advising the labor union or workers' representative of Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

D. 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 USC 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 60, "Office of the Federal Contract Compliance

Back to Agenda Back To Item Back to Item

Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

E. 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 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

F. In the event of Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this D-SNP Contract may be cancelled, terminated, or suspended in whole or in part and 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 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

G . Contractor will include the Provisions of Paragraphs A through G in every 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 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each vendor. Contractor will take such action with respect to any 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 Contractor becomes involved in, or is threatened with litigation by a vendor as a result of such direction by DHCS, the D-SNP Contractor may request in writing to DHCS, who, in turn, may request the

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

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

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

3. Procurement Rules

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

4. Equipment Ownership / Inventory / Disposition

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

5. Subcontract Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

6. Income Restrictions

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

7. Audit and Record Retention

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

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 and the premises in which it is being performed. If any inspection or evaluation is made of the premises of Contractor, Contractor shall 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 shall be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

A. It is mutually understood between the parties that this D-SNP Contract 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 D-SNP Contract were executed after that determination was made.

Back to Agenda Back To Item Back to Item

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

~~B. This D-SNP Contract 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 D-SNP Contract. In addition, this D-SNP Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress that may affect the provisions, terms or funding of this D-SNP Contract in any manner.~~

~~C. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this D-SNP Contract shall be amended to reflect any reduction in funds.~~

~~D. DHCS has the option to invalidate or cancel the D-SNP Contract with 30-days advance written notice or to amend the D-SNP Contract to reflect any reduction in funds.~~

10. Intellectual Property Rights

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

11. Air or Water Pollution Requirements

Any federally funded agreement in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5:

A. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act [42 USC 1857(h)], section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).

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 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

13. Confidentiality of Information

A. Contractor and its employees, agents shall protect from unauthorized disclosure names and other identifying information concerning persons either

Back to Agenda Back To Item Back to Item

receiving services pursuant to this D-SNP Contract or persons whose names or identifying information become available or are disclosed to Contractor, its employees or agents as a result of services performed under this D-SNP Contract, except for statistical information not identifying any such person.

B. Contractor and its employees or agents shall not use such identifying information for any purpose other than carrying out Contractor's obligations under this D-SNP Contract.

C. Contractor and its employees, or agents shall promptly transmit to the DHCS program contract manager all requests for disclosure of such identifying information not emanating from the client or person.

D. Contractor shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS program contract manager.

E. For purposes of this Provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

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 D-SNP Contract or incorporated into this D-SNP Contract by reference.

14. Documents, Publications and Written Reports

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

15. Dispute Resolution Process

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

16. Financial and Compliance Audit Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

17. Human Subjects Use Requirements

By signing this D-SNP Contract, Contractor agrees that if any performance under this D-SNP Contract includes any tests or examination of materials derived from the human body for the purpose of providing information,

diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC 263a (CLIA) and the regulations thereto.

18. Novation Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

19. Debarment and Suspension Certification

A. By signing this D-SNP Contract, Contractor agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

B. By signing this D-SNP Contract, 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 (3) year period preceding this D-SNP Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Subprovision B.(2) herein; and

4) Have not within a three (3) year period preceding this D-SNP Contract had one or more public transactions (federal, State or local) terminated for cause or default.

5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

6) Will include a clause entitled, “Debarment and Suspension Certification’’ that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

C. If Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS program funding this D-SNP Contract.

D. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

E. If Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this D-SNP Contract for cause or default.

20. Smoke-Free Workplace Certification

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 Women, Infants, and Children (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 D-SNP Contract, Contractor 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.

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

21. Covenant Against Contingent Fees

Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this D-SNP Contract 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 Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS shall have the right to annul this D-SNP Contract without liability or in its discretion to deduct from the D-SNP Contract price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

22. Payment Withholds

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

23. Performance Evaluation

DHCS may, at its discretion, evaluate the performance of Contractor at the conclusion of this D-SNP Contract. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

24. 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 D-SNP Contract, or to any benefit that may arise therefrom. This Provision shall not be construed to extend to this D-SNP Contract if made with a corporation for its general benefits.

25. Four-Digit Date Compliance

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

26. Prohibited Use of State Funds for Software

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 D-SNP Contract for the acquisition, operation or maintenance of computer software in violation of copyright laws.

Back to Agenda Back To Item Back to Item

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

27. Use of Small, Minority Owned and Women's Businesses

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

28. Alien Ineligibility Certification

By signing this D-SNP Contract, 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 USC 1601, et seq.)

29. Union Organizing

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

30. Contract Uniformity (Fringe Benefit Allowability)

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

31. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded contracts in excess of $100,000 per 31 USC Section 1352)

A. Certification and Disclosure Requirements

1) Each person (or recipient) who requests or receives a contract, grant, or subgrant, which is subject to 31 USC Section 1352, and which exceeds $100,000 at any tier, shall 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 shall 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 non appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information

Back to Agenda Back To Item Back to Item

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, grant or sub-grant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

B. Prohibition

Title 31 USC Section 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

Exhibit E, Attachment 1
DEFINITIONS

As used in this D-SNP Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this D-SNP Contract:

1. **Care Coordination or Coordination of Care** means the identification of a medical condition that requires referral for Medi-Cal benefits or services that are not covered by the Medicare Advantage health plan under whose authority the D-SNP Contractor operates.

2. **Confidential Information** means specific facts or documents identified as “confidential" by any law, regulations or contractual language.

3. **Coordinated Care Initiative (CCI)** means an initiative that includes a three-year Duals Demonstration project (Cal MediConnect) for beneficiaries who are dually eligible for Medicare and Medi-Cal (Duals) to combine the full continuum of acute, primary, institutional, and home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system. CCI was enacted through SB 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012) and SB 94 (Chapter 34, Statutes of 2013), and includes a mandatory Medi-Cal managed care enrollment for Duals, and the inclusion of long-term services and supports (LTSS) as Medi-Cal managed care benefits for Seniors and Persons with Disabilities (SPD) beneficiaries who are eligible for Medi-Cal only, and for Dual SPD beneficiaries. CCI counties include Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

4. **Covered Service(s) or covered service(s)**, as used in this contract, means care coordination or coordination of care. This is the only service covered under this contract.

5. **California Department of Health Care Services (DHCS)** means the single State Department responsible for administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

6. **D-SNP Contract** means this written agreement between DHCS and the D-SNP Contractor.

7. **Department of Health and Human Services (DHHS)** means the Federal agency responsible for management of the Medicare and Medicaid programs.

8. **Director** means the Director of the California Department of Health Care Services.

Back to Agenda Back To Item Back to Item

Exhibit E, Attachment 1
DEFINITIONS

9. **Dual-Eligible Beneficiary (or Enrollee)** means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and**/or** Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan.

10. **Enrollment** means the process by which a beneficiary eligible for enrollment as contained in Exhibit A, Attachment 1, Provision 3 becomes a Member of the Contractor's D-SNP.

11. **Facility** means any premise that is:

    A. Owned, leased, used or operated directly or indirectly by or for Contractor or its affiliates for purposes related to this Contract, or

    B. Maintained by a Provider to provide services on behalf of Contractor.

12. **Medi-Cal Managed Care Health Plan** means a managed care health plan that contracts with the Department of Health Care Services for provision or arrangement of Medi-Cal benefits and services.

13. **Member** means any beneficiary who is enrolled in the Contractor's D-SNP.

14. **Service Area** means the geographic area in which Members or potential Members reside and for whom Contractor is approved to provide services by CMS.

15. **State** means the State of California.

16. **Working day(s)** mean State calendar (State Appointment Calendar, Standard101) working day(s).

Back to Agenda Back To Item Back to Item

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

1. Governing Law

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

A. If it is necessary to interpret this D-SNP Contract, all applicable laws may be used as aids in interpreting the D-SNP Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHCS or D-SNP Contractor, unless such applicable laws are expressly incorporated into this D-SNP Contract in some section other than this provision, Governing Law. The parties agree that any remedies for DHCS' or D-SNP Contractor's non-compliance with laws not expressly incorporated into this D-SNP Contract, or any covenants implied to be part of this D-SNP Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This D-SNP Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this D-SNP Contract, both parties shall be deemed authors of this D-SNP Contract.

   Any provision of this D-SNP Contract which 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 D-SNP 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.

B. Such amendment shall constitute grounds for termination of this D-SNP Contract in accordance with the procedures and provisions of Provision 18, Paragraph C, Termination – D-SNP Contractor below. The parties shall be bound by the terms of the amendment until the effective date of the termination.

~~C. The final Balanced Budget Act of 1997 regulations are published in the Federal Register/ Volume 67, Number 115/ June 14, 2002, at 42 CFR, 400, 430, 431, 434, 435, 438, 440 and 447. D-SNP Contractor shall be in compliance with the final Balance Budget Act of 1997 regulations by August 13, 2003.~~

~~D~~**C.** All existing final Policy Letters issued by MMCD or the current Managed Care Operations Division (MCOD) can be viewed at www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx and shall be complied with by D-SNP Contractor. All Policy Letters issued by MMCD subsequent to the effective date of this D-SNP Contract shall

provide clarification of D-SNP Contractor's obligations pursuant to this D-SNP Contract, and may include instructions to D-SNP Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation. In the event DHCS determines that there is an inconsistency between this D-SNP Contract and a MMCD or MCOD Policy Letter or All Plan Letter, the D-SNP Contract shall prevail.

2. Entire Agreement

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

3. Amendment Process

In addition to Exhibit C, Provision 2, Amendment, D-SNP Contractor also agrees to the following:

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

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this D-SNP Contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the D-SNP Contract. The parties agree that the development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. D-SNP Contractor's Obligation to Implement

D-SNP Contractor will make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, federal guidelines, or judicial interpretation, DHCS may direct D-SNP Contractor to immediately begin implementation of any change by issuing a change order. If DHCS issues a change order, D-SNP Contractor will be obligated to implement the required changes while discussions are taking place. DHCS may, at any time, within the general scope of the D-SNP Contract, by written notice, issue change orders to the D-SNP Contract.

5. Delegation of Authority

DHCS intends to implement this D-SNP Contract through a single administrator, called the "Contracting Officer". The Director of DHCS will appoint the Contracting Officer. The Contracting Officer, on behalf of DHCS, will make all determinations and take all actions as are appropriate under this D-SNP Contract, subject to the limitations of applicable Federal and State laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to D-SNP Contractor.

D-SNP Contractor will designate a single administrator; hereafter called the "Contractor's Representative". The Contractor's Representative, on behalf of D-SNP Contractor, will make all determinations and take all actions as are appropriate to implement this D-SNP Contract, subject to the limitations of Contract, Federal and State laws and regulations. The Contractor's Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind D-SNP Contractor to all agreements reached with DHCS. D-SNP Contractor shall designate Contractor’s Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, Provision 14, Notices.

6. Authority of the State

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered services under the Medi-Cal program administered in this D-SNP Contract or coverage for such services, or the eligibility of the beneficiaries or providers to participate in the Medi-Cal Program reside with DHCS. Sole authority to establish or interpret policy and its application related to the above areas will reside with DHCS.

D-SNP Contractor may not make any limitations, exclusions, or changes in covered services; any changes in definition or interpretation of covered services; or any changes in the administration of the D-SNP Contract related to the scope of covered services, allowable coverage for those covered services, or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

7. Fulfillment of Obligations

No covenant, condition, duty, obligation, or undertaking continued or made a part of this D-SNP Contract will be waived except by written agreement of the parties hereto, and 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; and, 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 D-SNP Contract, or under law, notwithstanding such forbearance or indulgence.

8. Prohibition Against Assignments or Delegation of Contractor's Duties and Obligations Under this D-SNP Contract

D-SNP Contractor shall not negotiate or enter into any agreement to assign or delegate the duties and obligations under this D-SNP Contract. If D-SNP Contractor fails to comply with this Provision, DHCS may terminate the D-SNP Contract for cause in compliance with Exhibit E, Attachment 2, Provision 18.

~~**9. Prohibition Against Subcontracts**~~

~~D-SNP Contractor shall not enter into subcontracts, regardless of the cost of services reimbursed under the D-SNP Contract, and DHCS shall not approve any subcontracts for the provision of care coordination services.~~

~~10~~9. Prohibition Against Novations

D-SNP Contractor and DHCS shall not enter any novation agreements. Contractor shall not propose any novation agreements nor shall DHCS agree to or act upon any proposal.

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

~~11~~10. Obtaining DHCS Approval

D-SNP Contractor shall obtain written approval from DHCS prior to commencement of operation under this D-SNP Contract:

A. Within five (5) working days of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS pursuant to this Provision.

B. Within 60 calendar days of receipt, DHCS shall make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to this Provision to provide D-SNP Contractor with a written explanation why its use is not approved, or provide a written estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, D-SNP Contractor may elect to implement or use the material at D-SNP Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Provision shall not be construed to imply DHCS approval of any material that has not received written DHCS approval.

~~12~~11. Program

DHCS reserves the right to review and approve any changes to D-SNP Contractor's protocols, policies, and procedures as specified in this D-SNP Contract.

~~13~~12. Certifications

D-SNP Contractor shall comply with certification requirements set forth in 42 CFR 438.604 and 42 CFR 438.606.

In addition to Exhibit C, Provision 11, Certification Clauses, Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this D-SNP Contract, the Contractor's Representative or his/her designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by DHCS in writing.

Back to Agenda Back To Item Back to Item

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

~~14~~13. Notices

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

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

California
Attn: President
CA

~~15~~14. Term

The D-SNP Contract will become effective January 1, 20XX, and will continue in full force and effect through December 31, 20XX.

~~16~~15. Service Area

The Service Area covered under this D-SNP Contract includes:
County

All D-SNP Contract provisions apply separately to each Service Area.

~~17~~16. D-SNP Contract Extension

DHCS may extend this D-SNP Contract for any reason.

~~18~~17. Termination for Cause and Other Terminations

In addition to Exhibit C, Provision 7, Termination for Cause, D-SNP Contractor also agrees to the following:

A. Termination - State or Director

1) DHCS may terminate performance of work under this D-SNP Contract in whole, or in part, whenever for any reason DHCS determines that the termination is in the best interest of the State.

Back to Agenda Back To Item Back to Item

2) Notification shall be given at least 60 days prior to the effective date of termination, except in cases described below in Paragraph B, Termination for Cause.

B. Termination for Cause

1) DHCS shall terminate this D-SNP Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22 CCR Section 53873.

2) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the D-SNP Contract, the D-SNP Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination. Except for termination pursuant to this Paragraph B, item 3) below, D-SNP Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 19, Disputes. Termination of the D-SNP Contract shall be effective on the last day of the month in which the Secretary, DHHS, or the DMHC makes such determination, provided that DHCS provides D-SNP Contractor with at least 60 calendar days' notice of termination. The termination of this D-SNP Contract shall be effective on the last day of the second full month from the date of the notice of termination. D-SNP Contractor agrees that 60 calendar days' notice is reasonable.

3) DHCS may terminate this D-SNP Contract in the event that D-SNP Contractor enters negotiations to change ownership or actually changes ownership, enters negotiations to assign or delegate its duties and obligations under the contract to another party or actually assigns or delegates its duties or obligations under the D-SNP Contract.

C. Termination - D-SNP Contractor

Grounds under which D-SNP Contractor may terminate this D-SNP Contract are limited to 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 conditions under which D-SNP Contractor entered into this D-SNP Contract, such that D-SNP Contractor can demonstrate to the satisfaction of DHCS.

D. Termination of Obligations

All obligations to provide services under this D-SNP Contract will automatically terminate on the date the operations period ends.

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

~~19~~18. Disputes

In addition to Exhibit C, Provision 6, Disputes, D-SNP Contractor also agrees to the following:

This Disputes section will be used by D-SNP Contractor as the means of seeking resolution of disputes on contractual issues.

A. Disputes Resolution by Negotiation

DHCS and D-SNP Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

B. Notification of Dispute

1) Within 15 calendar days of the date the dispute concerning performance of this D-SNP Contract arises or otherwise becomes known to D-SNP Contractor, D-SNP Contractor will notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.

2) D-SNP Contractor's notification will state, on the basis of the most accurate information then available to D-SNP Contractor, the following:

a) That it is a dispute pursuant to this section.

b) The date, nature, and circumstances of the conduct which is subject of the dispute.

c) The names, phone numbers, function, and activity of each D-SNP Contractor, DHCS/State official or employee involved in or knowledgeable about the conduct.

d) The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.

e) The reason D-SNP Contractor is disputing the conduct.

f) The cost impact to D-SNP Contractor directly attributable to the alleged conduct, if any.

Back to Agenda Back To Item Back to Item

g) D-SNP Contractor's desired remedy.

3) The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by D-SNP Contractor. This documentation will serve as the basis for any subsequent appeal.

4) Following submission of the required notification, with supporting documentation, the D-SNP Contractor will comply with the requirements of Title 22, CCR, Section 53851(d) and diligently continue performance of this D-SNP Contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

h) Contracting Officer's or Alternate Dispute Officer's Decision

Pursuant to a request by D-SNP Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by DHCS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program. Any disputes concerning performance of this D-SNP Contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within 30 calendar days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer shall either:

a. Find in favor of D-SNP Contractor, in which case the Contracting Officer or alternate dispute officer may countermand the earlier conduct which caused D-SNP Contractor to file a dispute; or

b. Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

c. Request additional substantiating documentation in the event the information in D-SNP Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise D-SNP Contractor as to what additional information is required, and establish how that information shall be furnished. D-SNP Contractor shall have 30 calendar days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the Contracting Officer or alternate dispute officer within the time period specified above shall constitute waiver by D-SNP

Contractor of all claims in accordance with Paragraph F, Waiver of Claims, below.

A copy of the decision shall be served on D-SNP Contractor.

i) Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

D-SNP Contractor shall have 30 calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include D-SNP Contractor's contentions as to those issues. However, D-SNP Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B, Notification of Dispute above. Failure to timely appeal the decision shall constitute a waiver by D-SNP Contractor of all claims arising out of that conduct, in accordance with Paragraph F, Waiver of Claims below, D-SNP Contractor shall exhaust all procedures provided for in this Provision 19, Disputes, prior to initiating any other action to enforce this D-SNP Contract.

j) D-SNP Contractor Duty to Perform

Pending final determination of any dispute hereunder, D-SNP Contractor shall comply with the requirements of Title 22, CCR, Section 53851(d) and proceed diligently with the performance of this D-SNP Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision. If pursuant to an appeal under Paragraph D, Appeal of Contracting Officer’s or Alternate Dispute Officer’s Decision above, the Contracting Officer’s or alternate dispute officer’s decision is reversed, the effect of the decision pursuant to Paragraph D, shall be retroactive to the date of the Contracting Officer’s or alternate dispute officer’s decision, and D-SNP Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a Contracting Officer’s or alternate dispute officer’s decision or any appeal of such decision.

k) Waiver of Claims

If D-SNP Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required

information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this Provision 19, Disputes, that failure shall constitute a waiver by D-SNP Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

~~20~~19. Audit

In addition to Exhibit C, Provision 4, Audit, D-SNP Contractor also agrees to the following:

The D-SNP Contractor will maintain such books and records necessary to disclose how D-SNP Contractor discharged its obligations under this D-SNP Contract. These books and records will disclose the quantity of Covered Services provided under this D-SNP Contract, the quality of those services, the manner for those services, the persons eligible to receive Covered Services, and the manner in which Contractor administered its daily business.

A. Books and Records

These books and records will include, but are not limited to, all physical records originated or prepared pursuant to the performance under this D-SNP Contract including working papers; reports submitted to DHCS; all medical records, medical charts and prescription files; and other documentation pertaining Covered Services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this D-SNP Contract, these books and records will be maintained for a minimum of five years from the end of the current Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created or the D-SNP Contract is terminated, or, in the event D-SNP Contractor has been duly notified that DHCS, DHHS, Department of Justice (DOJ) or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the D-SNP Contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

~~21~~20. Inspection Rights

In addition to Exhibit D(F), Provision 8, Site Inspection, D-SNP Contractor also agrees to the following:

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

Through the end of the records retention period specified in Provision 20, Audit, Paragraph B, Records Retention above, D-SNP Contractor shall allow the DHCS, DHHS, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives, including DHCS' external quality review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this D-SNP Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, contracts, computers or other electronic systems and facilities maintained by D-SNP Contractor pertaining to these services at any time during normal business hours.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, and books of account, medical records, prescription files, laboratory results, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 20, Audit, Paragraph B, Records Retention above, D-SNP Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at D-SNP Contractor's sole expense.

A. Facility Inspections

DHCS shall conduct unannounced validation reviews on a number of D-SNP Contractor's primary care sites, selected at DHCS' discretion, to verify compliance of these sites with DHCS requirements.

B. Access Requirements and State's Right to Monitor

Authorized State and federal agencies will have the right to monitor all aspects of D-SNP Contractor's operation for compliance with the provisions of this D-SNP Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of D-SNP Contractor and provider facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time during D-SNP Contractor's or other facility's normal business hours. The monitoring activities will be either announced or unannounced.

To assure compliance with the D-SNP Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to D-SNP Contractor. This will include the Management Information System operations site or such other place where duties under the D-SNP Contract

Back to Agenda Back To Item Back to Item

are being performed.

Staff designated by authorized State agencies will have access to all security areas and D-SNP Contractor will provide reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of D-SNP Contractor.

~~22~~21. Confidentiality of Information

In addition to Exhibit D(F), Provision 13, Confidentiality of Information, D-SNP Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

C. Notwithstanding any other provision of this D-SNP Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with 42 CFR 431.300 et seq., Welfare and Institutions Code, Section 14100.2, and regulations adopted thereunder. For the purpose of this D-SNP Contract, all information, records, data, and data elements collected and maintained for the operation of the D-SNP Contract and pertaining to Members shall be protected by D-SNP Contractor from unauthorized disclosure.

D-SNP Contractor may release medical records in accordance with applicable law pertaining to the release of this type of information. D-SNP Contractor is not required to report requests for Medical Records made in accordance with applicable law. Exhibit G is hereby incorporated into this contract by reference.

D. With respect to any identifiable information concerning a Member under this D-SNP Contract that is obtained by D-SNP Contractor, D-SNP Contractor:

1) Will not use any such information for any purpose other than carrying out the express terms of this D-SNP Contract;

2) Will promptly transmit to DHCS all requests for disclosure of such information, except requests for Medical records in accordance with applicable law;

3) Will not disclose except as otherwise specifically permitted by this D-SNP Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR 431.300 et seq., Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder; and

4) Will, at the termination of this D-SNP Contract, return all such information to DHCS or maintain such information according to written procedures sent to D-SNP Contractor by DHCS for this purpose.

~~23~~21. Third-Party Tort Liability

D-SNP Contractor shall identify and notify DHCS' Third Party Liability and Recovery Branch of all instances or cases in which D-SNP Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under Welfare and Institutions Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, D-SNP Contractor shall make no claim for recovery of the value of case management rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability and Recovery Branch within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, D-SNP Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of reports for Covered Services to an individual Member, D-SNP Contractor shall deliver the requested information within 30 calendar days of the request.

B. Information to be delivered shall contain the following data items:

1) Member name.

2) Full 14-digit Medi-Cal number.

3) Social Security Number.

4) Date of birth.

5) Diagnosis code and description of illness/injury (if known).

6) Procedure code and/or description of services rendered (if known).

C. D-SNP Contractor shall identify to DHCS' Third Party Liability and Recovery Branch the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If D-SNP Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of referrals, D-SNP Contractor shall refer the request to the Third Party Liability and Recovery Branch with the

information contained in Paragraph B above, and shall provide the name, address and telephone number of the requesting party.

E. Information submitted to DHCS under this section shall be sent to:

California Department of Health Care Services
Third Party Liability and Recovery Branch, Recovery Section
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425.

~~24~~23. Records Related To Recovery for Litigation

A. Upon request by DHCS, D-SNP Contractor shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in D-SNP Contractor's possession, relating to threatened or pending litigation by or against DHCS.

B. If D-SNP Contractor asserts that any requested documents are covered by a privilege, D-SNP Contractor shall:

1) Identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and

2) State the privilege being claimed that supports withholding production of the document.

C. Such request shall include, but is not limited to a response to a request for documents submitted by any party in any litigation by or against DHCS D-SNP Contractor acknowledges that time may be of the essence in responding to such request. D-SNP Contractor shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by D-SNP Contractor related to this D-SNP Contract entered into under this D-SNP Contract.

~~25~~24. Equal Opportunity Employer

Contractor must comply with all applicable federal and State employment discrimination laws. D-SNP Contractor will, in all solicitations or advertisements for employees placed by or on behalf of D-SNP Contractor, state that it is an equal opportunity employer, and 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 DHCS, advising the labor union or workers' representative of D-SNP Contractor's commitment as an equal opportunity employer and will post

copies of the notice in conspicuous places available to employees and applicants for employment.

~~26~~25. Discrimination Prohibitions

A. Member Discrimination Prohibition

D-SNP Contractor shall not unlawfully discriminate against Members or beneficiaries eligible for enrollment into Contractor's D-SNP on the basis of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56 in accordance with the statues identified in Exhibit E, Attachment 2, Provision 27 below, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this D-SNP Contract, discrimination may include, but is not limited to, the following:

1) Denying any Member any Covered Services;

2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;

4) Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or a beneficiary eligible for enrollment into the Contractor's D-SNP differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;

5) The assignment of times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.

6) 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.

7) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and Potential Enrollees.

D-SNP Contractor shall 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 422.56, except as needed to provide equal access to Limited English Proficient (LEP) Members or Members with disabilities, or as medically indicated.

For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related To Health Status

D-SNP Contractor shall not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during enrollment, re-enrollment or disenrollment. D-SNP Contractor will not terminate the enrollment of an eligible individual based on an adverse change in the Member’s health.

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

~~27~~26. Federal and State Nondiscrimination Requirements

Contractor shall comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; Titles I and II 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 issued under the above-listed statutes. Contractor shall also comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Sections 7405 and 11135 of the Government Code, Section 14029.91 of the Welfare and Institutions Code, and state implementing regulations.

~~28~~27. D-SNP Contractor shall process a grievance for discrimination as required by federal and ~~state~~ **State nondiscrimination** law as stated in 45 CFR section~~s~~ 84.7 ~~and 92.7~~; 34 CFR section 106.8; 28 CFR section 35.107; and~~, to the extent applicable,~~ W&I Code section 14029.91(e)(4).

A. D-SNP Contractor shall 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. D-SNP Contractor shall adopt procedures to ensure the prompt and equitable resolution of discrimination grievances by D-SNP Contractor. D-SNP Contractor shall not require a Member or potential enrollee to file a discrimination Grievance with D-SNP Contractor before filing with the DHCS Office of Civil Rights or the U.S. Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a discrimination grievance resolution letter, D-SNP Contractor shall submit the following information regarding the discrimination grievance in a secure format to the DHCS Office of Civil Rights:

1) The original discrimination grievance;

2) The provider's or other accused party's response to the discrimination grievance;

3) Contact information for the personnel primarily responsible for investigating and responding to the discrimination grievance on

Back to Agenda Back To Item Back to Item

behalf of D-SNP Contractor;

4) Contact information for the person filing the discrimination grievance, and for the provider or other accused party that is the subject of the discrimination grievance;

5) All correspondence with the person filing the discrimination grievance regarding the discrimination grievance, including, but not limited to, the discrimination grievance acknowledgment letter and resolution letter; and

6) The results of D-SNP Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

D. D-SNP Contractor shall post (1) a DHCS-approved nondiscrimination notice, and (2) language taglines in **a conspicuously visible font size in English,** the threshold languages**,** and at least the top ~~16~~ **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 taglines shall include D-SNP Contractor's toll-free and TTY/TDD telephone number for obtaining these services, and shall be posted as follows:

1) In all conspicuous physical locations where D-SNP Contractor interacts with the public;

2) In a ~~conspicuous~~ location on D-SNP Contractor's website that is accessible on the D-SNP Contractor's home page, and in a manner that allows Members, potential enrollees, and members of the public to easily locate the information; and

3) In **the Evidence of Coverage,** all **Member information, informational notices, and materials critical to obtaining services** ~~significant communications and significant publications~~ targeted to Members, potential enrollees, applicants, and members of the public, ~~except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures. (~~**in accordance with 42 CFR section 438.10(d)(2)-(3) and W&I Code section 14029.91(f)** ~~45 C.F.R. § 92.8(d)(1), (f)(1)(i)-(iii))~~.

~~E. D-SNP Contractor shall post (1) a DHCS-approved nondiscrimination statement and (2) language taglines in at least the top two non-English~~

Back to Agenda Back To Item Back to Item

~~languages in the State (as determined by DHCS), explaining the availability of free language assistance services, and the toll-free and TTY/TDD telephone number for obtaining these services, in all significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures. (45 C.F.R. § 92.8(d)(2), (g)).~~

~~F~~ **E**. D-SNP Contractor's nondiscrimination notice shall include all information required by **W&I Code section 14029.91(e),** ~~Section 92.8 of Title 45 of the Code of Federal Regulations,~~ any additional information required by DHCS, and shall provide information on how to file a discrimination grievance with:

1) Both D-SNP Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination in the Medi-Cal program based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation **or identification with any other persons or groups defined in Penal Code 422.56**. (~~45 C.F.R. section 92.8(A)(5);~~ W&I Code section 14029.9~~2~~**1**(e); H&S Code section 11135).

2) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (~~45 C.F.R. section 92.8(A)(7)~~**W&I Code section 14029.91(e)**).

~~29~~28. Disabled Veteran Business Enterprises (DVBE)

D-SNP Contractor shall comply with applicable requirements of California law relating to DVBE commencing at Section 10115 of the Public Contract Code.

Back to Agenda Back To Item Back to Item

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

~~30~~29. Word Usage

Unless the context of this D-SNP Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall 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.

~~31~~30. Federal False Claims Act Compliance

Effective January 1, 2007, D-SNP Contractor shall comply with 42 USC Section 1396a (a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this D-SNP Contract. Upon request by DHCS, D-SNP Contractor shall demonstrate compliance with this provision, which may include providing DHCS with copies of Contactor's applicable written policies and procedures and any relevant employee handbook excerpts.

Back to Agenda Back To Item Back to Item

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 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's 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. 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 only to perform functions, activities or services specified in this Agreement

Back to Agenda Back To Item Back to Item

on behalf of DHCS, provided that such use or disclosure would not violate HIPAA 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, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

9.1 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.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 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

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall maintain, at a minimum, industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a

Back to Agenda Back To Item Back to Item

confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, 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 shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible,

Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

18.1.2 Business Associate shall notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of:

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 data affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS

Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or confidential breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request

approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

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 shall promptly remedy any violation of this Agreement

and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 **Termination for Cause**. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 **Judicial or Administrative Proceedings.** DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 **Disclaimer**. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. **Amendment**.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 **Assistance in Litigation or Administrative Proceedings**. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Consider Authorizing Execution of Amendment(s) to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Insurance Portability and Accountability Act (HIPAA)

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Carmen Dobry, Executive Director, Compliance, (657) 235-6997

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between DHCS and CalOptima related to the updated Exhibit G: Health Insurance Portability and Accountability Act (HIPAA)

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with the DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 49, which extends the agreement through December 31, 2021. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services. As a health plan, CalOptima is a covered entity under HIPAA, but it is also a business associate of DHCS, and Exhibit G to the Primary Agreement is CalOptima's business associate agreement with DHCS.

Discussion

In June 2021, DHCS notified CalOptima that an updated Exhibit G: Health Insurance Portability and Accountability Act (HIPAA) will be incorporated into CalOptima's Primary Agreement with the DHCS along with the bridge period contract amendments covering the July 1, 2019 – December 31, 2020 period. Staff expects to receive the final version of the new Exhibit G in August 2021.

These language changes were expected by Staff, based on DHCS's previous notification that the updated Exhibit G would be incorporated into CalOptima's Primary Agreement with the DHCS, as it was previously incorporated into Agreement 16 – 93274, in order to ensure consistent application of the requirements across all of CalOptima's lines of business.

Authority to incorporate the updated Exhibit G into CalOptima's Care Coordination Agreement (Agreement 16 – 93274) was granted to Chairman of the CalOptima Board of Directors during August 2020 Board meeting. Authority is now being sought to incorporate similar language into the Primary Agreement. The changes in the updated Exhibit G included the following:

1. The title was changed from Exhibit G, Health Insurance Portability and Accountability Act (HIPAA) to Exhibit G, Business Associate Addendum (BAA);
2. Revisions were made to the Information Security controls; and

Back to Agenda

3. The 72 – hour reporting requirement for privacy and security incidents was removed.

CalOptima staff plans to be meeting the referenced new information security control requirements ahead of the new Exhibit G language taking effect. If, upon receipt the amendment is not consistent with staff's understanding as presented in this document, or if it includes significant unexpected language changes, staff will return to the Board of Directors to request a revised and updated authority through ratification.

Fiscal Impact
The recommended action to execute an amendment related to the updated Exhibit G: HIPAA is projected to be budget neutral.

Rationale for Recommendation
The addition of the updated Exhibit G to CalOptima's Primary Agreement with the DHCS will ensure consistent application of the requirements across all of CalOptima's lines of business.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Attachment 1_Appendix summary of amendments to Primary Agreements with DHCS

/s/ Richard Sanchez *07/28/2021*
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 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 Agenda Back To Item

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

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
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

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020

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

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

A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2023.	June 3, 2021

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

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Consider Approval of Modification to CalOptima Policy AA.1223: Participation in Community Events with External Entities to Update Staff Approval Threshold

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Actions

1. Approve proposed modifications to CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities to increase the Chief Executive Officer's (CEO's) authority to approve financial participation in community events from $1,000 to $2,500 per organization per fiscal year; and
2. Authorize the CEO to implement the proposed policy changes.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops and other public activities in furtherance of the organization's mission and statutory purpose.

Prior to September 2015, CalOptima's CEO was authorized to approve CalOptima's financial support of community events of up to $10,000. In September 2015, this cap was reduced to $500 pending an Ad Hoc Committee of the Board's review of CalOptima's policy on endorsements and financial support of community events. On February 2, 2017, at the recommendation of the Board Ad Hoc, CalOptima's Board of Directors approved CalOptima Policy AA.1223: Participation in Community Events by External Entities (the Policy), including a requirement that staff seek Board approval for financial support in excess of $1,000 per organization per fiscal year. This $1,000 threshold remains in place today. Since the Policy was adopted, the Board increased the recommended dollar amount for one event and has approved all others as recommended by staff.

Discussion

The Board more recently has voiced interest in streamlining meeting materials and agendas to allow focus on the most critical information and requests. For example, in October 2020, the Board adopted a Receive and File category as part of the Consent Item agenda.

Staff considered whether the existing $1,000 threshold could be modified while retaining meaningful opportunity for the Board to weigh in on events whose organizers are requesting greater financial participation levels. As a result of this review, staff recommends modification of the CEO's approval threshold from $1,000 to $2,500 per organization per fiscal year. As reflected in the table below, had the CEO's authority for the proposed dollar threshold been in place, the number of items requiring Board approval would have been reduced by nearly 50%.

Back to Agenda

Comparison of Fiscal Support Recommendations Under Existing and Proposed Thresholds		
	Existing Threshold: In Excess of $1,000	Proposed Threshold: In Excess of $2,500
2017–18	10	5
2018–19	14	6
2019–20	14	7
2020–21	4	4
Total	**42**	**22**

Following is a description of the proposed changes to the impacted Policy, with an attachment showing the substantive changes in redline. The table below does not include non-substantive changes that may also be reflected in the redline (e.g., formatting, spelling, punctuation, minor clarifying language and grammatical changes).

Policy AA.1223: Participation in Community Events by External Entities establishes guidelines for CalOptima's participation in community events, programs, projects and activities involving external entities.

Policy Sections	Proposed Change	Rationale	Impact
Section II.G.2, 2a, c, e Section II.G.3, 3a, b, e Section IX Attachment A, Section V Attachment B	Change threshold from $1,000 to $2,500.	To provide efficiencies while maintaining Board oversight of financial participation recommendations of amounts in excess of $2,500.	Based on prior experience, the number of requests requiring Board consideration may be reduced by approximately 50%.

Staff recommends this change, which would provide Board and staff efficiencies, while retaining meaningful Board oversight. Staff will continue to regularly report CalOptima's participation in community events to the Board.

Fiscal Impact

The recommended action to modify CalOptima Policy AA.1223 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget approved by the CalOptima Board of Directors on June 3, 2021.

Rationale for Recommendation

Approval of this recommended action would support more efficient processing of community requests for financial support, while ensuring Board approval is required for requests exceeding the $2,500 threshold. By reducing the number of required Board requests, staff will also be able to respond more quickly to community partners seeking CalOptima financial participation under the threshold. Thus, the proposed

modifications are consistent with the Board-approved CalOptima Strategic Plan Priorities to Enhance Operational Excellence and Efficiency and Strengthen Community Partnerships.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Previous Board Action dated February 2, 2017: Consider Approval and Implementation of the Revised CalOptima Endorsement Policy AA.1214 and Proposed New Policy Regarding Participation in Community Events
2. Revised CalOptima Policy AA.1223: Participation in Community Events by External Entities (redlined and clean versions -- with Attachments – redlined and clean)

/s/ Richard Sanchez *07/28/2021*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken February 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Approval and Implementation of the Revised CalOptima Endorsement Policy AA.1214 and Proposed New Policy Regarding Participation in Community Events

Contact
Phil Tsunoda, Executive Director Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Approve the Revised CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima's Name or Logo;
2. Approve CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities; and
3. Authorize the Chief Executive Officer to implement the policies.

Background
CalOptima has a long history of participating in community events and public activities as well as providing endorsements for our community partners. CalOptima has historically provided Letters of Support, approval of the Use of CalOptima's Name or Logo, staff participation and/or financial participation in external events. CalOptima routinely participates in events such as health and resource fairs, town halls, workshops, and other community activities in furtherance of the organization's statutory purpose. Consistent with these activities, staff participation provides opportunities to conduct outreach and education about CalOptima's programs and services to current and potential members.

CalOptima also provides financial participation through registration fees and/or financial sponsorships. CalOptima participates in community events when the events are open to the public and for the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima develops and cultivates a strong reputation in Orange County with community partners and key stakeholders.

Requests for letter of support, use of CalOptima Name or Logo, and for staff and/or financial participation in community events are considered based on several factors, including the opportunity to create positive visibility for CalOptima in the community and promote CalOptima's mission, programs, and purpose. Additional considerations include the number of current and potential CalOptima members, other participating stakeholders the activity/event will reach, the opportunity for CalOptima to share information, staff and budget availability, and the opportunity to strengthen relationships with our community partners.

Discussion
In September 2015, the Board of Directors requested a comprehensive review of CalOptima's Policy AA.1214: Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo. In

addition, the CalOptima Board chairman appointed a Board Ad Hoc Committee to work with staff regarding policy AA.1214.

Staff conducted a thorough review and comprehensive analysis of the policy with the Board Ad Hoc committee. The review and analysis highlighted the permissible use of Medi-Cal and Medicare funds for sponsorships, endorsements, marketing and other relevant activities. Based on these findings, staff and the Ad Hoc committee are recommending revising the current Board approved Policy AA.1214: Guidelines for Endorsement by CalOptima and Use of CalOptima Name or Logo and creating a new policy for Participation in Community Events.

Revised Policy AA. 1214: Guidelines for Endorsement by CalOptima, for Letters of Support and Use of CalOptima Name or Logo

CalOptima's revised Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name or Logo establishes specific criteria to guide the decision-making process, which includes defining eligible external entities and establishing criteria for Letters of Support and Use of CalOptima Name or Logo. The most significant change to the policy is the reduction of the number of days in advance a request must be received to process from sixty (60) calendar days to twenty-one (21) calendar days.

New Policy AA.1223: Participation in Community Events Involving External Entities

The new Policy AA.1223: Participation in Community Events Involving External Entities establishes criteria and requirements to guide the decision-making process and administrative review, which includes defining eligible entities and establishing criteria for staff participation and/or financial participation in external events. The most significant changes to the policy are:

- Establishes the timeframe to receive requests for staff participation in community events to at least fourteen (14) calendar days in advance of the date of the event.

- Reduces the Board's prior delegation to the CEO to approve financial requests by 90% from ten thousand dollars ($10,000) to one thousand dollars ($1,000)

- Reduces the number of days requests must be received in advance to process for financial participation in an amount up to and including one thousand dollars ($1,000) from sixty (60) calendar days to at least twenty-one (21) calendar days in advance of the date of the event.

- Requires approval by the CalOptima Board of Directors for requests for financial participation in amounts more than one thousand dollars ($1,000). Requests must still be received at least sixty (60) calendar days in advance of the date of the event.

As part of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities are in the public interest and in furtherance of CalOptima's statutory purpose. In addition, as part of the Board's approval of the Policies, the Board will also be authorizing the CEO to implement the requirements of the Policies.

Fiscal Impact
There is no fiscal impact. Staff will request separate Board requests for staff or financial participation in community events with funding included in the annual CalOptima Operating Budget.

Rationale for Recommendation
Staff recommends approval of the recommended actions in order to support activities that provide opportunities for CalOptima to collaborate and strengthen relationships with community partners. Participation in these activities support CalOptima's mission, encourage broader participation in CalOptima's programs and services, and promote health and wellness. The revised Policy AA.1214 and new Policy AA.1223 provides definitions, criteria, a procedure and requirements to support these activities.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Revised Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name or Logo New Policy (redlined and clean versions – with revised Attachments
2. New Policy AA.1223: Participation in Community Events Involving External Entities (clean) – with Attachments

/s/ Michael Schrader — *01/26/2017*
Authorized Signature — **Date**

Policy #:	AA.1214
Title:	**Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo**
Department:	Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	~~2/4~~02/04/97
Last Review Date:	02/02/17
Last Revised Date:	02/01/17
~~Board Approvals: 10/2/2008~~	~~Revised: 7/1/07, 10/2/08, 11/1/13~~

I. PURPOSE

~~To clarify CalOptima's~~This policy establishes guidelines for providing an Endorsement to external entities by CalOptima, for Letters of Support, and for approving the use of the CalOptima name, or logo, by external entities.

II. POLICY

A. CalOptima's name carries considerable value, particularly for external entities seeking to associate themselves with the organization. Moreover, CalOptima's role as a public agency requires that its name and reputation be preserved and protected, and that activities and organizations associated with CalOptima's name must be consistent with CalOptima's mission and purpose. Requests for an Endorsement, including ~~letters~~LOS and u~~U~~se of ~~support, commitments for financial participation, and collaborations or partnerships with~~ CalOptima n~~N~~ame, or l~~L~~ogo, shall be approved only if compatible with CalOptima's mission and~~,~~ in accordance with this policy.

B. An external entity may be eligible to submit a request for an Endorsement including requests for a LOS, or Use of CalOptima n~~N~~ame, or l~~L~~ogo, if the entity is a community-based, non-profit organization, or health care partner, that serves CalOptima members, or supports CalOptima's mission.

C. Except as provided in this policy, CalOptima prohibits direct and implied endorsements. The name, logo, or images of CalOptima may not be used in any statement, website, print, or electronic communication, or activity to explicitly, or implicitly, endorse any specific commercial product, or service, any religion, any ballot measure/initiative, or any candidate for public office. In addition, the name, logo, or images of CalOptima may not be used explicitly, or implicitly, to endorse, or create, the appearance of partiality towards any vendor, or particular health care provider.

~~B.~~ Requests for an Endorsement~~, in the form of financial participation by CalOptima in a project, program, event, or other effort proposed by an external entity~~ or LOS, shall require the written approval ~~as follows:~~

~~1.~~D. ~~Requests for financial participation up to and including ten thousand dollars ($10,000) shall require the prior written approval of CalOptima's~~ of the Chief Executive Officer (CEO). The CEO shall consider such requests based on:

a.1. The potential for such financial participationthe Endorsement, or LOS, to create a positive visibility for CalOptima; and

b. The potential for such financial participation to create a long-term collaborative partnership between CalOptima and the requesting entity.

2. Requests for financial participation above ten thousand dollars ($10,000) shall require the prior approval of the CalOptima Board of Directors. The CalOptima Board of Directors may approve the budgeting of such financial participation in the annual budget or may approve unbudgeted financial participation through a separate action.

2. Financial participation includes the use of CalOptima staff time (e.g., in their capacity as a CalOptima employee) and current or future CalOptima funds.Whether the Endorsement, or LOS, would promote, or advocate, positions that are consistent with CalOptima's mission, programs, standards, and purposes; and

3. Whether the Endorsement, or LOS, may conflict with CalOptima policies and/or applicable local, state, and federal laws and regulations, and/or whether the Endorsement, or LOS, could constitute any real, or perceived, conflict of interest.

C.E. Use, or reproduction, of the CalOptima name, or logo, by external entities shall be restricted by CalOptima, in accordance with federal and state trademark rules and regulations.

D.F. Requests to utilize the CalOptima name, or logo, for any project, document, event, or other purpose shall require the advance written approval of CalOptima's CEO for approval and signature.

E. CalOptima shall not explicitly or implicitly endorse any specific commercial product or service (e.g., pharmaceuticals or health care products).

F.G. CalOptima shall report any Endorsement, or LOS, approved by the CEO, including the use of CalOptima's name, or logo, for any project, document, event, or other purpose, to the CalOptima Board of Directors, in writing, within thirty (30) calendar daysat the next available regularly scheduled Board of Directors meeting after such approval.

G.H. Effective January 1, 2009, anAn Endorsement, LOS, and use of CalOptima's name, or logo, as approved, in accordance with this policy, shall be posted on CalOptima's website (www.caloptima.org) and updated on a monthly basis.

I. CalOptima employees should refrain from wearing attire containing CalOptima's logo while participating in non-CalOptima related activities, such as political fundraisers, in order to avoid the appearance of CalOptima's Eendorsement.

III. PROCEDURE

A. Requests for Endorsements, or LOS:

1. All requests shall be submitted to CalOptima's Public AffairsCommunity Relations Department,, in writing.

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2. A written request shall include the following information, as appropriate:

a. ~~Copy~~The name and description of the organization seeking an Endorsement, or LOS, and the organization's contact information;

b. Name of the program or project, and name of the program -or project director, or primary contact;

~~a.~~c. The reason for the request, including, but not limited to, a copy of the program or project description for which the ~~letter of support, E~~endorsement~~,~~ or ~~commitment~~LOS, is ~~requested~~sought;

~~b.~~d. Scope and purpose of the program or project, including projected outcome;

~~c.~~e. Description, background, and pertinent information (e.g., names of members of the Board of Directors) regarding the requesting ~~entity~~organization and any other ~~entity~~organization having a substantial role in the project;

~~d.~~f. Information regarding the ~~entity's~~organization's ability to successfully carry out the program or project;

~~d.~~

~~f. Name of the program or project, name of the program or project director or principal investigator and his or her qualifications in regard to the program or project;~~

g. A list of other individuals, or entities, supporting the program or project;

~~h. Project budget information, including budget detail if the request is for financial participation by CalOptima;~~

~~i. Detailed timeline for the project, including planning, implementation, evaluation, and other phases of the project;~~

h. ~~Purpose for~~ Date Endorsement, or LOS, is due to the organization;

i. Conditions under which the name of CalOptima and/or its logo will be used;

j. Draft template letter provided by the organization, where applicable; and

~~j.~~ Description of relationship between organization's work and CalOptima's ~~involvement in the program or project and a detailed description of its proposed role;~~

k. ~~Anticipated time commitment required~~programs/lines of business, mission, values, and/or purpose.

~~k. of individual CalOptima staff;~~

~~l. Specific data elements requested from CalOptima and a description of their specific use in the proposed project;~~business, mission, values, and

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1.Projected outcome of the proposed project/or purpose.

3. All requests shall be submitted at least sixty (60twenty-one (21) calendar days in advance of the date for which the Endorsement, is requiredor LOS, is requested, or if in a shorter amount of time, at the discretion of the CEO, so long as such request is submitted to the CEO in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

4. Upon receipt of a complete request for an Endorsement, or LOS, CalOptima's Public AffairsCommunity Relations Department shall review and analyze the request with input from appropriate internal departments, including the Finance within five (5) business days of receipt of the complete request.

4. The Community Relations Department for eachshall submit a request involving financial participation.

5. Endorsements involving requests for financial participation in the amount of ten thousand dollars ($10,000)for Endorsement, or less are forwardedLOS, to the CEO for review and consideration.

6. Endorsements that involve financial participation in an amount greater than ten thousand dollars ($10,000) are forwarded, to the Board of Directors for review and consideration.

7.6. CalOptima The Community Relations Department shall notify any entitythe organization that requests an Endorsement, or LOS, in writing, after CalOptima's determination is made.

7. The Community Relations Department shall process an approved Endorsement, or LOS, request within three (3) business days of approval.

8. The Community Relations Department shall document and track all Endorsements and LOS and shall be responsible for fulfillment of any stated commitment(s).

B. Use of the CalOptima name, or logo:

1. Requests shall be submitted to CalOptima's Public AffairsCommunity Relations Department, in writing, at least thirty (30twenty-one (21) calendar days in advance of the date for which use of the name, or logo, is requiredrequested, or if in a shorter amount of time, at the discretion of the CEO, so long as such request is submitted to the CEO in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

2. Requests shall include the following:

   a. Description of the project, event, publication, or other purpose for which the CalOptima name, or logo will be used;

   b. Intended audience for the project, event, or publication for which the name name, or logo, will be used;

DRAFT

c. Description, background, and pertinent information (e.g., names of members of the Board of Directors) regarding the requesting entity and any other entity whose name will appear on the document, project, or event;

d. Time frame during which the name, or logo, is requested to be used; and

e. Mock-up of how the name, or logo, will be used.

3. Upon receipt of a complete request for use of the CalOptima name, or logo, CalOptima's ~~Public Affairs~~Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

4. The ~~Public Affairs~~Community Relations Department shall submit a request for use of the CalOptima name, or logo, to the CEO for review and consideration.

5. ~~CalOptima~~The Community Relations Department shall notify ~~any~~the requesting entity, ~~that requests use of the CalOptima name or logo,~~ in writing, after CalOptima's determination is made.

6. The Community Relat~~e~~ions Department shall process an approved request within three (3) business days of approval.

IV. ATTACHMENTS

A. Endorsement Request Form: Letter of Support & Use of Logo
B. Endorsement Transmittal Form: Letter of Support & Use of Logo

V. REFERENCES

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1223: Participation in Community Events Involving External Entities

~~A. California Constitution Article 16, section 6~~
~~B. California Government Code, section 8314~~
E. CalOptima Policy GA.5002: Purchasing Policy
~~C. CalOptima Policy GA.1223: Participation in Community Events Involving External Entities~~
F. CalOptima Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVALS ~~OR~~

~~Not Applicable~~None to Date

~~VI.~~VII. BOARD ACTIONS

A. ~~10/2/2008:~~02/02/17: ~~———————~~Regular Meeting of the CalOptima Board ~~Meeting~~of Directors ~~———~~

B. 10/02/~~20~~08: ~~———~~Regular Meeting of the CalOptima Board of Directors

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~~VII.~~VIII. REVIEW/REVISION HISTORY

~~A. 10/2/2008: AA.1214: Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo~~
~~B. 7/1/07: AA.1214: Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo~~
~~C. 2/4/97: AA.1214: Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo~~

~~VIII. KEYWORDS~~

~~Endorsement~~
~~Logo~~
~~Name~~

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/04/1997	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	07/01/2007	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	10/02/2008	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	02/02/2017	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative

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IX. GLOSSARY

Term	Definition
Endorsement	The support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima does not receive a comparable benefit. Endorsement does not include any sponsorship, educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Letter of Support (LOS)	A letter supporting a community-based organization or health care partner detailing compelling reasons why the organization or project is credible and of value to the community and conveying the relationship between CalOptima and the organization, thereby lending credibility to the organization requesting support. LOS does not include a formal partnership agreement or interagency agreement.
Marketing Activities	Any activity conducted by or on behalf of CalOptima where information regarding the services offered by CalOptima is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and participation. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of CalOptima.

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Policy #:	AA.1214
Title:	**Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo**
Department:	Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	02/04/97
Last Review Date:	02/02/17
Last Revised Date:	02/01/17

I. PURPOSE

This policy establishes guidelines for providing an Endorsement to external entities by CalOptima, for Letters of Support, and for approving the use of the CalOptima name, or logo, by external entities.

II. POLICY

A. CalOptima's name carries considerable value, particularly for external entities seeking to associate themselves with the organization. Moreover, CalOptima's role as a public agency requires that its name and reputation be preserved and protected, and that activities and organizations associated with CalOptima's name must be consistent with CalOptima's mission and purpose. Requests for an Endorsement, including LOS and use of CalOptima name, or logo, shall be approved only if compatible with CalOptima's mission and in accordance with this policy.

B. An external entity may be eligible to submit a request for an Endorsement including requests for a LOS, or Use of CalOptima name, or logo, if the entity is a community-based, non-profit organization, or health care partner, that serves CalOptima members, or supports CalOptima's mission.

C. Except as provided in this policy, CalOptima prohibits direct and implied endorsements. The name, logo, or images of CalOptima may not be used in any statement, website, print, or electronic communication, or activity to explicitly, or implicitly, endorse any specific commercial product, or service, any religion, any ballot measure/initiative, or any candidate for public office. In addition, the name, logo, or images of CalOptima may not be used explicitly, or implicitly, to endorse, or create, the appearance of partiality towards any vendor, or particular health care provider.

D. Requests for an Endorsement, or LOS, shall require the written approval of the Chief Executive Officer (CEO). The CEO shall consider such requests based on:

1. The potential for the Endorsement, or LOS, to create a positive visibility for CalOptima;

2. Whether the Endorsement, or LOS, would promote, or advocate, positions that are consistent with CalOptima's mission, programs, standards, and purposes; and

3. Whether the Endorsement, or LOS, may conflict with CalOptima policies and/or applicable local, state, and federal laws and regulations, and/or whether the Endorsement, or LOS, could constitute any real, or perceived, conflict of interest.

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E. Use, or reproduction, of the CalOptima name, or logo, by external entities shall be restricted by CalOptima, in accordance with federal and state trademark rules and regulations.

F. Requests to utilize the CalOptima name, or logo, for any project, document, event, or other purpose shall require the advance written approval of CalOptima's CEO.

G. CalOptima shall report any Endorsement, or LOS, approved by the CEO, including the use of CalOptima's name, or logo, for any project, document, event, or other purpose, to the CalOptima Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

H. An Endorsement, LOS, and use of CalOptima's name, or logo, as approved in accordance with this policy, shall be posted on CalOptima's website (www.caloptima.org) and updated on a monthly basis.

I. CalOptima employees should refrain from wearing attire containing CalOptima's logo while participating in non-CalOptima related activities, such as political fundraisers, in order to avoid the appearance of CalOptima's Endorsement.

III. PROCEDURE

A. Requests for Endorsements, or LOS:

1. All requests shall be submitted to CalOptima's Community Relations Department, in writing.

2. A written request shall include the following information, as appropriate:

a. The name and description of the organization seeking an Endorsement, or LOS, and the organization's contact information;

b. Name of the program or project, and name of the program or project director, or primary contact;

c. The reason for the request, including, but not limited to, a copy of the program or project description for which the Endorsement, or LOS, is sought;

d. Scope and purpose of the program or project, including projected outcome;

e. Description, background, and pertinent information (e.g., names of members of the Board of Directors) regarding the requesting organization and any other organization having a substantial role in the project;

f. Information regarding the organization's ability to successfully carry out the program or project;

g. A list of other individuals, or entities, supporting the program or project;

h. Date Endorsement, or LOS, is due to the organization;

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i. Conditions under which the name of CalOptima and/or its logo will be used;

j. Draft template letter provided by the organization, where applicable; and

k. Description of relationship between organization's work and CalOptima's programs/lines of business, mission, values, and/or purpose.

3. All requests shall be submitted at least twenty-one (21) calendar days in advance of the date for which the Endorsement, or LOS, is requested, or if in a shorter amount of time, at the discretion of the CEO, so long as such request is submitted to the CEO in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

4. Upon receipt of a complete request for an Endorsement, or LOS, CalOptima's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days of receipt of the complete request.

5. The Community Relations Department shall submit a request for Endorsement, or LOS, to the CEO for review and consideration.

6. The Community Relations Department shall notify the organization that requests an Endorsement, or LOS, in writing, after CalOptima's determination is made.

7. The Community Relations Department shall process an approved Endorsement, or LOS, request within three (3) business days of approval.

8. The Community Relations Department shall document and track all Endorsements and LOS and shall be responsible for fulfillment of any stated commitment(s).

B. Use of the CalOptima name, or logo:

1. Requests shall be submitted to CalOptima's Community Relations Department, in writing, at least twenty-one (21) calendar days in advance of the date for which use of the name, or logo, is requested, or if in a shorter amount of time, at the discretion of the CEO, so long as such request is submitted to the CEO in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

2. Requests shall include the following:

a. Description of the project, event, publication, or other purpose for which the CalOptima name, or logo will be used;

b. Intended audience for the project, event, or publication for which the name, or logo, will be used;

c. Description, background, and pertinent information (e.g., names of members of the Board of Directors) regarding the requesting entity and any other entity whose name will appear on the document, project, or event;

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d. Time frame during which the name, or logo, is requested to be used; and

e. Mock-up of how the name, or logo, will be used.

3. Upon receipt of a complete request for use of the CalOptima name, or logo, CalOptima's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

4. The Community Relations Department shall submit a request for use of the CalOptima name, or logo, to the CEO for review and consideration.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima's determination is made.

6. The Community Relations Department shall process an approved request within three (3) business days of approval.

IV. ATTACHMENTS

A. Endorsement Request Form: Letter of Support & Use of Logo
B. Endorsement Transmittal Form: Letter of Support & Use of Logo

V. REFERENCES

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1223: Participation in Community Events Involving External Entities
E. CalOptima Policy GA.5002: Purchasing Policy
F. CalOptima Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 02/02/17: Regular Meeting of the CalOptima Board of Directors
B. 10/02/08: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/04/1997	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative

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Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	07/01/2007	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	10/02/2008	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	02/02/2017	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative

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IX. GLOSSARY

Term	Definition
Endorsement	The support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima does not receive a comparable benefit. Endorsement does not include any sponsorship, educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Letter of Support (LOS)	A letter supporting a community-based organization or health care partner detailing compelling reasons why the organization or project is credible and of value to the community and conveying the relationship between CalOptima and the organization, thereby lending credibility to the organization requesting support. LOS does not include a formal partnership agreement or interagency agreement.
Marketing Activities	Any activity conducted by or on behalf of CalOptima where information regarding the services offered by CalOptima is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and participation. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of CalOptima.

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Endorsement Request Form – Letter of Support (LOS) & Use of Logo

Requests for Letter of Support (LOS) and/or Use of CalOptima's Logo must be submitted to the Community Relations Department no less than 21 calendar days in advance. ~~Please provide the information requested below, as appropriate. For Letters of Support, must complete at least the items marked by an asterisk (*).~~

Endorsement Details			
Organization:*			
Address:*			
City:*		**Zip Code:***	
POC Name & Title:*			
Phone Number:*	☒	**Fax #:**	
E-mail:*	☐		
~~**Type:***~~	~~Letter of Support~~		
Type:	☐ Letter of Support ~~Commitment for Financial Participation~~		
	☐ Use of CalOptima Name or Logo Only		
	☐ ~~Other:~~ ☐ ~~CalOptima Master Logo~~ ☐ ~~PACE Logo~~		
	☐ ~~OneCare Connect Logo~~ ☐ OneCare		
Endorsement Needed By:*			

If more space is needed, you may attach additional pages.	
1. Program or project description, including:* a. Name of the program or project b. Name of the program or project director or principle investigator, including his/her qualifications in regards to the program or project c. Scope and purpose of the program or project	
2. Background information of requesting entity, including:* a. Information regarding entity's ability to successfully carry out the program or project b. Names of members of the Board of Directors	

Endorsement Request Form – Letter of Support (LOS) & Use of Logo

3. Other individuals or entities supporting the program or project, including:* a. A description of their role in the program or project	
4. Detailed program or project timeline for planning, implementation, evaluation, and other phases of the program or project	
5. Projected outcome of the program or project	
~~6. Amount requested and program or project budget Information, including:~~ ~~a. Budget detail if the request is for financial participation by CalOptima~~ ~~*(Note: Requests for financial participation up to and including $10,000 shall require prior written approval of CalOptima's CEO. Requests for financial participation above $10,000 shall require prior approval of the CalOptima Board of Directors.)*~~	
6. Purpose for CalOptima's involvement in the program or ~~7.~~ project, including: a. Detailed description of its proposed role b. Anticipated time commitment required of CalOptima staff c. Specific data elements requested from CalOptima and a description of their specific use in the program or project	

Endorsement Request Form – Letter of Support (LOS) & Use of Logo

7. Conditions under which CalOptima's name and/or logo will be used.	
8. Time frame during which CalOptima's name or logo will be used.	
9. ~~Request for~~Please provide a LOS template letter and/or mock-up of how CalOptima's name or~~f~~ logo will be used.	

Endorsement Request Form – Letter of Support (LOS) & Use of Logo

Requests for Letter of Support (LOS) and/or Use of CalOptima's Logo must be submitted to the Community Relations Department no less than 21 calendar days in advance.

Endorsement Details			
Organization:			
Address:			
City:		**Zip Code:***	
POC Name & Title:			
Phone Number:		**Fax #:**	
E-mail:			
Type:	☐ Letter of Support		
	☐ Use of CalOptima Name or Logo Only		
	☐ CalOptima Master Logo ☐ PACE Logo		
	☐ OneCare Connect Logo ☐ OneCare		
Endorsement Needed By:			

If more space is needed, you may attach additional pages.	
1. Program or project description, including: a. Name of the program or project b. Name of the program or project director or principle investigator, including his/her qualifications in regards to the program or project c. Scope and purpose of the program or project	
2. Background information of requesting entity, including: a. Information regarding entity's ability to successfully carry out the program or project b. Names of members of the Board of Directors	

Endorsement Request Form – Letter of Support (LOS) & Use of Logo

3. Other individuals or entities supporting the program or project, including: a. A description of their role in the program or project	
4. Detailed program or project timeline for planning, implementation, evaluation, and other phases of the program or project	
5. Projected outcome of the program or project	
6. Purpose for CalOptima's involvement in the program or project, including: a. Detailed description of its proposed role b. Anticipated time commitment required of CalOptima staff c. Specific data elements requested from CalOptima and a description of their specific use in the program or project	
7. Conditions under which CalOptima's name and/or logo will be used.	

Endorsement Request Form – Letter of Support (LOS) & Use of Logo

8. Time frame during which CalOptima's name or logo will be used.	
9. Please provide a LOS template letter and/or mock-up of how CalOptima's name or logo will be used.	

Endorsement Transmittal Form: Letter of Support (LOS) & Use of Logo

Guidelines for Endorsements by CalOptima

A CalOptima endorsement is given to projects and programs that are strongly aligned with our mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. Endorsements are considered for programs and projects that have:

1. Have tThe potential for the Endorsement or LOS to create positive visibility for CalOptima; and

2. The potential to create a long-term collaborative partnership between CalOptima and the requesting entity.
2. Whether the Endorsement LOS would pPromote or advocate positions that are consistent with CalOptima's mission, programs, standards and purposes; and.

3. CalOptima will also consider wWhether the Endorsement or LOS may conflict with CalOptima with CalOptima policies and/or applicable local, state and federal laws and regulations, and/or whether the Endorsement or LOS could constitute any real or perceived conflict of interest.
4.

Organization: _____

Endorsement Needed By: _____

Today's Date: _____

Endorsement Review					
Required to go to the Board: ☐ No ☐ Yes (If approved by CEO)					
Name	**Signature**	**Date**	**Decision**		**Remarks**
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
CEO Approved:			**Date:**		

For PA Department Use Only	
Notification Sent:	
Reported for Board Update:	
Posted on CalOptima Website:	

Back to Agenda Back to Item

Notes:	

Revised ~~08/15/2010~~1/26/17

Endorsement Transmittal Form: Letter of Support (LOS) & Use of Logo

Guidelines for Endorsements by CalOptima

A CalOptima endorsement is given to projects and programs that are strongly aligned with our mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. Endorsements are considered for programs and projects that:

1. Have the potential for the Endorsement or LOS to create positive visibility for CalOptima; and

2. Promote or advocate positions that are consistent with CalOptima's mission, programs, standards and purposes.

CalOptima will also consider whether the Endorsement or LOS may conflict with CalOptima policies and/or applicable local, state and federal laws and regulations, and/or whether the Endorsement or LOS could constitute any real or perceived conflict of interest.

Organization: _____

Endorsement Needed By: _____

Today's Date: _____

Endorsement Review					
Required to go to the Board: ☐ **No** ☐ **Yes (If approved by CEO)**					
Name	**Signature**	**Date**	**Decision**		**Remarks**
			☐ **Yes**	☐ **No**	
			☐ **Yes**	☐ **No**	
			☐ **Yes**	☐ **No**	
			☐ **Yes**	☐ **No**	
			☐ **Yes**	☐ **No**	
			☐ **Yes**	☐ **No**	
CEO Approved:			**Date:**		

For PA Department Use Only	
Notification Sent:	
Reported for Board Update:	
Posted on CalOptima Website:	
Notes:	

Policy #:	AA.1223
Title:	**Participation in Community Events Involving External Entities**
Department:	Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	02/02/17
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy establishes guidelines for CalOptima's Participation in community events, programs, projects, and activities involving external entities.

II. POLICY

A. CalOptima recognizes the value of partnering with external entities to provide additional health care related services of benefit to the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for CalOptima's Participation in community events involving external entities, financially, or otherwise, shall be approved only if:

1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of healthcare; and

3. In accordance with this Policy.

B. An external entity may be eligible for CalOptima's Participation in its event if the entity is a community-based, non-profit organization, or health care partner (collectively, "external entities") that serves CalOptima members, or supports CalOptima's mission. Religious organizations are not eligible for CalOptima's Participation unless the event is open to the general public and is for a non-sectarian purpose.

C. The expenditure of CalOptima's funds shall only be made for a direct and primary public purpose within CalOptima's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima's authority and jurisdiction, CalOptima shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not use CalOptima's Participation in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

D. CalOptima's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima representative;

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2. A presentation, or panel presentation, by a CalOptima representative;

3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members and/or potential members who could be enrolled in any of CalOptima's programs; or

4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima.

E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (*e.g.*, United Way, etc.), may be permitted based on a finding by the CalOptima Board of Directors that the request for financial Participation falls within CalOptima's authority and purpose, and meets one (1) of the following criteria:

1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides; or

2. There is an identifiable benefit to CalOptima and/or its members.

F. The expenditure of CalOptima funds and the use of resources, staff time, and CalOptima facilities shall not be inconsistent with, or in conflict with, CalOptima's obligations under applicable state and federal laws and contracts.

G. Requests for Participation by CalOptima in an event proposed by an external entity shall require approval as follows:

1. Requests for Participation, other than financial contributions, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:

a. Requests for non-financial Participation from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.

b. The Chief Executive Officer (CEO), or his/her designee, is authorized to approve non-financial requests from external entities for community/member oriented events that meet the eligibility requirements as provided in this Policy.

c. Non-financial Participation requests from external entities for community/member oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected

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number of attendees, primary demographics of people served, purpose and outcome of the proposed event, and description of CalOptima's Participation in the event.

2. Requests for financial Participation, up to and including, a cumulative value of one thousand dollars ($1,000) per organization per fiscal year, which shall include all materials and supplies:

   a. Requests for financial Participation in an amount up to and including one thousand dollars ($1,000) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, so long as such request is submitted to the CEO in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

   b. The CEO, or his/her designee, is authorized to approve requests for financial Participation for qualifying external entities and events for a cumulative amount of up to and including one thousand dollars ($1,000) per organization per fiscal year, subject to availability of budgeted funds.

   c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

      i. Member interaction/enrollment – The activity shall include participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

      ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

   d. The CEO, or his/her designee, is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

   e. The CEO, or his/her designee, will report all approved Participation in events involving financial Participation in an amount up to and including one thousand dollars ($1,000) per organization per fiscal year to the CalOptima Board of Directors in the CEO's regular Board communications, including, but not limited to, the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

3. Requests for financial Participation in amounts of more than one thousand dollars ($1,000) per organization per fiscal year:

   a. Requests for financial Participation for the amount of more than one thousand dollars ($1,000) per organization per fiscal year shall be submitted no less than sixty (60) calendar days in advance of the date of the event.

DRAFT

b. Financial requests from qualified external entities for eligible events valued at more than one thousand dollars ($1,000) require approval from the CalOptima Board of Directors and a finding that such financial Participation is in the public good, subject to availability of budgeted funds, and within CalOptima's authority and statutory purpose.

c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's program, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose, and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

d. The CEO is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

e. The CEO, or his/her designee, will report all approved Participation in events involving financial Participation in amounts more than one thousand dollars ($1,000) per organization per fiscal year to the CalOptima Board of Directors in the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

4. In determining the value of CalOptima's Participation in events involving external entities, the following factors shall be considered:

a. The use of CalOptima staff time (*e.g.*, in their capacity as a CalOptima employee) to attend events such as health fairs, educational or community events;

b. The use of CalOptima resources (*e.g.*, CalOptima facilities);

c. The use of current, or future, CalOptima eligible funds; and

d. The value of items donated with the CalOptima master brand/logo.

H. In no event shall approval of CalOptima's Participation in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such Participation constitute Endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. Endorsements and use of CalOptima's name, or logo, in any material by an external entity shall be governed by CalOptima Policy AA.1214: Guidelines for Endorsements, for Letters of Support, and Use of CalOptima's Name and Logo.

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I. The CEO, or his/her designee, shall report any Participation approved by the CEO to the CalOptima Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

J. The CEO, or his/her designee, shall provide members of the CalOptima Board of Directors with advanced notice so they have the opportunity to attend events in which CalOptima Participates.

K. Payment for actual and necessary expenses incurred in the course of performing services for CalOptima, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid, according to CalOptima Policy GA.5004: Travel Policy to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima pay, or reimburse, a CalOptima employee for expenses arising from personal expenses, political campaigns, or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

L. In the event CalOptima's Participation in an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima Policy MA.2002: Marketing Activity Standards.

III. PROCEDURE

A. All requests for Participation shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;

2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;

3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;

4. Description of relationship between external entity's work, or event, and CalOptima's programs/lines of business, mission, values, and/or purpose;

5. Description, background, and pertinent information (*e.g.*, names of members of the Board of Directors) regarding the requesting entity and any other entity having a substantial role in the event;

6. A list of other individuals, or entities, supporting the event;

7. Event budget information; and

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8. Purpose, role, and anticipated time commitment for CalOptima's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, CalOptima's Community Relations Department shall:

1. Review and analyze the request to ensure each criteria is met;

2. Complete the Event Participation Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;

3. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be so notified.

C. Upon receipt of the approved request for Participation from the CEO, his/her designee, or the Board of Directors, CalOptima's Community Relations Department shall:

1. Notify the requesting entity of CalOptima's determination; and

2. Process the financial request and any necessary documents within three (3) business days of the determination date.

3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Logo:

1. Requests shall be submitted to CalOptima's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima master logo.

2. Upon receipt of a complete request to distribute items branded with the CalOptima master logo, CalOptima's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. The Community Relations Department shall submit a request to the Chief Executive Officer (CEO), or his/her designee, for approval of a donation of items valued at five dollars ($5), or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CalOptima Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima master logo within three (3) business days of approval.

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7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENTS

A. CalOptima Public Activity Participation Request Form
B. CalOptima Public Activity Transmittal Form

V. REFERENCES

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo
E. CalOptima Policy GA.5004: Travel Policy
F. CalOptima Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

02/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/02/2017	AA.1223	Participation in Community Events Involving External Entities	Administrative

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IX. GLOSSARY

Term	Definition
Endorsement	The support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima does not receive a comparable benefit. Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Marketing Activities	Any activity conducted by or on behalf of CalOptima where information regarding the services offered by CalOptima is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and participation. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of CalOptima.
Participate/ Participation	The provision of financial assistance or in-kind contribution of goods, materials, facilities, staff time, and/or services by CalOptima to an external entity in support of one or more events, programs, projects, and/or activities (collectively, "events") in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose.

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Public Activity Participation Request Form

Requesting Entity: _____

Requesting Entity's principal office/base of operations location: _____

How long Requesting Entity has been operating: _____

Requesting Entity's service area(s): _____

Description of relationship between Requesting Entity's work/event and CalOptima's lines of business, mission, values, and/or purpose: _____

Description, background and pertinent info. (eg. members of Board of Directors) and other entities with a substantial role in event: _____

List of individuals or entities supporting the event: _____

Entity Type: ☐ Non-Profit Org ☐ For-Profit Org ☐ Religious Org ☐ Health Care Partner

Purpose, role and anticipated time commitment for CalOptima's involvement: _____

Section I: Event Details			
Name:			
Day/Date:			
Start Time:		**End Time:**	
Location:			
City:		**Zip Code:**	
POC Name:			
Phone#:		**Fax #:**	
Email:			
Type of Event	☐1 Opportunity to outreach to members or potential members		
	☐2 Opportunity to outreach to health care professionals, non-profit orgs or policy-makers		
	☐3 Other:		
Expected # of Attendees:			
Event Budget:			

Public Activity Participation Request Form

Section II: About the Attendees (check all that apply)				
Primary Language Spoken:	☐ English	☐ Spanish	☐ Vietnamese	☐ Other:

Event for:	☐ Children	☐ Persons with disabilities	
	☐ Low-income families	☐ General public	
	☐ Low-income older adults/seniors	☐ Other:	
Event for CalOptima LOB:	☐ OC/OCC	☐ PACE	☐ Medi-Cal

Section III: Cost to CalOptima to Participate		
Registration Fee:		
Sponsorship Request:	☐ No	☐ Yes, amount:

Section IV: Notes/Comments

Section V: Disclosures
Requests must be submitted to the Community Relations Department: Staff Participation - 14 calendar days in advance; Financial Participation at or under $1,000 - 21 calendar days in advance; Financial Participation more than $1,000 - 60 calendar days in advance. *****All event materials/information must be attached*****

Public Activity Transmittal Form

Please complete your portion of this form and route it in the order indicated below. Please contact Lisa Nguyen at ext. 8809 if you have any questions.

Today's Date: _____ **Complete Routing By:** _____

Routing Order			
1. Department POC:		**Complete Review By:**	
2. Department POC:		**Complete Review By:**	
3. Department POC:		**Complete Review By:**	

For CR Use Only: CR Initial Review		
Requests for CalOptima's Participation in community events involving external entities must be:		
1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.	☐ Yes	☐ No
2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of health care; and	☐ Yes	☐ No
3. In accordance with Policy AA.1223: Participation in Community Events Involving External Entities	☐ Yes	☐ No
CalOptima's Participation shall include at least one (1) of the following:		
1. A speaking opportunity for a CalOptima representative	☐ Yes	☐ No
2. A presentation, or panel presentation, by a CalOptima representative	☐ Yes	☐ No
3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members/potential members	☐ Yes	☐ No
4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima	☐ Yes	☐ No
Financial Participation must meet one (1) of the following criteria, if applicable:		
1. The financial participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides	☐ Yes	☐ No
2. There is an identifiable benefit to CalOptima and/or its members	☐ Yes	☐ No

Other considerations:		
Process as an Endorsement (i.e. policy AA.1214)	☐ Yes	☐ No
Event affiliated with a member of the Board, MAC, PAC, or Employee	☐ Yes	☐ No
Request Legal Review (i.e. conflict analysis)	☐ Yes	☐ No
Included in budget	☐ Yes, amount	☐ No
CalOptima participated in the past	☐ Yes, year(s)	☐ No
Notes:		

CR Participation Commitment:	**YES**	**NO**	**N/A**
Assume "Lead Department" role	☐ Staff:	☐	☐
Assume "Support Department" role	☐ Staff:	☐	☐
Provide financial support (i.e. registration fee, sponsorship, etc.)	☐ Amount:	☐	☐

Revised 01/26/17

Back to Agenda Back to Item

Public Activity Transmittal Form

Provide promotional items	☐	☐	☐
Provide brochures/educational materials	☐	☐	☐
Other:	☐ Specify:	☐	☐
Notes:			

Signature Required Only for Sponsorships, Endorsements and Registration Fees.

Date:

Tiffany Kaaiakamanu, Manager of Community Relations

***CalOptima's CEO has delegated authority to approve requests for financial participation in an amount up to and including $1,000 if it is determined that CalOptima's participation is of public purpose.**

Revised 01/26/17

Back to Agenda

Back to Item

Policy:	AA.1223
Title:	**Participation in Community Events by External Entities**
Department:	CalOptima Administrative
Section:	Strategic Development, Community Relations
CEO Approval:	*/s/*
Effective Date:	02/02/2017
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20210805 BOD Review Only

I. PURPOSE

This policy establishes guidelines for CalOptima's Participation in community events, programs, projects, and activities involving external entities.

II. POLICY

A. CalOptima recognizes the value of partnering with external entities to provide additional health care related services of benefit to the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for CalOptima's Participation in community events involving external entities, financially, or otherwise, shall be approved only if:

1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of healthcare; and

3. In accordance with this Policy.

B. An external entity may be eligible for CalOptima's Participation in its event if the entity is a community-based, non-profit organization, health care partner, public or government entity (collectively, "external entities") that serves CalOptima members~~,~~ or supports CalOptima's mission. Religious organizations are not eligible for CalOptima's Participation unless the event is open to the general public and is for a non-~~—~~sectarian purpose.

C. The expenditure of CalOptima's funds shall only be made for a direct and primary public purpose within CalOptima's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima's authority and jurisdiction, CalOptima shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not use CalOptima's Participation in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

Back to Agenda Back to Item

D. CalOptima's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima representative;

2. A presentation, or panel presentation, by a CalOptima representative;

3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members and/or potential members who could be enrolled in any of CalOptima's programs; or

4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima.

E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (*e.g.*, United Way, etc.), may be permitted based on a finding by the CalOptima Board of Directors that the request for financial Participation falls within CalOptima's authority and purpose, and meets one (1) of the following criteria:

1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides; or

2. There is an identifiable benefit to CalOptima and/or its members.

F. The expenditure of CalOptima funds and the use of resources, staff time, and CalOptima facilities shall not be inconsistent with, or in conflict with, CalOptima's obligations under applicable state and federal laws and contracts.

G. Requests for Participation by CalOptima in an event proposed by an external entity shall require approval as follows:

1. Requests for Participation, other than financial contributions, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:

a. Requests for non-financial Participation from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.

b. The Chief Executive Officer (CEO~~),~~) or his/her designee~~,~~ is authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.

c. Non-financial Participation requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of ~~–~~the proposed event, and description of CalOptima's Participation in the event.

For 20210805 BOD Review Only

2. Requests for financial Participation, up to and including, a cumulative value of ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year, which shall include all materials and supplies:

   a. Requests for financial Participation in an amount up to and including ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, ~~-~~in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

   b. The CEO~~,~~ or his/her designee~~,~~ is authorized to approve requests for financial Participation for qualifying external entities and events for a cumulative amount of up to and including ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year, subject to availability of budgeted funds.

   c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

      i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

      ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

   d. The CEO~~,~~ or his/her designee~~,~~ is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

   e. The CEO~~,~~ or his/her designee~~,~~ will report all approved Participation in events involving financial Participation in an amount up to and including ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year to the CalOptima Board of Directors in the CEO's regular~~-~~ Board communications, including, but not limited to, the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

3. Requests for financial Participation in amounts of more than ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year:

   a. Requests for financial Participation for the amount of more than ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year shall be submitted no less than sixty (60) calendar days in advance of the date of the event.

   b. Financial requests from qualified external entities for eligible events valued at more than ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) require approval from the CalOptima Board of Directors and a finding that such financial Participation is in the public good, subject to availability of budgeted funds, and within CalOptima's authority and statutory purpose.

For 20210805 BOD Review Only

c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's program, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose, and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

d. The CEO~~,~~ or his/her designee~~,~~ is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

e. The CEO~~,~~ or his/her designee~~,~~ will report all approved Participation in events involving financial Participation in amounts more than ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year to the CalOptima Board of Directors in the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

4. In determining the value of CalOptima's Participation in events involving external entities, the following factors shall be considered:

a. The use of CalOptima staff time (*e.g.*, in their capacity as a CalOptima employee) to attend events such as health fairs, educational or community events;

b. The use of CalOptima resources (*e.g.*, CalOptima facilities);

c. The use of current, or future, CalOptima eligible funds; and

d. The value of items donated with the CalOptima master brand/logo.

H. In no event shall approval of CalOptima's Participation in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such Participation constitute Endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. Endorsements and use of CalOptima's name, or logo, in any material by an external entity shall be governed by CalOptima Policy AA.1214: Guidelines for Endorsements, for Letters of Support, and Use of CalOptima's Name and Logo.

I. The CEO~~,~~ or his/her designee~~,~~ shall report any Participation approved by the CEO to the CalOptima Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

J. The CEO~~,~~ or his/her designee~~,~~ shall provide members of the CalOptima Board of Directors with advanced notice so they have the opportunity to attend events in which CalOptima Participates.

For 20210805 BOD Review Only

K. Payment for actual and necessary expenses incurred in the course of performing services for CalOptima, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid~~, according to~~ in accordance with CalOptima Policy GA.5004: Travel Policy, to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima pay~~,~~ or reimburse~~,~~ a CalOptima employee for expenses arising from personal expenses, political campaigns~~,~~ or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

L. In the event CalOptima's Participation in an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima ~~Policy~~Policies MA.2002: Marketing Activity Standards and PA.2010: Enrollment and Intake.

III. PROCEDURE

A. All requests for Participation shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;

2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;

3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;

4. Description of relationship between external entity's work, or event, and CalOptima's programs/lines of business, mission, values, and/or purpose;

5. Description, background, and pertinent information (*e.g.*, names of members of the Board of Directors) regarding the requesting entity and any other entity having a substantial role in the event;

6. A list of other individuals, or entities, supporting the event;

7. Event budget information; and

8. Purpose, role, and anticipated time commitment for CalOptima's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, CalOptima's Community Relations Department shall:

1. Review and analyze the request to ensure each criteria is met;

2. Complete the Event Participation Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;

For 20210805 BOD Review Only

3. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be so notified.

C. Upon receipt of the approved request for Participation from the CEO, his/her designee, or the Board of Directors, CalOptima's Community Relations Department shall:

1. Notify the requesting entity of CalOptima's determination; and

2. Process the financial request and any necessary documents within three (3) business days of the determination date.

3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Logo:

1. Requests shall be submitted to CalOptima's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima master logo.

2. Upon receipt of a complete request to distribute items branded with the CalOptima master logo, CalOptima's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. The Community Relations Department shall submit a request to the Chief Executive Officer (CEO~~),~~) or his/her designee~~,~~ for approval of a donation of items valued at five dollars ($5~~),~~) or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CalOptima Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima master logo within three (3) business days of approval.

7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENT(S)

A. CalOptima Public Activity Participation Request Form
B. CalOptima Public Activity Transmittal Form

V. REFERENCE(S)

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo
D. CalOptima Policy GA.5004: Travel Policy

For 20210805 BOD Review Only

E. CalOptima Policy MA.2002: Marketing Activity Standards
F. CalOptima Policy PA.2010: Enrollment and Intake

VI. REGULATORY AGENCY APPROVAL

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	02/02/2017	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2018	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	02/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	10/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	TBD	AA.1223	Participation in Community Events by External Entities	Administrative

For 20210805 BOD Review Only

IX. GLOSSARY

Term	Definition
Endorsement	~~The~~For purposes of this policy, the support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima does not receive a comparable benefit. ~~-~~Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Marketing Activities	~~Any~~For purposes of this policy, any activity conducted by or on behalf of CalOptima where information regarding the services offered by CalOptima is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and Participation. Marketing also includes any similar activity to secure the Endorsement of any individual or organization on behalf of CalOptima.
Participate/ Participation	For purposes of this policy, this is the provision of financial assistance or in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima to an external entity in support of one or more events, programs, projects, and/or activities (collectively, "events") in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose.

For 20210805 BOD Review Only

Policy:	AA.1223
Title:	**Participation in Community Events by External Entities**
Department:	CalOptima Administrative
Section:	Strategic Development, Community Relations
CEO Approval:	*/s/*
Effective Date:	02/02/2017
Revised Date:	TBD

Applicable to:
- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☒ Administrative

For 20210805 BOD Review Only

I. PURPOSE

This policy establishes guidelines for CalOptima's Participation in community events, programs, projects, and activities involving external entities.

II. POLICY

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1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of healthcare; and

3. In accordance with this Policy.

B. An external entity may be eligible for CalOptima's Participation in its event if the entity is a community-based, non-profit organization, health care partner, public or government entity (collectively, "external entities") that serves CalOptima members or supports CalOptima's mission. Religious organizations are not eligible for CalOptima's Participation unless the event is open to the general public and is for a non-sectarian purpose.

C. The expenditure of CalOptima's funds shall only be made for a direct and primary public purpose within CalOptima's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima's authority and jurisdiction, CalOptima shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not use CalOptima's Participation in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

Back to Agenda Back to Item

D. CalOptima's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima representative;

2. A presentation, or panel presentation, by a CalOptima representative;

3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members and/or potential members who could be enrolled in any of CalOptima's programs; or

4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima.

E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (*e.g.*, United Way, etc.), may be permitted based on a finding by the CalOptima Board of Directors that the request for financial Participation falls within CalOptima's authority and purpose, and meets one (1) of the following criteria:

1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides; or

2. There is an identifiable benefit to CalOptima and/or its members.

F. The expenditure of CalOptima funds and the use of resources, staff time, and CalOptima facilities shall not be inconsistent with, or in conflict with, CalOptima's obligations under applicable state and federal laws and contracts.

G. Requests for Participation by CalOptima in an event proposed by an external entity shall require approval as follows:

1. Requests for Participation, other than financial contributions, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:

a. Requests for non-financial Participation from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.

b. The Chief Executive Officer (CEO) or his/her designee is authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.

c. Non-financial Participation requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, and description of CalOptima's Participation in the event.

For 20210805 BOD Review Only

2. Requests for financial Participation, up to and including, a cumulative value of two thousand five hundred dollars ($2,500) per organization per fiscal year, which shall include all materials and supplies:

   a. Requests for financial Participation in an amount up to and including two thousand five hundred dollars ($2,500) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

   b. The CEO or his/her designee is authorized to approve requests for financial Participation for qualifying external entities and events for a cumulative amount of up to and including two thousand five hundred dollars ($2,500) per organization per fiscal year, subject to availability of budgeted funds.

   c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

      i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

      ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

   d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

   e. The CEO or his/her designee will report all approved Participation in events involving financial Participation in an amount up to and including two thousand five hundred dollars ($2,500) per organization per fiscal year to the CalOptima Board of Directors in the CEO's regular Board communications, including, but not limited to, the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

3. Requests for financial Participation in amounts of more than two thousand five hundred dollars ($2,500) per organization per fiscal year:

   a. Requests for financial Participation for the amount of more than two thousand five hundred dollars ($2,500) per organization per fiscal year shall be submitted no less than sixty (60) calendar days in advance of the date of the event.

   b. Financial requests from qualified external entities for eligible events valued at more than two thousand five hundred dollars ($2,500) require approval from the CalOptima Board of Directors and a finding that such financial Participation is in the public good, subject to availability of budgeted funds, and within CalOptima's authority and statutory purpose.

For 20210805 BOD Review Only

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4. In determining the value of CalOptima's Participation in events involving external entities, the following factors shall be considered:

a. The use of CalOptima staff time (*e.g.*, in their capacity as a CalOptima employee) to attend events such as health fairs, educational or community events;

b. The use of CalOptima resources (*e.g.*, CalOptima facilities);

c. The use of current, or future, CalOptima eligible funds; and

d. The value of items donated with the CalOptima master brand/logo.

H. In no event shall approval of CalOptima's Participation in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such Participation constitute Endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. Endorsements and use of CalOptima's name, or logo, in any material by an external entity shall be governed by CalOptima Policy AA.1214: Guidelines for Endorsements, for Letters of Support, and Use of CalOptima's Name and Logo.

I. The CEO or his/her designee shall report any Participation approved by the CEO to the CalOptima Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

J. The CEO or his/her designee shall provide members of the CalOptima Board of Directors with advanced notice so they have the opportunity to attend events in which CalOptima Participates.

For 20210805 BOD Review Only

K. Payment for actual and necessary expenses incurred in the course of performing services for CalOptima, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid in accordance with CalOptima Policy GA.5004: Travel Policy, to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima pay or reimburse a CalOptima employee for expenses arising from personal expenses, political campaigns or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

L. In the event CalOptima's Participation in an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima Policies MA.2002: Marketing Activity Standards and PA.2010: Enrollment and Intake.

III. PROCEDURE

A. All requests for Participation shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;

2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;

3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;

4. Description of relationship between external entity's work, or event, and CalOptima's programs/lines of business, mission, values, and/or purpose;

5. Description, background, and pertinent information (*e.g.*, names of members of the Board of Directors) regarding the requesting entity and any other entity having a substantial role in the event;

6. A list of other individuals, or entities, supporting the event;

7. Event budget information; and

8. Purpose, role, and anticipated time commitment for CalOptima's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, CalOptima's Community Relations Department shall:

1. Review and analyze the request to ensure each criteria is met;

2. Complete the Event Participation Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;

For 20210805 BOD Review Only

3. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be so notified.

C. Upon receipt of the approved request for Participation from the CEO, his/her designee, or the Board of Directors, CalOptima's Community Relations Department shall:

1. Notify the requesting entity of CalOptima's determination; and

2. Process the financial request and any necessary documents within three (3) business days of the determination date.

3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Logo:

1. Requests shall be submitted to CalOptima's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima master logo.

2. Upon receipt of a complete request to distribute items branded with the CalOptima master logo, CalOptima's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. The Community Relations Department shall submit a request to the Chief Executive Officer (CEO) or his/her designee for approval of a donation of items valued at five dollars ($5) or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CalOptima Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima master logo within three (3) business days of approval.

7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENT(S)

A. CalOptima Public Activity Participation Request Form
B. CalOptima Public Activity Transmittal Form

V. REFERENCE(S)

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo
D. CalOptima Policy GA.5004: Travel Policy

For 20210805 BOD Review Only

E. CalOptima Policy MA.2002: Marketing Activity Standards
F. CalOptima Policy PA.2010: Enrollment and Intake

VI. REGULATORY AGENCY APPROVAL

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	02/02/2017	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2018	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	02/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	10/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	TBD	AA.1223	Participation in Community Events by External Entities	Administrative

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IX. GLOSSARY

Term	Definition
Endorsement	For purposes of this policy, the support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima does not receive a comparable benefit. Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Marketing Activities	For purposes of this policy, any activity conducted by or on behalf of CalOptima where information regarding the services offered by CalOptima is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and Participation. Marketing also includes any similar activity to secure the Endorsement of any individual or organization on behalf of CalOptima.
Participate/ Participation	For purposes of this policy, this is the provision of financial assistance or in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima to an external entity in support of one or more events, programs, projects, and/or activities (collectively, "events") in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose.

For 20210805 BOD Review Only

Public Activity Participation Request Form

Requesting Entity:	
Requesting Entity's Principal Office/ Base Operations Location:	
How long Requesting Entity has been operating:	
Requesting Entity's service areas:	
Description of relationship between Requesting Entity's work/event and CalOptima's lines of business, mission, values, and/or purpose:	
Description, background and pertinent information (eg. Members of Board of Directors) and other entities with a substantial role in event:	
List of individuals or entities supporting the event:	
Entity Type:	Non-Profit Org ___ For-Profit Org ___ Religious Org ___ Health Care Partner

Section I: Event Details			
Name:			
Day/Date:			
Start Time:		**End Time:**	
Location:			
City:		**Zip Code:**	
POC Name:			
Phone#:		**Fax #:**	
Email:			
Type of Event	___ 1 Opportunity to outreach to members or potential members		
	___ 2 Opportunity to outreach to health care professionals, non-profit orgs or policy-makers		
	___ 3 Other:		
Expected # of Attendees:			

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Public Activity Participation Request Form

Section II: About the Attendees (check all that apply)				
Primary Language Spoken:	☐ English	☐ Spanish	☐ Vietnamese	☐ Other:

Event for:	☐ Children	☐ Persons with disabilities	
	☐ Low-income families	☐ General public	
	☐ Low-income older adults/seniors	☐ Other:	
Event for CalOptima LOB:	☐ OC/OCC	☐ PACE	☐ Medi-Cal

Section III: Cost to CalOptima to Participate		
Registration Fee:	☐ No	☐ Yes, amount:
Sponsorship Request:	☐ No	☐ Yes, amount:

Section IV: Notes/Comments

Section V: Disclosures

Requests must be submitted to the Community Relations Department: Staff Participation (14) days in advance; Financial Participation at or under $2,5001,000 (21) days in advance; Financial Participation more than $2,5001,000 (60) days in advance.

*****All event materials/information must be attached*****

For 20210805 BOD Review Only

Public Activity Participation Request Form

Requesting Entity:	
Requesting Entity's Principal Office/ Base Operations Location:	
How long Requesting Entity has been operating:	
Requesting Entity's service areas:	
Description of relationship between Requesting Entity's work/event and CalOptima's lines of business, mission, values, and/or purpose:	
Description, background and pertinent information (eg. Members of Board of Directors) and other entities with a substantial role in event:	
List of individuals or entities supporting the event:	
Entity Type:	Non-Profit Org ___ For-Profit Org ___ Religious Org ___ Health Care Partner

Section I: Event Details			
Name:			
Day/Date:			
Start Time:		**End Time:**	
Location:			
City:		**Zip Code:**	
POC Name:			
Phone#:		**Fax #:**	
Email:			
Type of Event	___ 1 Opportunity to outreach to members or potential members		
	___ 2 Opportunity to outreach to health care professionals, non-profit orgs or policy-makers		
	___ 3 Other:		
Expected # of Attendees:			

For 20210805 BOD Review Only

Public Activity Participation Request Form

Section II: About the Attendees (check all that apply)				
Primary Language Spoken:	☐ English	☐ Spanish	☐ Vietnamese	☐ Other:

Event for:	☐ Children	☐ Persons with disabilities	
	☐ Low-income families	☐ General public	
	☐ Low-income older adults/seniors	☐ Other:	
Event for CalOptima LOB:	☐ OC/OCC	☐ PACE	☐ Medi-Cal

Section III: Cost to CalOptima to Participate		
Registration Fee:	☐ No	☐ Yes, amount:
Sponsorship Request:	☐ No	☐ Yes, amount:

Section IV: Notes/Comments

Section V: Disclosures

Requests must be submitted to the Community Relations Department: Staff Participation (14) days in advance; Financial Participation at or under $2,500 (21) days in advance; Financial Participation more than $2,500 (60) days in advance.

*****All event materials/information must be attached*****

For 20210805 BOD Review Only

Public Activity Transmittal Form

Please complete your portion of this form and route it in the order indicated below. Please contact Lisa Nguyen at ext. 8809 if you have any questions.

Today's Date:_____ Complete Routing By: _____

Routing Order			
1. Department POC:		**Complete Review By:**	
2. Department POC:		**Complete Review By:**	
3. Department POC:		**Complete Review By:**	

For CR Use Only: CR Initial Review

Requests for CalOptima's Participation in community events involving external entities must be:

1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.	☐ Yes	☐ No
2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of health care; and	☐ Yes	☐ No
3. In accordance with Policy AA.1223: Participation in Community Events Involving External Entities	☐ Yes	☐ No

CalOptima's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima representative	☐ Yes	☐ No
2. A presentation, or panel presentation, by a CalOptima representative	☐ Yes	☐ No
3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members/potential members	☐ Yes	☐ No
4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima	☐ Yes	☐ No

Financial Participation must meet one (1) of the following criteria, if applicable:

1. The financial participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides	☐ Yes	☐ No
2. There is an identifiable benefit to CalOptima and/or its members	☐ Yes	☐ No

Board of Directors Approval Required if an Entity Exceeds the $2,5001,000 per Fiscal Year Limit:

1. Is the requesting entity acting as the fiscal agent?	☐ Yes	☐ No
2. Has CalOptima provided prior financial sponsorship to the requesting entity within the current fiscal year?	☐ Yes	☐ No
3. Does the cumulative total for this FY exceed the $2,5001,000 limit per entity, which requires Board approval?	☐ Yes	☐ No
4. If yes, then date of Board of Directors approval:		

Other considerations:

For 20210805 BOD Review Only

Public Activity Transmittal Form

Process as an Endorsement (i.e. policy AA.1214)	☐ Yes	☐ No
Event affiliated with a member of the Board, MAC, PAC, or Employee	☐ Yes	☐ No
Request Legal Review (i.e. conflict analysis)	☐ Yes	☐ No
Included in budget	☐ Yes, amount	☐ No
CalOptima participated in the past	☐ Yes, year(s)	☐ No

Notes:

CR Participation Commitment:	**YES**	**NO**	**NA**
Assume "Lead Department" role	☐ Staff:	☐	☐
Assume "Support Department" role	☐ Staff:	☐	☐
Provide financial support (i.e. registration fee, sponsorship, etc.)	☐ Amount:	☐	☐
Provide promotional items	☐	☐	☐
Provide brochures/educational materials	☐	☐	☐
Other:	☐ Specify:	☐	☐

Note:

Signature Required Only for Sponsorships, Endorsements and Registration Fees.

Date:

Tiffany Kaaiakamanu, Manager of Community Relations

***CalOptima's CEO has delegated authority to approve requests for financial participation in an amount up to and including $2,5001,000 if it is determined that CalOptima's participation is of public purpose.**

For 20210805 BOD Review Only

Public Activity Transmittal Form

Please complete your portion of this form and route it in the order indicated below. Please contact Lisa Nguyen at ext. 8809 if you have any questions.

Today's Date:_____ Complete Routing By: _____

Routing Order			
1. Department POC:		**Complete Review By:**	
2. Department POC:		**Complete Review By:**	
3. Department POC:		**Complete Review By:**	

For CR Use Only: CR Initial Review

Requests for CalOptima's Participation in community events involving external entities must be:

1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.	☐ Yes	☐ No
2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of health care; and	☐ Yes	☐ No
3. In accordance with Policy AA.1223: Participation in Community Events Involving External Entities	☐ Yes	☐ No

CalOptima's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima representative	☐ Yes	☐ No
2. A presentation, or panel presentation, by a CalOptima representative	☐ Yes	☐ No
3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members/potential members	☐ Yes	☐ No
4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima	☐ Yes	☐ No

Financial Participation must meet one (1) of the following criteria, if applicable:

1. The financial participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides	☐ Yes	☐ No
2. There is an identifiable benefit to CalOptima and/or its members	☐ Yes	☐ No

Board of Directors Approval Required if an Entity Exceeds the $2,500 per Fiscal Year Limit:

1. Is the requesting entity acting as the fiscal agent?	☐ Yes	☐ No
2. Has CalOptima provided prior financial sponsorship to the requesting entity within the current fiscal year?	☐ Yes	☐ No
3. Does the cumulative total for this FY exceed the $2,500 limit per entity, which requires Board approval?	☐ Yes	☐ No
4. If yes, then date of Board of Directors approval:		

Other considerations:

For 20210805 BOD Review Only

Public Activity Transmittal Form

Process as an Endorsement (i.e. policy AA.1214)	☐ Yes	☐ No
Event affiliated with a member of the Board, MAC, PAC, or Employee	☐ Yes	☐ No
Request Legal Review (i.e. conflict analysis)	☐ Yes	☐ No
Included in budget	☐ Yes, amount	☐ No
CalOptima participated in the past	☐ Yes, year(s)	☐ No

Notes:

CR Participation Commitment:	**YES**	**NO**	**NA**
Assume "Lead Department" role	☐ Staff:	☐	☐
Assume "Support Department" role	☐ Staff:	☐	☐
Provide financial support (i.e. registration fee, sponsorship, etc.)	☐ Amount:	☐	☐
Provide promotional items	☐	☐	☐
Provide brochures/educational materials	☐	☐	☐
Other:	☐ Specify:	☐	☐

Note:

Signature Required Only for Sponsorships, Endorsements and Registration Fees.

Date:

Tiffany Kaaiakamanu, Manager of Community Relations

***CalOptima's CEO has delegated authority to approve requests for financial participation in an amount up to and including $2,500 if it is determined that CalOptima's participation is of public purpose.**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Approving CalOptima Positions on Proposed Legislation

Contacts
Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Actions
1. Approve CalOptima's formal positions on proposed legislation, as follows:
    a. H.R. 2166 (Sewell): Support
    b. S. 764 (Wyden)/H.R. 1914 (DeFazio): Support
2. Authorize the Chief Executive Officer, or designee, to implement legislative education and advocacy efforts in alignment with the approved CalOptima positions.

Background
As part of its Government Affairs program, CalOptima staff track and analyze state and federal legislation that may impact CalOptima and its members, providers and other stakeholders. Staff also engage with federal and state trade associations, federal and state advocates, and elected officials at all levels of government to educate them on how proposed legislation and regulatory guidance may impact CalOptima. Subject to Board direction, these efforts may include advocating for or against legislation in the United States Congress and California State Legislature in alignment with CalOptima's 2020–22 Strategic Plan, 2021–22 Legislative Platform and/or other agency goals and policy priorities.

On April 1, 2021, the Board adopted CalOptima's 2021–22 Legislative Priorities and Legislative Platform to help guide legislative advocacy efforts by staff.

Summary
Staff recommends approval of CalOptima's formal positions on proposed legislation, as follows:

Bill Number (Author)	Bill Title	Summary/Impact	Legislative Priority Areas	Recommended Position
H.R. 2166 (Sewell)	Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021	Would require the Centers for Medicare & Medicaid Services (CMS) to include audio-only telehealth diagnoses in the determination of risk adjustment payments for Medicare Advantage and Program of All-Inclusive Care for the	Telehealth Services	**SUPPORT**

Back to Agenda

Bill Number (Author)	Bill Title	Summary/Impact	Legislative Priority Areas	Recommended Position
		Elderly (PACE) plans during the COVID-19 pandemic. This would ensure accurate risk scores and appropriate plan payments for CalOptima's OneCare, OneCare Connect and PACE programs.		
S. 764 (Wyden) H.R. 1914 (DeFazio)	Crisis Assistance Helping Out on the Streets (CAHOOTS) Act	Would allow state Medicaid programs to cover 24/7 mobile crisis intervention services for those experiencing a mental health or substance use disorder crisis. Would provide states with a 95% Federal Medical Assistance Percentage to cover such services for three years as well as a total of $25 million in planning grants.	Response to COVID-19 Medi-Cal Managed Care: Operations & Administration	**SUPPORT**

A detailed summary and impact analysis of the proposed legislation, as well as the current text of the proposed legislation, are included as attachments.

Staff also recommends authorization for the Chief Executive Officer, or designee, to implement legislative education and advocacy efforts in alignment with the approved positions. These efforts may include executing letters expressing CalOptima's positions to legislators or other government officials, meeting with such officials or their staff, and/or directing CalOptima's contracted lobbyists to advocate the approved positions on behalf of CalOptima.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Educating stakeholders and proactive engagement with trade associations, advocates and elected officials is critical to influencing policy decisions that are likely to impact CalOptima. Based on

discussions with CalOptima's contracted lobbyists and trade associations, staff recommends that CalOptima takes formal positions on the referenced proposed legislation.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Legislative Analysis: H.R. 2166
2. Current Text of H.R. 2166 (as of March 23, 2021)
3. Legislative Analysis: S. 764/H.R. 1914
4. Current Text of S. 764 (as of March 16, 2021)
5. Current Text of H.R. 1914 (as of March 16, 2021)

/s/ Richard Sanchez *07/28/2021*
Authorized Signature **Date**

Back to Agenda

Legislative Analysis: H.R. 2166

Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021

Background

In response to the COVID-19 pandemic, the Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) expanded access to telehealth services to ensure providers can deliver medically necessary services in a safe manner for Medicare and Medi-Cal beneficiaries. Temporary flexibilities, such as virtual assessments and audio-only telehealth calls, have contributed to an increase in access to providers and use of telehealth services, particularly for CalOptima's Program of All-Inclusive Care for the Elderly (PACE) participants.

At present, CMS only permits diagnoses resulting from in-person or telehealth encounters using both audio and video to be submitted to CMS' Risk Adjustment Processing System (RAPS).

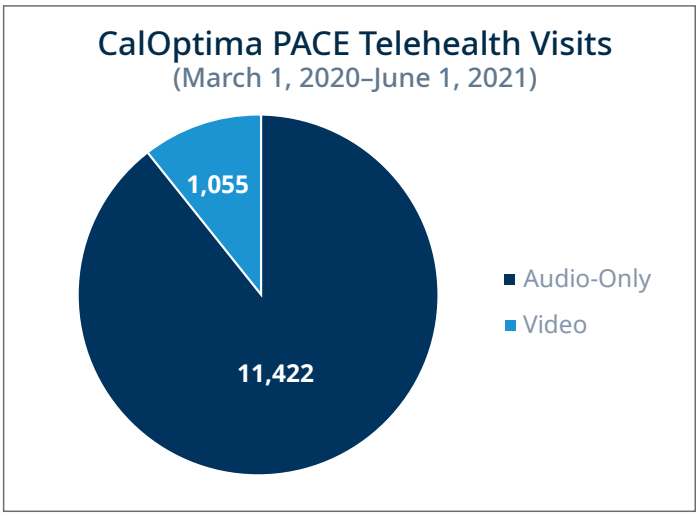
Overview

The Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021 (H.R. 2166) was introduced by U.S. Rep. Terri Sewell. It would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for Medicare Advantage (MA) and PACE plans during the COVID-19 public health emergency. It would also require MA plans to reimburse providers for audio-only telehealth visits at the same rate as in-person visits.

Impact on CalOptima

CalOptima PACE serves nearly 400 participants, all of whom have complex, chronic medical conditions in addition to functional and/or cognitive impairments. In response to the pandemic, PACE participants transitioned to a home-based setting, relying on primarily telephonic interactions to address medical needs.

Almost half of PACE participants live with dementia, and nearly all have a functional limitation that impedes their ability to use video technology. In addition, many PACE participants lack access to technology, such as the internet, computers or smartphone devices. As a result, these participants are unable to connect to providers via video.



CalOptima providers are still able to make diagnoses during an audio-only telehealth visit, particularly for established participants with a chronic illness. Providers are also able to order labs and manage PACE participants appropriately.

PACE participants who have more complex conditions and require face-to-face interventions are seen at the PACE clinic or sent to the emergency department if needed.

Requiring interactive video for telehealth encounters to be eligible for risk adjustment poses a barrier for PACE, since the majority of encounters have been audio-only. Without the ability to submit resulting diagnoses into RAPS, risk scores and capitation rates remain the same, even if the cost of care increases. To ensure accurate risk scores and appropriate plan payments, audio-only encounters need to be included in risk adjustment calculations.

CalOptima also has 16,500 members in two Medicare programs, OneCare and OneCare Connect. However, it is unknown how many members use audio-only telehealth services due to a discrepancy in how providers bill for telehealth services.

Recommended Action: Support

CalOptima staff recommends formal support of H.R. 2166.

117TH CONGRESS
1ST SESSION

H. R. 2166

To amend title XVIII of the Social Security Act to require the inclusion of certain audio-only diagnoses in the determination of risk adjustment for Medicare Advantage plans and PACE programs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 23, 2021

Ms. SEWELL (for herself, Mr. BILIRAKIS, Mr. CÁRDENAS, Mrs. WALORSKI, Mr. KIND, Mr. SMITH of Missouri, Ms. HOULAHAN, and Mr. FITZPATRICK) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to require the inclusion of certain audio-only diagnoses in the determination of risk adjustment for Medicare Advantage plans and PACE programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021".

SEC. 2. REQUIRING THE INCLUSION OF CERTAIN AUDIO-ONLY DIAGNOSES IN THE DETERMINATION OF RISK ADJUSTMENT FOR MEDICARE ADVANTAGE PLANS AND PACE PROGRAMS.

Back to Agenda

Back To Item

(a) IN GENERAL.—Section 1853(a)(1) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)) is amended by adding at the end the following new subparagraph:

"(J) INCLUSION OF CERTAIN AUDIO-ONLY DIAGNOSES FOR PURPOSES OF RISK ADJUSTMENT.—

"(i) IN GENERAL.—For purposes of determining the appropriate adjustment for health status under subparagraph (C)(i) for plan years 2020 and 2021 (and for such other plan years determined appropriate by the Secretary), the Secretary, in determining the diseases or conditions of an individual, shall take into account diagnoses obtained through a telehealth encounter, and in the case of a qualified diagnosis (as defined in clause (ii)) made with respect to such individual by a qualified provider (as so defined), shall not require the use of video communications with respect to such telehealth encounter.

"(ii) DEFINITIONS.—For purposes of this subparagraph:

"(I) QUALIFIED DIAGNOSIS.—The term 'qualified diagnosis' means a diagnosis made with respect to a chronic disease or condition of an individual during a plan year if such diagnosis was also made with respect to such individual in one of the last of the 3 plan years preceding such plan year.

"(II) QUALIFIED PROVIDER.—The term 'qualified provider' means, with respect to a qualified diagnosis made with respect to an individual during a plan year, a provider of services, clinician or supplier that—

"(aa) furnished an item or service to such individual during the 3-year period ending on the date such diagnosis was so made; or

"(bb) is in the same practice (as determined by tax identification number) of a provider of services or supplier who furnished such an item or service to such individual during such period.".

(b) PACE PROGRAM CONFORMING AMENDMENT.—Section 1894(d)(2) of the Social Security Act (42 U.S.C. 1395eee(d)(2)) is amended by adding at the end the following new sentence: "For purposes of applying the adjustment under subparagraph (C)(i) of section 1853(a)(1) to such amounts, subparagraph (J) of such section shall be applied as if each reference to 'plan year' and 'plan years 2020 and 2021' were instead a reference to 'year' and '2020 and 2021', respectively.".

Back to Agenda

Back To Item

SEC. 3. REQUIRING PARITY IN TELEHEALTH PAYMENTS DURING THE COVID–19 EMERGENCY.

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended by adding at the end the following new paragraph:

"(9) SPECIAL RULE FOR TELEHEALTH PAYMENT PARITY DURING THE COVID–19 EMERGENCY.—In the case of a telehealth service furnished during the emergency period described in section 1135(g)(1)(B) for which payment may be made under this subsection (including any service for which payment may be so made due to application of a waiver made under section 1135(b)), the amount of such payment shall be equal to the amount that would have been paid for such service had such service been furnished in-person.".

Back to Agenda

Back To Item

Legislative Analysis: S. 764/H.R. 1914

Crisis Assistance Helping Out On The Streets (CAHOOTS) Act

Background

The American Rescue Plan Act (ARPA) of 2021, signed into law by President Joseph R. Biden Jr. on March 11, 2021, is a comprehensive legislative package to provide relief to individuals and businesses negatively impacted by the COVID-19 pandemic. This includes expanded mental health services to address social isolation, loss and other behavioral health (BH) needs brought upon by the pandemic.

Section 9813 of ARPA allows state Medicaid programs to cover 24/7 community-based mobile crisis intervention services for those experiencing a mental health or substance use disorder crisis. The responding crisis teams must include BH professionals — trained in trauma care and de-escalation techniques — who provide assessment, stabilization and necessary referrals to other services. Mobile crisis services may be covered under a State Plan Amendment (SPA) or waiver.

Section 9813 also provides states with an 85% Federal Medical Assistance Percentage (FMAP) for providing mobile crisis services for three years as well as a total of $15 million in planning grants to assist states in developing an SPA or waiver request. On May 25, 2021, the Centers for Medicare & Medicaid Services (CMS) announced it will solicit applications for state planning grants later this summer.

Overview

The Crisis Assistance Helping Out On The Streets (CAHOOTS) Act (S. 764/H.R. 1914) was introduced by U.S. Sen. Ron Wyden and U.S. Rep. Peter DeFazio. It would expand Section 9813 of ARPA by increasing the FMAP for mobile crisis intervention services to 95% as well as provide an additional total of $25 million in planning grants to states.

S. 764 and H.R. 1914 are currently pending in committees in the U.S. Senate and U.S. House of Representatives.

Impact on CalOptima

Medi-Cal, California's state Medicaid program, would be required to pursue an SPA, Section 1115 demonstration or Section 1915(b) or 1915(c) waiver program request (or amendment) to provide mobile crisis services as a covered benefit and to receive federal funding. Covered mobile crisis services would expand the scope and utilization of BH services provided by CalOptima and the Orange County Health Care Agency (HCA).

HCA currently operates Crisis Assessment Team (CAT) and Psychiatric Emergency and Response Team (PERT) programs, which offer limited mobile crisis services due to Mental Health Services Act (MHSA) funding constraints. In addition to expanding these services, these bills may lead to increased follow-up care by BH providers, CalOptima's BH Integration department and/or the Be Well OC Orange Campus.

Pending guidance from DHCS, mobile crisis intervention services could be covered through the Medi-Cal managed care system, Medi-Cal fee-for-service or County Mental Health Plans.

Recommended Action: Support

CalOptima staff recommends formal support of S. 764 and H.R. 1914.

117TH CONGRESS
1ST SESSION

S. 764

To amend title XIX of the Social Security Act to encourage State Medicaid programs to provide community-based mobile crisis intervention services, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 16, 2021

Mr. WYDEN (for himself, Ms. CORTEZ MASTO, Mr. MERKLEY, Mr. CASEY, Ms. SMITH, Mrs. FEINSTEIN, Mr. WHITEHOUSE, and Mr. SANDERS) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XIX of the Social Security Act to encourage State Medicaid programs to provide community-based mobile crisis intervention services, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Crisis Assistance Helping Out On The Streets Act" or the "CAHOOTS Act".

SEC. 2. ENHANCED FEDERAL MEDICAID SUPPORT FOR COMMUNITY-BASED MOBILE CRISIS INTERVENTION SERVICES.

Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

Back to Agenda

Back To Item

"(cc) COMMUNITY-BASED MOBILE CRISIS INTERVENTION SERVICES.—

"(1) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to Statewideness), section 1902(a)(10)(B) (relating to comparability), section 1902(a)(23)(A) (relating to freedom of choice of providers), or section 1902(a)(27) (relating to provider agreements), a State may provide medical assistance for qualifying community-based mobile crisis intervention services under a State plan amendment or waiver approved under section 1115 or 1915.

"(2) QUALIFYING COMMUNITY-BASED MOBILE CRISIS INTERVENTION SERVICES DEFINED.—For purposes of this subsection, the term 'qualifying community-based mobile crisis intervention services' means, with respect to a State, items and services for which medical assistance is available under the State plan under this title or a waiver of such plan, that are—

"(A) furnished outside of a hospital or other facility setting to an individual who is—

"(i) entitled to medical assistance under such plan or waiver; and

"(ii) experiencing a mental health or substance use disorder crisis;

"(B) furnished by a multidisciplinary mobile crisis team—

"(i) that includes at least 1 behavioral health care professional who is capable of conducting an assessment of the individual, in accordance with the professional's permitted scope of practice under State law, and other professionals or paraprofessionals with appropriate expertise in behavioral health or mental health crisis response, including nurses, social workers, peer support specialists, and others, as designated by the State and approved by the Secretary;

"(ii) whose members are trained in trauma-informed care, de-escalation strategies, and harm reduction;

"(iii) that is able to respond in a timely manner and, where appropriate, provide the following—

"(I) screening and assessment;

"(II) stabilization and de-escalation;

"(III) coordination with, and referrals to, health, social, and other services and supports as needed; and

Back to Agenda

Back To Item

"(IV) facilitate an individual into the State's Medicaid transportation process to ensure access to the next step in care or treatment;

"(iv) that maintains relationships with relevant community partners, including medical, primary care, and behavioral health providers, community health centers, crisis respite centers, managed care organizations (if applicable), entities able to provide assistance with application and enrollment in the State plan or a waiver of the plan, entities able to provide assistance with applying for and enrolling in benefit programs, entities that provide assistance with housing (such as public housing authorities, Continuum of Care programs, or not-for-profit entities that provide housing assistance), and entities that provide assistance with other social services;

"(v) that coordinates with crisis intervention hotlines and emergency response systems;

"(vi) that maintains the privacy and confidentiality of patient information consistent with Federal and State requirements; and

"(vii) that operates independently from (but may coordinate with) State or local law enforcement agencies;

"(C) available 24 hours per day, every day of the year; and

"(D) voluntary to receive.

"(3) PAYMENTS.—

"(A) IN GENERAL.—Notwithstanding section 1905(b), beginning October 1, 2020, during each of the first 12 fiscal quarters that a State meets the requirements described in paragraph (4), the Federal medical assistance percentage applicable to amounts expended by the State for medical assistance for qualifying community-based mobile crisis intervention services furnished during such quarter shall be equal to 95 percent.

"(B) EXCLUSION OF ENHANCED PAYMENTS FROM TERRITORIAL CAPS.—To the extent that the amount of a payment to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for medical assistance for qualifying community-based mobile crisis intervention services that is based on the Federal medical assistance percentage specified in subparagraph (A) exceeds the amount that would have been paid to such territory for such services if the Federal

Back to Agenda

Back To Item

medical assistance percentage for the territory had been determined without regard to such subparagraph—

"(i) the limitation on payments to territories under subsections (f) and (g) of section 1108 shall not apply to the amount of such excess; and

"(ii) the amount of such excess shall be disregarded in applying such subsections.

"(4) REQUIREMENTS.—The requirements described in this paragraph are the following:

"(A) The State demonstrates, to the satisfaction of the Secretary—

"(i) that it will be able to support the provision of qualifying community-based mobile crisis intervention services that meet the conditions specified in paragraph (2); and

"(ii) how it will support coordination between mobile crisis teams and community partners, including health care providers, to enable the provision of services, needed referrals, and other activities identified by the Secretary.

"(B) The State provides assurances satisfactory to the Secretary that —

"(i) any additional Federal funds received by the State for qualifying community-based mobile crisis intervention services provided under this subsection that are attributable to the increased Federal medical assistance percentage under paragraph (3)(A) will be used to supplement, and not supplant, the level of State funds expended for such services in the fiscal year preceding the first fiscal year in which the State elected to provide medical assistance under this subsection;

"(ii) if the State made qualifying community-based mobile crisis intervention services available in a region of the State in such preceding fiscal year, the State will continue to make such services available in such region under this subsection; and

"(iii) the State will conduct the evaluation and assessment, and submit the report, required under paragraph (5).

"(5) STATE EVALUATION AND REPORT.—

Back to Agenda

Back To Item

"(A) STATE EVALUATION.—Not later than 4 fiscal quarters after a State begins providing qualifying community-based mobile crisis intervention services in accordance with this subsection, the State shall enter into a contract with an independent entity or organization to conduct an evaluation for the purposes of—

"(i) determining the effect of the provision of such services on—

"(I) emergency room visits;

"(II) use of ambulatory services;

"(III) hospitalizations;

"(IV) the involvement of law enforcement in mental health or substance use disorder crisis events; and

"(V) the diversion of individuals from jails or similar settings; and

"(ii) assessing—

"(I) the types of services provided to individuals;

"(II) the types of events responded to;

"(III) cost savings or cost-effectiveness attributable to such services;

"(IV) the experiences of individuals who receive qualifying community-based mobile crisis intervention services;

"(V) the successful connection of individuals with follow-up services; and

"(VI) other relevant outcomes identified by the Secretary.

"(B) COMPARISON TO HISTORICAL MEASURES.—The contract described in subparagraph (A) shall specify that the evaluation is based on a comparison of the historical measures of State performance with respect to the outcomes specified under such subparagraph to the State's performance with respect to such outcomes during the period beginning with the first quarter in which the State begins providing qualifying community-based mobile crisis intervention services in accordance with this subsection.

Back to Agenda

Back To Item

"(C) REPORT.—Not later than 2 years after a State begins to provide qualifying community-based mobile crisis intervention services in accordance with this subsection, the State shall submit a report to the Secretary on the following:

"(i) The results of the evaluation carried out under subparagraph (A).

"(ii) The number of individuals who received qualifying community-based mobile crisis intervention services.

"(iii) Demographic information regarding such individuals when available, including the race or ethnicity, age, sex, sexual orientation, gender identity, and geographic location of such individuals.

"(iv) The processes and models developed by the State to provide qualifying community-based mobile crisis intervention services under the State plan or waiver, including the processes developed to provide referrals for, or coordination with, follow-up care and services.

"(v) Lessons learned regarding the provision of such services.

"(D) PUBLIC AVAILABILITY.—The State shall make the report required under subparagraph (C) publicly available, including on the website of the appropriate State agency, upon submission of such report to the Secretary.

"(6) BEST PRACTICES REPORT.—

"(A) IN GENERAL.—Not later than 3 years after the first State begins to provide qualifying community-based mobile crisis intervention services in accordance with this subsection, the Secretary shall submit a report to Congress that—

"(i) identifies the States that elected to provide services in accordance with this subsection;

"(ii) summarizes the information reported by such States under paragraph (5)(C); and

"(iii) identifies best practices for the effective delivery of community-based mobile crisis intervention services.

"(B) PUBLIC AVAILABILITY.—The report required under subparagraph (A) shall be made publicly available, including on the

Back to Agenda

Back To Item

website of the Department of Health and Human Services, upon submission to Congress.

"(7) STATE PLANNING AND EVALUATION GRANTS.—

"(A) IN GENERAL.—As soon as practicable after the date of enactment of this subsection, the Secretary may award planning and evaluation grants to States for purposes of developing a State plan amendment or section 1115 or 1915 waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services and conducting the evaluation required under paragraph (5)(A). A grant awarded to a State under this paragraph shall remain available until expended.

"(B) STATE CONTRIBUTION.—A State awarded a grant under this subsection shall contribute for each fiscal year for which the grant is awarded an amount equal to the State percentage determined under section 1905(b) (without regard to the temporary increase in the Federal medical assistance percentage of the State under section 6008(a) of the Families First Coronavirus Response Act (Public Law 116–127) or any other temporary increase in the Federal medical assistance percentage of the State for fiscal year 2020 or any succeeding fiscal year) of the grant amount.

"(8) FUNDING.—

"(A) IMPLEMENTATION AND ADMINISTRATION.—There is appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, such sums as are necessary for purposes of implementing and administering this section.

"(B) PLANNING AND EVALUATION GRANTS.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, $25,000,000 to the Secretary for fiscal year 2021 for purposes of making grants under paragraph (7), to remain available until expended.".

Back to Agenda

Back To Item

117TH CONGRESS
1ST SESSION

H. R. 1914

To amend title XIX of the Social Security Act to encourage State Medicaid programs to provide community-based mobile crisis intervention services, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 16, 2021

Mr. DEFAZIO (for himself, Mr. BLUMENAUER, Ms. BONAMICI, Ms. NORTON, Mrs. HAYES, Mr. THOMPSON of California, and Ms. PRESSLEY) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

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Back to Agenda

Back To Item

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Back to Agenda

Back To Item

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Back to Agenda

Back To Item

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Back to Agenda

Back To Item

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Back to Agenda

Back To Item

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Back to Agenda

Back To Item

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"(A) IMPLEMENTATION AND ADMINISTRATION.—There is appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, such sums as are necessary for purposes of implementing and administering this section.

"(B) PLANNING AND EVALUATION GRANTS.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, $25,000,000 to the Secretary for fiscal year 2021 for purposes of making grants under paragraph (7), to remain available until expended.".

Back to Agenda

A Public Agency

CalOptima

Better. Together.

Financial Summary

May 31, 2021

Board of Directors Meeting
August 5, 2021

Nancy Huang, Chief Financial Officer

Back to Agenda

FY 2020–21: Management Summary

- Change in Net Assets (Deficit) or Surplus
  - MTD: $11.0 million, favorable to budget $20.8 million or 213.0%
    - Primarily driven by prior period Incurred But Not Reported (IBNR) adjustments and pharmacy rebates
  - YTD: $46.8 million, favorable to budget $82.3 million or 231.5%
- Enrollment
  - MTD: 839,030 members, favorable to budget 23,760 or 2.9%
  - YTD: 8,875,177 member months, favorable to budget 88,121 or 1.0%
- Revenue
  - MTD: $367.4 million, favorable to budget $96.1 million or 35.4% driven by Medi-Cal (MC) line of business (LOB):
    - $53.5 million of prescription drug revenue due to the Department of Health Care Services (DHCS) postponing pharmacy benefit transition to Fee For Service (FFS)
    - $19.9 million of Proposition 56 risk corridor reserve
    - $6.7 million favorable volume related variance
  - YTD: $3.7 billion, favorable to budget $453.6 million or 13.8% driven by MC LOB:
    - Fiscal Year (FY) 2019 hospital Directed Payments (DP) and pharmacy benefit transition postponement
    - Offset by the Bridge Period Gross Medical Expenditure (GME) risk corridor and Proposition 56 risk corridor reserve

Back to Agenda

CalOptima
A Public Agency

FY 2020–21: Management Summary (cont.)

- Medical Expenses
  - MTD: $347.1 million, unfavorable to budget $77.2 million or 28.6% driven by MC LOB:
    - Prescription Drugs expense unfavorable variance of $53.2 million due to DHCS postponing pharmacy benefit transition to FFS
    - Provider Capitation expense unfavorable variance of $36.0 million due to $26.2 million of additional accruals for Proposition 56 risk corridor, $6.7 million due to Whole Child Model (WCM) retroactive risk corridor (RRC) and 5% short-term supplemental payments to the networks
    - Offset by Facilities Claims expense favorable variance of $10.9 million
  - YTD: $3.6 billion, unfavorable to budget $382.6 million or 12.0% driven by:
    - MC LOB FY 2019 hospital DP and pharmacy benefit transition postponement, offset by decreased utilization during COVID-19 pandemic at the start of the fiscal year
    - OCC LOB unfavorable to budget $19.3 million or 7.1% due to higher Provider Capitation and Facilities Claims expenses
- Administrative Expenses
  - MTD: $11.8 million, favorable to budget $0.6 million or 4.9%
  - YTD: $124.2 million, favorable to budget $14.9 million or 10.7%
- Net Investment & Other Income
  - MTD: $2.6 million, favorable to budget $1.3 million or 105.8%
  - YTD: $10.2 million, unfavorable to budget $3.6 million or 25.9% due to decrease in long-term bond values that are affected by higher interest rates

Back to Agenda

CalOptima
A Public Agency

FY 2020–21: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 94.5% (94.5% excluding DP), Budget 99.5%
  - YTD: Actual 95.7% (95.5% excluding DP), Budget 97.3%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.2% (3.2% excluding DP), Budget 4.6%
  - YTD: Actual 3.3% (3.5% excluding DP), Budget 4.2%
- Balance Sheet Ratios
  - Current ratio: 1.3
  - Board-designated reserve funds level: 1.85
  - Net position: $1.1 billion, including required Tangible Net Equity (TNE) of $106.0 million

Back to Agenda

CalOptima
A Public Agency

Enrollment Summary: May 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
116,863	111,167	5,696	5.1%	SPD	1,265,260	1,220,706	44,554	3.6%
520	462	58	12.6%	BCCTP	5,673	5,230	443	8.5%
297,688	319,998	(22,310)	(7.0%)	TANF Child	3,225,079	3,430,779	(205,700)	(6.0%)
106,551	96,163	10,388	10.8%	TANF Adult	1,107,575	1,031,494	76,081	7.4%
2,988	3,525	(537)	(15.2%)	LTC	34,889	38,665	(3,776)	(9.8%)
285,510	256,312	29,198	11.4%	MCE	2,924,843	2,755,026	169,817	6.2%
11,810	11,930	(120)	(1.0%)	WCM	127,875	131,246	(3,371)	(2.6%)
821,930	**799,557**	**22,373**	**2.8%**	**Medi-Cal Total**	**8,691,194**	**8,613,146**	**78,048**	**0.9%**
14,853	**13,870**	**983**	**7.1%**	**OneCare Connect**	**161,615**	**154,013**	**7,602**	**4.9%**
1,854	**1,378**	**476**	**34.5%**	**OneCare**	**18,095**	**15,158**	**2,937**	**19.4%**
393	**465**	**(72)**	**(15.5%)**	**PACE**	**4,273**	**4,739**	**(466)**	**(9.8%)**
839,030	**815,270**	**23,760**	**2.9%**	**CalOptima Total**	**8,875,177**	**8,787,056**	**88,121**	**1.0%**

Back to Agenda

CalOptima
A Public Agency

Financial Highlights: May 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
839,030	815,270	23,760	2.9%	Member Months	8,875,177	8,787,056	88,121	1.0%
367,394,151	271,334,505	96,059,646	35.4%	Revenues	3,736,377,311	3,282,778,508	453,598,803	13.8%
347,144,390	269,904,664	(77,239,726)	(28.6%)	Medical Expenses	3,575,594,053	3,192,972,959	(382,621,094)	(12.0%)
11,811,976	12,421,699	609,723	4.9%	Administrative Expenses	124,195,029	139,129,498	14,934,469	10.7%
8,437,785	**(10,991,858)**	**19,429,643**	**176.8%**	**Operating Margin**	**36,588,229**	**(49,323,949)**	**85,912,178**	**174.2%**
2,572,377	1,250,000	1,322,377	105.8%	Non Operating Income (Loss)	10,185,897	13,750,000	(3,564,103)	(25.9%)
11,010,162	**(9,741,858)**	**20,752,020**	**213.0%**	**Change in Net Assets**	**46,774,126**	**(35,573,949)**	**82,348,075**	**231.5%**
94.5%	99.5%	5.0%		Medical Loss Ratio	95.7%	97.3%	1.6%	
3.2%	4.6%	1.4%		Administrative Loss Ratio	3.3%	4.2%	0.9%	
2.3%	(4.1%)	6.3%		Operating Margin Ratio	1.0%	(1.5%)	2.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
94.5%	99.5%	5.0%		*MLR (excluding Directed Payments)	95.5%	97.3%	1.8%	
3.2%	4.6%	1.4%		*ALR (excluding Directed Payments)	3.5%	4.2%	0.7%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

Back to Agenda

CalOptima
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Consolidated Performance Actual vs. Budget: May 2021(in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
5.7	(9.7)	15.4	Medi-Cal	32.4	(40.8)	73.3
2.3	(1.4)	3.7	OCC	0.5	(10.4)	10.9
0.3	(0.1)	0.4	OneCare	(0.0)	(0.0)	(0.0)
0.1	0.1	(0.0)	PACE	3.7	1.9	1.8
8.4	**(11.0)**	**19.4**	**Operating**	**36.6**	**(49.3)**	**85.9**
2.6	1.3	1.3	Inv./Rental Inc, MCO tax	10.2	13.8	(3.6)
2.6	**1.3**	**1.3**	**Non-Operating**	**10.2**	**13.8**	**(3.6)**
11.0	**(9.7)**	**20.8**	**TOTAL**	**46.8**	**(35.6)**	**82.3**

Back to Agenda

CalOptima
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Consolidated Revenue & Expenses: May 2021 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	524,610	285,510	11,810	821,930	14,853	1,854	393	839,030
REVENUES								
Capitation Revenue	168,626,831	$ 141,014,362	$ 25,321,659	$ 334,962,853	$ 26,852,690	$ 2,340,943	$ 3,237,665	$ 367,394,151
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	168,626,831	141,014,362	25,321,659	334,962,853	26,852,690	2,340,943	3,237,665	367,394,151
MEDICAL EXPENSES								
Provider Capitation	56,505,592	58,435,980	19,381,662	134,323,233	10,449,422	615,066		145,387,721
Facilities	23,496,767	24,427,149	4,655,822	52,579,739	4,658,045	367,434	793,795	58,399,013
Professional Claims	22,490,128	9,856,466	1,622,179	33,968,773	1,158,773	110,821	777,475	36,015,841
Prescription Drugs	18,647,909	28,525,252	6,049,098	53,222,259	4,042,978	659,782	280,493	58,205,513
MLTSS	33,813,209	3,319,896	1,460,677	38,593,782	1,223,899	71,186	93,734	39,982,601
Medical Management	2,336,684	1,345,763	296,174	3,978,621	1,086,609	31,768	844,771	5,941,768
Quality Incentives	865,756	555,772	35,932	1,457,459	217,725		4,913	1,680,097
Reinsurance & Other	567,800	593,370	13,182	1,174,352	207,436	17,620	132,428	1,531,836
Total Medical Expenses	158,723,844	127,059,648	33,514,727	319,298,218	23,044,886	1,873,678	2,927,607	347,144,390
Medical Loss Ratio	94.1%	90.1%	132.4%	95.3%	85.8%	80.0%	90.4%	94.5%
GROSS MARGIN	**9,902,987**	**13,954,715**	**(8,193,068)**	**15,664,634**	**3,807,804**	**467,265**	**310,058**	**20,249,762**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				7,147,088	723,982	72,830	128,246	8,072,146
Professional fees				168,662	66,976	15,999	123	251,761
Purchased services				872,654	76,042	8,943	58,274	1,015,913
Printing & Postage				162,469	44,408	5,451	13,168	225,495
Depreciation & Amortization				411,062			2,013	413,075
Other expenses				1,516,463	235		2,066	1,518,764
Indirect cost allocation & Occupancy				(316,841)	585,999	41,437	4,226	314,822
Total Administrative Expenses				9,961,557	1,497,642	144,661	208,117	11,811,976
Admin Loss Ratio				3.0%	5.6%	6.2%	6.4%	3.2%
INCOME (LOSS) FROM OPERATIONS				5,703,078	2,310,162	322,605	101,941	8,437,785
INVESTMENT INCOME								1,199,242
TOTAL MCO TAX				1,373,103				1,373,103
OTHER INCOME				32				32
CHANGE IN NET ASSETS				**$ 7,076,212**	**$ 2,310,162**	**$ 322,605**	**$ 101,941**	**$ 11,010,162**
BUDGETED CHANGE IN NET ASSETS				(9,679,154)	(1,359,209)	(97,355)	143,860	(9,741,858)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 16,755,366	$ 3,669,371	$ 419,960	$ (41,919)	$ 20,752,020

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Back to Agenda

Consolidated Revenue & Expenses: May 2021 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	5,638,476	2,924,843	127,875	8,691,194	161,615	18,095	4,273	8,875,177
REVENUES								
Capitation Revenue	1,737,210,675	$ 1,369,220,192	$ 261,725,241	$ 3,368,156,109	$ 309,754,429	$ 22,847,554	$ 35,619,220	$ 3,736,377,311
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,737,210,675	1,369,220,192	261,725,241	3,368,156,109	309,754,429	22,847,554	35,619,220	3,736,377,311
MEDICAL EXPENSES								
Provider Capitation	437,358,444	509,841,548	137,920,088	1,085,120,080	131,416,951	6,275,247		1,222,812,278
Facilities	262,183,319	274,558,405	26,828,945	563,570,669	54,752,834	6,351,431	8,044,576	632,719,510
Professional Claims	220,324,060	102,501,043	12,496,757	335,321,860	11,168,902	901,857	7,373,270	354,765,889
Prescription Drugs	220,954,116	286,169,817	60,799,319	567,923,251	64,300,401	6,846,150	3,140,878	642,210,681
MLTSS	364,489,762	31,935,878	20,025,812	416,451,452	15,189,660	410,076	726,955	432,778,143
Medical Management	25,820,499	15,346,521	3,267,894	44,434,914	12,055,381	387,453	9,437,321	66,315,070
Quality Incentives	11,519,507	5,761,587	598,421	17,879,515	2,379,030		137,772	20,396,316
Reinsurance & Other	113,643,468	86,998,936	132,418	200,774,823	1,509,446	20,148	1,291,749	203,596,166
Total Medical Expenses	1,656,293,174	1,313,113,736	262,069,654	3,231,476,564	292,772,605	21,192,362	30,152,522	3,575,594,053
Medical Loss Ratio	95.3%	95.9%	100.1%	95.9%	94.5%	92.8%	84.7%	95.7%
GROSS MARGIN	**80,917,502**	**56,106,456**	**(344,413)**	**136,679,545**	**16,981,823**	**1,655,191**	**5,466,698**	**160,783,258**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				75,440,932	7,687,699	888,747	1,254,115	85,271,493
Professional fees				1,386,084	256,825	188,972	1,397	1,833,278
Purchased services				9,096,821	996,169	91,943	273,870	10,458,804
Printing & Postage				2,728,947	822,579	60,358	128,931	3,740,815
Depreciation & Amortization				3,666,352			22,259	3,688,611
Other expenses				15,046,780	269,568	653	57,422	15,374,423
Indirect cost allocation & Occupancy				(3,117,939)	6,445,985	455,812	43,747	3,827,605
Total Administrative Expenses				104,247,977	16,478,825	1,686,486	1,781,741	124,195,029
Admin Loss Ratio				3.1%	5.3%	7.4%	5.0%	3.3%
INCOME (LOSS) FROM OPERATIONS				32,431,569	502,998	(31,294)	3,684,957	36,588,229
INVESTMENT INCOME								6,849,012
TOTAL MCO TAX				3,321,898				3,321,898
TOTAL GRANT INCOME				14,050				14,050
OTHER INCOME				937				937
CHANGE IN NET ASSETS				**$ 35,768,453**	**$ 502,998**	**$ (31,294)**	**$ 3,684,957**	**$ 46,774,126**
BUDGETED CHANGE IN NET ASSETS				(40,843,765)	(10,383,350)	(720)	1,903,886	(35,573,949)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 76,612,218	$ 10,886,348	$ (30,574)	$ 1,781,071	$ 82,348,075

Back to Agenda

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Balance Sheet: As of May 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$198,835,254	Accounts Payable	$32,520,232
Investments	1,221,832,539	Medical Claims liability	1,107,290,784
Capitation receivable	322,867,241	Accrued Payroll Liabilities	15,629,408
Receivables - Other	49,506,700	Deferred Revenue	57,681,889
Prepaid expenses	13,158,044	Deferred Lease Obligations	130,184
		Capitation and Withholds	164,900,941
Total Current Assets	**1,806,199,778**	**Total Current Liabilities**	**1,378,153,438**
Capital Assets			
Furniture & Equipment	44,476,086		
Building/Leasehold Improvements	6,571,955		
505 City Parkway West	51,646,314		
	102,694,355		
Less: accumulated depreciation	(56,949,650)		
Capital assets, net	45,744,705	Other (than pensions) post employment benefits liability	26,300,608
Other Assets		Net Pension Liabilities	27,462,720
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	(100,000)
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,431,816,767**
Cash and Cash Equivalents	888,352		
Long-term Investments	588,806,644	**Deferred Inflows**	
Total Board-designated Assets	589,694,996	Excess Earnings	506,547
		OPEB 75 Difference in Experience	804,000
		Change in Assumptions	3,728,725
Total Other Assets	646,793,909	OPEB Changes in Assumptions	1,638,000
		Net Position	
TOTAL ASSETS	**2,498,738,392**	TNE	106,026,339
		Funds in Excess of TNE	965,879,084
Deferred Outflows		**TOTAL NET POSITION**	1,071,905,423
Contributions	1,047,297		
Difference in Experience	4,280,308		
Excess Earning	-		
Changes in Assumptions	5,060,465		
OPEB 75 Changes in Assumptions	703,000		
Pension Contributions	570,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,510,399,462**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,510,399,462**

Back to Agenda

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Board Designated Reserve and TNE Analysis: As of May 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	161,218,682				
	Tier 1 - MetLife	160,238,703				
	Tier 1 - Wells Capital	160,413,891				
Board-designated Reserve		481,871,275	339,675,211	530,690,161	142,196,065	(48,818,885)
TNE Requirement	Tier 2 - MetLife	107,823,721	106,026,339	106,026,339	1,797,382	1,797,382
	Consolidated:	**589,694,996**	**445,701,550**	**636,716,500**	**143,993,446**	**(47,021,503)**
	Current reserve level	*1.85*	*1.40*	*2.00*		

Back to Agenda

CalOptima
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Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Back to Agenda

CalOptima
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UNAUDITED FINANCIAL STATEMENTS

May 31, 2021

Back to Agenda

Table of Contents

Financial Highlights 3
Financial Dashboard 4
Statement of Revenues and Expenses – Consolidated Month to Date 5
Statement of Revenues and Expenses – Consolidated Year to Date 6
Statement of Revenues and Expenses – Consolidated LOB Month to Date 7
Statement of Revenues and Expenses – Consolidated LOB Year to Date 8
Highlights – Overall 9
Enrollment Summary 10
Enrollment Trended by Network Type 11
Highlights – Enrollment 12
Statement of Revenues and Expenses – Medi-Cal 13
Highlights – Medi-Cal 14
Statement of Revenues and Expenses – OneCare Connect 15
Highlights – OneCare Connect 16
Statement of Revenues and Expenses – OneCare 17
Statement of Revenues and Expenses – PACE 18
Statement of Revenues and Expenses – 505 City Parkway 19
Highlights – OneCare, PACE & 505 City Parkway 20
Balance Sheet 21
Board Designated Reserve & TNE Analysis 22
Statement of Cash Flow 23
Highlights – Balance Sheet & Statement of Cash Flow 24
Homeless Health Reserve Report 25
Budget Allocation Changes 26

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the Eleven Months Ended May 31, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
839,030	815,270	23,760	2.9%	Member Months	8,875,177	8,787,056	88,121	1.0%
367,394,151	271,334,505	96,059,646	35.4%	Revenues	3,736,377,311	3,282,778,508	453,598,803	13.8%
347,144,390	269,904,664	(77,239,726)	(28.6%)	Medical Expenses	3,575,594,053	3,192,972,959	(382,621,094)	(12.0%)
11,811,976	12,421,699	609,723	4.9%	Administrative Expenses	124,195,029	139,129,498	14,934,469	10.7%
8,437,785	**(10,991,858)**	**19,429,643**	**176.8%**	**Operating Margin**	**36,588,229**	**(49,323,949)**	**85,912,178**	**174.2%**
2,572,377	1,250,000	1,322,377	105.8%	Non Operating Income (Loss)	10,185,897	13,750,000	(3,564,103)	(25.9%)
11,010,162	**(9,741,858)**	**20,752,020**	**213.0%**	**Change in Net Assets**	**46,774,126**	**(35,573,949)**	**82,348,075**	**231.5%**
94.5%	99.5%	5.0%		Medical Loss Ratio	95.7%	97.3%	1.6%	
3.2%	4.6%	1.4%		Administrative Loss Ratio	3.3%	4.2%	0.9%	
2.3%	(4.1%)	6.3%		Operating Margin Ratio	1.0%	(1.5%)	2.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
94.5%	99.5%	5.0%		*MLR (excluding Directed Payments)	95.5%	97.3%	1.8%	
3.2%	4.6%	1.4%		*ALR (excluding Directed Payments)	3.5%	4.2%	0.7%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Eleven Months Ended May 31, 2021

MONTH - TO - DATE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	821,930	799,557	22,373	2.8%
OneCare Connect	14,853	13,870	983	7.1%
OneCare	1,854	1,378	476	34.5%
PACE	393	465	(72)	(15.5%)
Total	839,030	815,270	23,760	2.9%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,076	$ (9,679)	$ 16,755	173.1%
OneCare Connect	2,310	(1,359)	3,669	270.0%
OneCare	323	(97)	420	433.0%
PACE	102	144	(42)	(29.2%)
505 Bldg.	-	-	-	0.0%
Investment Income & Other	1,199	1,250	(51)	(4.1%)
Total	$ 11,010	$ (9,741)	$ 20,751	213.0%

MLR	Actual	Budget	% Point Var
Medi-Cal	95.3%	99.7%	4.4
OneCare Connect	85.8%	99.0%	13.2
OneCare	80.0%	97.5%	17.5

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,962	$ 10,482	$ 521	5.0%
OneCare Connect	1,498	1,608	111	6.9%
OneCare	145	136	(9)	(6.3%)
PACE	208	195	(13)	(6.6%)
Total	$ 11,812	$ 12,422	$ 610	4.9%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,068	1,161	93
OneCare Connect	193	210	17
OneCare	10	9	(1)
PACE	92	116	24
Total	1,363	1,496	133

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	769	689	81
OneCare Connect	77	66	11
OneCare	187	148	39
PACE	4	4	0
Total	1,038	907	131

YEAR - TO - DATE

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	8,691,194	8,613,146	78,048	0.9%
OneCare Connect	161,615	154,013	7,602	4.9%
OneCare	18,095	15,158	2,937	19.4%
PACE	4,273	4,739	(466)	(9.8%)
Total	8,875,177	8,787,056	88,121	1.0%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 35,768	$ (40,844)	$ 76,612	187.6%
OneCare Connect	503	(10,383)	10,886	104.8%
OneCare	(31)	(1)	(30)	(3000.0%)
PACE	3,685	1,904	1,781	93.5%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	6,849	13,750	(6,901)	(50.2%)
Total	$ 46,774	$ (35,574)	$ 82,348	231.5%

MLR	Actual	Budget	% Point Var
Medi-Cal	95.9%	97.4%	1.5
OneCare Connect	94.5%	97.4%	2.8
OneCare	92.8%	91.6%	(1.2)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 104,248	$ 117,810	$ 13,562	11.5%
OneCare Connect	16,479	17,785	1,306	7.3%
OneCare	1,686	1,508	(179)	(11.9%)
PACE	1,782	2,027	245	12.1%
Total	$ 124,195	$ 139,129	$ 14,934	10.7%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	11,859	12,769	910
OneCare Connect	2,111	2,307	196
OneCare	110	102	(8)
PACE	1,014	1,279	265
Total	15,094	16,457	1,363

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	733	675	58
OneCare Connect	77	67	10
OneCare	164	148	16
PACE	4	4	1
Total	978	893	85

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended May 31, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	839,030		815,270		23,760	
REVENUE						
Medi-Cal	$ 334,962,853	$ 407.53	$ 241,014,765	$ 301.44	$ 93,948,088	$ 106.09
OneCare Connect	26,852,690	1,807.90	25,022,627	1,804.08	1,830,063	3.82
OneCare	2,340,943	1,262.64	1,546,801	1,122.50	794,142	140.14
PACE	3,237,665	8,238.33	3,750,312	8,065.19	(512,647)	173.14
Total Operating Revenue	367,394,151	437.88	271,334,505	332.82	96,059,646	105.06
MEDICAL EXPENSES						
Medi-Cal	319,298,218	388.47	240,211,697	300.43	(79,086,521)	(88.04)
OneCare Connect	23,044,886	1,551.53	24,773,690	1,786.13	1,728,804	234.60
OneCare	1,873,678	1,010.61	1,508,070	1,094.39	(365,608)	83.78
PACE	2,927,607	7,449.38	3,411,207	7,335.93	483,600	(113.45)
Total Medical Expenses	347,144,390	413.74	269,904,664	331.06	(77,239,726)	(82.68)
GROSS MARGIN	20,249,762	24.14	1,429,841	1.76	18,819,921	22.38
ADMINISTRATIVE EXPENSES						
Salaries and benefits	8,072,146	9.62	7,858,536	9.64	(213,610)	0.02
Professional fees	251,761	0.30	376,770	0.46	125,009	0.16
Purchased services	1,015,913	1.21	1,086,326	1.33	70,413	0.12
Printing & Postage	225,495	0.27	557,651	0.68	332,156	0.41
Depreciation & Amortization	413,075	0.49	460,570	0.56	47,495	0.07
Other expenses	1,518,764	1.81	1,705,341	2.09	186,577	0.28
Indirect cost allocation & Occupancy expense	314,822	0.38	376,505	0.46	61,683	0.08
Total Administrative Expenses	11,811,976	14.08	12,421,699	15.24	609,723	1.16
INCOME (LOSS) FROM OPERATIONS	8,437,785	10.06	(10,991,858)	(13.48)	19,429,643	23.54
INVESTMENT INCOME						
Interest income	672,615	0.80	1,250,000	1.53	(577,385)	(0.73)
Realized gain/(loss) on investments	80,278	0.10	-	-	80,278	0.10
Unrealized gain/(loss) on investments	446,349	0.53	-	-	446,349	0.53
Total Investment Income	1,199,242	1.43	1,250,000	1.53	(50,758)	(0.10)
TOTAL MCO TAX	1,373,103	1.64	0	-	1,373,103	1.64
OTHER INCOME	32	-	-	-	32	-
CHANGE IN NET ASSETS	**11,010,162**	**13.12**	**(9,741,858)**	**(11.95)**	**20,752,020**	**25.07**
MEDICAL LOSS RATIO	**94.5%**		**99.5%**		**5.0%**	
ADMINISTRATIVE LOSS RATIO	**3.2%**		**4.6%**		**1.4%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Eleven Months Ended May 31, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	8,875,177		8,787,056		88,121	
REVENUE						
Medi-Cal	$ 3,368,156,109	$ 387.54	$ 2,945,671,290	$ 342.00	$ 422,484,819	$ 45.54
OneCare Connect	309,754,429	1,916.62	280,831,306	1,823.43	28,923,123	93.19
OneCare	22,847,554	1,262.64	17,891,806	1,180.35	4,955,748	82.29
PACE	35,619,220	8,335.88	38,384,106	8,099.62	(2,764,886)	236.26
Total Operating Revenue	3,736,377,311	420.99	3,282,778,508	373.59	453,598,803	47.40
MEDICAL EXPENSES						
Medi-Cal	3,231,476,564	371.81	2,868,705,119	333.06	(362,771,445)	(38.75)
OneCare Connect	292,772,605	1,811.54	273,429,494	1,775.37	(19,343,111)	(36.17)
OneCare	21,192,362	1,171.17	16,384,861	1,080.94	(4,807,501)	(90.23)
PACE	30,152,522	7,056.52	34,453,485	7,270.20	4,300,963	213.68
Total Medical Expenses	3,575,594,053	402.88	3,192,972,959	363.37	(382,621,094)	(39.51)
GROSS MARGIN	160,783,258	18.11	89,805,549	10.22	70,977,709	7.89
ADMINISTRATIVE EXPENSES						
Salaries and benefits	85,271,493	9.61	87,610,533	9.97	2,339,040	0.36
Professional fees	1,833,278	0.21	4,107,330	0.47	2,274,052	0.26
Purchased services	10,458,804	1.18	13,127,337	1.49	2,668,533	0.31
Printing & Postage	3,740,815	0.42	6,336,658	0.72	2,595,843	0.30
Depreciation & Amortization	3,688,611	0.42	5,066,270	0.58	1,377,659	0.16
Other expenses	15,374,423	1.73	18,682,922	2.13	3,308,499	0.40
Indirect cost allocation & Occupancy expense	3,827,605	0.43	4,198,448	0.48	370,843	0.05
Total Administrative Expenses	124,195,029	13.99	139,129,498	15.83	14,934,469	1.84
INCOME (LOSS) FROM OPERATIONS	36,588,229	4.12	(49,323,949)	(5.61)	85,912,178	9.73
INVESTMENT INCOME						
Interest income	10,085,639	1.14	13,750,000	1.56	(3,664,361)	(0.42)
Realized gain/(loss) on investments	5,138,947	0.58	-	-	5,138,947	0.58
Unrealized gain/(loss) on investments	(8,375,574)	(0.94)	-	-	(8,375,574)	(0.94)
Total Investment Income	6,849,012	0.77	13,750,000	1.56	(6,900,988)	(0.79)
TOTAL MCO TAX	3,321,898	0.37	-	-	3,321,898	0.37
TOTAL GRANT INCOME	14,050	-	-	-	14,050	-
OTHER INCOME	937	-	-	-	937	-
CHANGE IN NET ASSETS	**46,774,126**	**5.27**	**(35,573,949)**	**(4.05)**	**82,348,075**	**9.32**
MEDICAL LOSS RATIO	**95.7%**		**97.3%**		**1.6%**	
ADMINISTRATIVE LOSS RATIO	**3.3%**		**4.2%**		**0.9%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended May 31, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	524,610	285,510	11,810	821,930	14,853	1,854	393	839,030
REVENUES								
Capitation Revenue	168,626,831	$ 141,014,362	$ 25,321,659	$ 334,962,853	$ 26,852,690	$ 2,340,943	$ 3,237,665	$ 367,394,151
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	168,626,831	141,014,362	25,321,659	334,962,853	26,852,690	2,340,943	3,237,665	367,394,151
MEDICAL EXPENSES								
Provider Capitation	56,505,592	58,435,980	19,381,662	134,323,233	10,449,422	615,066		145,387,721
Facilities	23,496,767	24,427,149	4,655,822	52,579,739	4,658,045	367,434	793,795	58,399,013
Professional Claims	22,490,128	9,856,466	1,622,179	33,968,773	1,158,773	110,821	777,475	36,015,841
Prescription Drugs	18,647,909	28,525,252	6,049,098	53,222,259	4,042,978	659,782	280,493	58,205,513
MLTSS	33,813,209	3,319,896	1,460,677	38,593,782	1,223,899	71,186	93,734	39,982,601
Medical Management	2,336,684	1,345,763	296,174	3,978,621	1,086,609	31,768	844,771	5,941,768
Quality Incentives	865,756	555,772	35,932	1,457,459	217,725		4,913	1,680,097
Reinsurance & Other	567,800	593,370	13,182	1,174,352	207,436	17,620	132,428	1,531,836
Total Medical Expenses	158,723,844	127,059,648	33,514,727	319,298,218	23,044,886	1,873,678	2,927,607	347,144,390
Medical Loss Ratio	94.1%	90.1%	132.4%	95.3%	85.8%	80.0%	90.4%	94.5%
GROSS MARGIN	**9,902,987**	**13,954,715**	**(8,193,068)**	**15,664,634**	**3,807,804**	**467,265**	**310,058**	**20,249,762**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				7,147,088	723,982	72,830	128,246	8,072,146
Professional fees				168,662	66,976	15,999	123	251,761
Purchased services				872,654	76,042	8,943	58,274	1,015,913
Printing & Postage				162,469	44,408	5,451	13,168	225,495
Depreciation & Amortization				411,062			2,013	413,075
Other expenses				1,516,463	235		2,066	1,518,764
Indirect cost allocation & Occupancy				(316,841)	585,999	41,437	4,226	314,822
Total Administrative Expenses				9,961,557	1,497,642	144,661	208,117	11,811,976
Admin Loss Ratio				3.0%	5.6%	6.2%	6.4%	3.2%
INCOME (LOSS) FROM OPERATIONS				5,703,078	2,310,162	322,605	101,941	8,437,785
INVESTMENT INCOME								1,199,242
TOTAL MCO TAX				1,373,103				1,373,103
OTHER INCOME				32				32
CHANGE IN NET ASSETS				**$ 7,076,212**	**$ 2,310,162**	**$ 322,605**	**$ 101,941**	**$ 11,010,162**
BUDGETED CHANGE IN NET ASSETS				(9,679,154)	(1,359,209)	(97,355)	143,860	(9,741,858)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 16,755,366	$ 3,669,371	$ 419,960	$ (41,919)	$ 20,752,020

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eleven Months Ended May 31, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	5,638,476	2,924,843	127,875	8,691,194	161,615	18,095	4,273	8,875,177
REVENUES								
Capitation Revenue	1,737,210,675	$ 1,369,220,192	$ 261,725,241	$ 3,368,156,109	$ 309,754,429	$ 22,847,554	$ 35,619,220	$ 3,736,377,311
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,737,210,675	1,369,220,192	261,725,241	3,368,156,109	309,754,429	22,847,554	35,619,220	3,736,377,311
MEDICAL EXPENSES								
Provider Capitation	437,358,444	509,841,548	137,920,088	1,085,120,080	131,416,951	6,275,247		1,222,812,278
Facilities	262,183,319	274,558,405	26,828,945	563,570,669	54,752,834	6,351,431	8,044,576	632,719,510
Professional Claims	220,324,060	102,501,043	12,496,757	335,321,860	11,168,902	901,857	7,373,270	354,765,889
Prescription Drugs	220,954,116	286,169,817	60,799,319	567,923,251	64,300,401	6,846,150	3,140,878	642,210,681
MLTSS	364,489,762	31,935,878	20,025,812	416,451,452	15,189,660	410,076	726,955	432,778,143
Medical Management	25,820,499	15,346,521	3,267,894	44,434,914	12,055,381	387,453	9,437,321	66,315,070
Quality Incentives	11,519,507	5,761,587	598,421	17,879,515	2,379,030		137,772	20,396,316
Reinsurance & Other	113,643,468	86,998,936	132,418	200,774,823	1,509,446	20,148	1,291,749	203,596,166
Total Medical Expenses	1,656,293,174	1,313,113,736	262,069,654	3,231,476,564	292,772,605	21,192,362	30,152,522	3,575,594,053
Medical Loss Ratio	95.3%	95.9%	100.1%	95.9%	94.5%	92.8%	84.7%	95.7%
GROSS MARGIN	**80,917,502**	**56,106,456**	**(344,413)**	**136,679,545**	**16,981,823**	**1,655,191**	**5,466,698**	**160,783,258**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				75,440,932	7,687,699	888,747	1,254,115	85,271,493
Professional fees				1,386,084	256,825	188,972	1,397	1,833,278
Purchased services				9,096,821	996,169	91,943	273,870	10,458,804
Printing & Postage				2,728,947	822,579	60,358	128,931	3,740,815
Depreciation & Amortization				3,666,352			22,259	3,688,611
Other expenses				15,046,780	269,568	653	57,422	15,374,423
Indirect cost allocation & Occupancy				(3,117,939)	6,445,985	455,812	43,747	3,827,605
Total Administrative Expenses				104,247,977	16,478,825	1,686,486	1,781,741	124,195,029
Admin Loss Ratio				3.1%	5.3%	7.4%	5.0%	3.3%
INCOME (LOSS) FROM OPERATIONS				32,431,569	502,998	(31,294)	3,684,957	36,588,229
INVESTMENT INCOME								6,849,012
TOTAL MCO TAX				3,321,898				3,321,898
TOTAL GRANT INCOME				14,050				14,050
OTHER INCOME				937				937
CHANGE IN NET ASSETS				**$ 35,768,453**	**$ 502,998**	**$ (31,294)**	**$ 3,684,957**	**$ 46,774,126**
BUDGETED CHANGE IN NET ASSETS				(40,843,765)	(10,383,350)	(720)	1,903,886	(35,573,949)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 76,612,218	$ 10,886,348	$ (30,574)	$ 1,781,071	$ 82,348,075

May 31, 2021 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $11.0 million, $20.8 million favorable to budget
- Operating surplus is $8.4 million, with a surplus in non-operating income of $2.6 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $46.8 million, $82.3 million favorable to budget
- Operating surplus is $36.6 million, with a surplus in non-operating income of $10.2 million
- Investment Income & Other unfavorable variance of $3.6 million due to decrease in long-term bond values that are affected by higher interest rates

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
5.7	(9.7)	15.4	Medi-Cal	32.4	(40.8)	73.3
2.3	(1.4)	3.7	OCC	0.5	(10.4)	10.9
0.3	(0.1)	0.4	OneCare	(0.0)	(0.0)	(0.0)
0.1	0.1	(0.0)	PACE	3.7	1.9	1.8
8.4	**(11.0)**	**19.4**	**Operating**	**36.6**	**(49.3)**	**85.9**
2.6	1.3	1.3	Inv./Rental Inc, MCO tax	10.2	13.8	(3.6)
2.6	**1.3**	**1.3**	**Non-Operating**	**10.2**	**13.8**	**(3.6)**
11.0	**(9.7)**	**20.8**	**TOTAL**	**46.8**	**(35.6)**	**82.3**

CalOptima - Consolidated
Enrollment Summary
For the Eleven Months Ended May 31, 2021

Month-to-Date					Year-to-Date			
		$	%				$	%
Actual	**Budget**	**Variance**	**Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**Variance**	**Variance**
116,863	111,167	5,696	5.1%	SPD	1,265,260	1,220,706	44,554	3.6%
520	462	58	12.6%	BCCTP	5,673	5,230	443	8.5%
297,688	319,998	(22,310)	(7.0%)	TANF Child	3,225,079	3,430,779	(205,700)	(6.0%)
106,551	96,163	10,388	10.8%	TANF Adult	1,107,575	1,031,494	76,081	7.4%
2,988	3,525	(537)	(15.2%)	LTC	34,889	38,665	(3,776)	(9.8%)
285,510	256,312	29,198	11.4%	MCE	2,924,843	2,755,026	169,817	6.2%
11,810	11,930	(120)	(1.0%)	WCM	127,875	131,246	(3,371)	(2.6%)
821,930	**799,557**	**22,373**	**2.8%**	**Medi-Cal Total**	**8,691,194**	**8,613,146**	**78,048**	**0.9%**
14,853	**13,870**	**983**	**7.1%**	**OneCare Connect**	**161,615**	**154,013**	**7,602**	**4.9%**
1,854	**1,378**	**476**	**34.5%**	**OneCare**	**18,095**	**15,158**	**2,937**	**19.4%**
393	**465**	**(72)**	**(15.5%)**	**PACE**	**4,273**	**4,739**	**(466)**	**(9.8%)**
839,030	**815,270**	**23,760**	**2.9%**	**CalOptima Total**	**8,875,177**	**8,787,056**	**88,121**	**1.0%**
				Enrollment (by Network)				
190,203	177,122	13,081	7.4%	HMO	1,987,909	1,915,527	72,382	3.8%
226,099	230,611	(4,512)	(2.0%)	PHC	2,429,702	2,484,720	(55,018)	(2.2%)
200,351	199,885	466	0.2%	Shared Risk Group	2,102,814	2,127,923	(25,109)	(1.2%)
205,277	191,939	13,338	6.9%	Fee for Service	2,170,769	2,084,976	85,793	4.1%
821,930	**799,557**	**22,373**	**2.8%**	**Medi-Cal Total**	**8,691,194**	**8,613,146**	**78,048**	**0.9%**
14,853	**13,870**	**983**	**7.1%**	**OneCare Connect**	**161,615**	**154,013**	**7,602**	**4.9%**
1,854	**1,378**	**476**	**34.5%**	**OneCare**	**18,095**	**15,158**	**2,937**	**19.4%**
393	**465**	**(72)**	**(15.5%)**	**PACE**	**4,273**	**4,739**	**(466)**	**(9.8%)**
839,030	**815,270**	**23,760**	**2.9%**	**CalOptima Total**	**8,875,177**	**8,787,056**	**88,121**	**1.0%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2021

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,536	10,583	10,588	10,639	10,658	10,725	11,756	9,640	10,723	10,691	10,672		117,211	113,846	3,365
BCCTP	1	1	1	1	1	1	1	1	1	1	1		11	11	0
TANF Child	54,644	55,088	55,115	55,276	55,934	56,264	56,566	56,582	56,962	57,177	57,360		616,968	644,229	(27,261)
TANF Adult	29,033	29,687	30,001	30,679	30,990	31,336	31,677	31,995	32,455	32,764	33,242		343,859	325,429	18,430
LTC	(1)	402	197	215	239	238	(1,283)						7	22	(15)
MCE	74,441	75,955	76,054	78,435	79,490	80,792	82,386	82,587	84,474	85,757	86,843		887,214	809,495	77,719
WCM	1,721	1,726	2,086	2,507	2,007	2,067	2,109	2,149	2,117	2,065	2,085		22,639	22,495	144
Total	**170,375**	**173,442**	**174,042**	**177,752**	**179,319**	**181,423**	**183,212**	**182,954**	**186,732**	**188,455**	**190,203**		**1,987,909**	**1,915,527**	**72,382**
PHCs															
SPD	7,145	7,205	6,855	6,760	7,010	7,042	7,103	6,774	6,926	6,945	6,901		76,666	77,241	(575)
BCCTP													-		0
TANF Child	149,810	151,008	148,874	150,336	152,122	152,428	152,751	152,998	153,502	153,529	154,354		1,671,712	1,763,462	(91,750)
TANF Adult	11,688	12,097	12,071	12,492	12,728	12,694	12,930	13,071	13,277	13,422	13,587		140,057	129,915	10,142
LTC		158	81	65	76	80	(456)				1		5	11	(6)
MCE	39,815	40,711	39,935	41,371	41,820	42,350	42,781	42,628	43,255	43,643	43,907		462,216	435,075	27,141
WCM	5,625	5,716	7,990	8,497	6,957	7,099	7,533	7,208	7,518	7,554	7,349		79,046	79,016	30
Total	**214,083**	**216,895**	**215,806**	**219,521**	**220,713**	**221,693**	**222,642**	**222,679**	**224,478**	**225,093**	**226,099**		**2,429,702**	**2,484,720**	**(55,018)**
Shared Risk Groups															
SPD	10,264	10,312	10,068	10,117	10,120	10,261	10,927	9,519	10,229	10,143	10,097		112,057	110,403	1,654
BCCTP													-		0
TANF Child	58,289	58,687	57,269	58,133	58,881	58,952	59,011	58,901	58,985	58,891	58,880		644,879	720,784	(75,905)
TANF Adult	28,914	29,648	29,235	30,414	30,910	31,050	31,495	31,655	32,014	32,135	32,444		339,914	330,124	9,790
LTC	1	365	178	209	217	219	(1,185)	(1)			1		4	22	(18)
MCE	82,747	84,907	83,063	87,432	88,969	90,268	92,357	92,006	94,565	96,296	97,552		990,162	947,971	42,191
WCM	924	1,000	1,954	2,189	1,382	1,408	1,419	1,380	1,357	1,408	1,377		15,798	18,619	(2,821)
Total	**181,139**	**184,919**	**181,767**	**188,494**	**190,479**	**192,158**	**194,024**	**193,460**	**197,150**	**198,873**	**200,351**		**2,102,814**	**2,127,923**	**(25,109)**
Fee for Service (Dual)															
SPD	74,615	75,198	75,269	76,815	76,628	77,616	85,109	73,178	78,487	78,673	78,981		850,569	809,980	40,589
BCCTP	12	17	18	18	14	14	16	15	18	17	16		175	187	(12)
TANF Child	1	1	1	1	1	1	1	1	1	1	1		11	28	(17)
TANF Adult	909	1,266	994	1,107	1,015	1,030	1,064	1,119	1,173	1,205	1,252		12,134	11,079	1,055
LTC	3,079	4,461	3,855	3,838	3,818	3,817	(2,123)	2,706	2,651	2,681	2,685		31,468	34,837	(3,369)
MCE	1,658	1,859	1,948	2,077	2,138	2,334	2,430	2,390	2,674	2,914	3,102		25,524	17,717	7,807
WCM	13	17	16	17	15	14	17	15	16	16	18		174	141	33
Total	**80,287**	**82,819**	**82,101**	**83,873**	**83,629**	**84,826**	**86,514**	**79,424**	**85,020**	**85,507**	**86,055**		**920,055**	**873,969**	**46,086**
Fee for Service (Non-Dual - Total)															
SPD	9,830	9,822	10,264	9,977	9,304	9,774	10,737	8,838	9,978	10,021	10,212		108,757	109,236	(479)
BCCTP	497	492	499	506	485	490	515	501	496	503	503		5,487	5,032	455
TANF Child	25,494	27,007	28,092	26,150	26,005	25,664	26,404	26,451	26,129	27,020	27,093		291,509	302,276	(10,767)
TANF Adult	23,028	24,014	24,847	24,196	24,229	24,315	24,823	25,042	25,187	25,904	26,026		271,611	234,947	36,664
LTC	351	788	580	573	560	580	(1,237)	302	297	310	301		3,405	3,773	(368)
MCE	45,498	47,292	52,445	48,625	49,046	49,527	52,810	52,979	53,128	54,271	54,106		559,727	544,768	14,959
WCM	791	806	974	1,076	896	899	1,014	870	923	988	981		10,218	10,975	(757)
Total	**105,489**	**110,221**	**117,701**	**111,103**	**110,525**	**111,249**	**115,066**	**114,983**	**116,138**	**119,017**	**119,222**		**1,250,714**	**1,211,007**	**39,707**
SPD	112,390	113,120	113,044	114,308	113,720	115,418	125,632	107,949	116,343	116,473	116,863		1,265,260	1,220,706	44,554
BCCTP	510	510	518	525	500	505	532	517	515	521	520		5,673	5,230	443
TANF Child	288,238	291,791	289,351	289,896	292,943	293,309	294,733	294,933	295,579	296,618	297,688		3,225,079	3,430,779	(205,700)
TANF Adult	93,572	96,712	97,148	98,888	99,872	100,425	101,989	102,882	104,106	105,430	106,551		1,107,575	1,031,494	76,081
LTC	3,430	6,174	4,891	4,900	4,910	4,934	(6,284)	3,007	2,948	2,991	2,988		34,889	38,665	(3,776)
MCE	244,159	250,724	253,445	257,940	261,463	265,271	272,764	272,590	278,096	282,881	285,510		2,924,843	2,755,026	169,817
WCM	9,074	9,265	13,020	14,286	11,257	11,487	12,092	11,622	11,931	12,031	11,810		127,875	131,246	(3,371)
Total Medi-Cal MM	**751,373**	**768,296**	**771,417**	**780,743**	**784,665**	**791,349**	**801,458**	**793,500**	**809,518**	**816,945**	**821,930**		**8,691,194**	**8,613,146**	**78,048**
OneCare Connect	**14,465**	**14,541**	**14,529**	**14,720**	**14,587**	**14,938**	**14,921**	**14,569**	**14,748**	**14,744**	**14,853**		**161,615**	**154,013**	**7,602**
OneCare	**1,525**	**1,523**	**1,594**	**1,627**	**1,625**	**1,609**	**1,615**	**1,645**	**1,714**	**1,764**	**1,854**		**18,095**	**15,158**	**2,937**
PACE	**382**	**381**	**380**	**387**	**393**	**394**	**389**	**391**	**388**	**395**	**393**		**4,273**	**4,739**	**(466)**
Grand Total	**767,745**	**784,741**	**787,920**	**797,477**	**801,270**	**808,290**	**818,383**	**810,105**	**826,368**	**833,848**	**839,030**		**8,875,177**	**8,787,056**	**88,121**

ENROLLMENT:

Overall, May enrollment was 839,030

- Favorable to budget 23,760 or 2.9%
- Increased 5,182 or 0.6% from prior month (PM) (April 2021)
- Increased 94,199 or 12.6% from prior year (PY) (May 2020)

Medi-Cal enrollment was 821,930

- Favorable to budget 22,373 or 2.8%
  - Medi-Cal Expansion (MCE) favorable 29,198
  - Seniors and Persons with Disabilities (SPD) favorable 5,696
  - Breast and Cervical Cancer Treatment Program (BCCTP) favorable 58
  - Temporary Assistance for Needy Families (TANF) unfavorable 11,922
  - Long-Term Care (LTC) unfavorable 537
  - Whole Child Model (WCM) unfavorable 120
- Increased 4,985 from PM

OneCare Connect enrollment was 14,853

- Favorable to budget 983 or 7.1%
- Increased 109 from PM

OneCare enrollment was 1,854

- Favorable to budget 476 or 34.5%
- Increased 90 from PM

PACE enrollment was 393

- Unfavorable to budget 72 or 15.5%
- Decreased 2 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
821,930	**799,557**	**22,373**	**2.8%**	**Member Months**	**8,691,194**	**8,613,146**	**78,048**	**0.9%**
				Revenues				
334,962,853	241,014,765	93,948,088	39.0%	Capitation Revenue	3,368,156,109	2,945,671,290	422,484,819	14.3%
-	-	-	0.0%	Other Income	-	-	-	0.0%
334,962,853	**241,014,765**	**93,948,088**	**39.0%**	**Total Operating Revenue**	**3,368,156,109**	**2,945,671,290**	**422,484,819**	**14.3%**
				Medical Expenses				
135,780,693	97,036,416	(38,744,277)	(39.9%)	Provider Capitation	1,102,999,595	1,072,050,054	(30,949,541)	(2.9%)
52,579,739	61,747,202	9,167,463	14.8%	Facilities Claims	563,570,669	647,140,814	83,570,145	12.9%
33,968,773	34,646,465	677,692	2.0%	Professional Claims	335,321,860	365,153,759	29,831,899	8.2%
53,222,259	-	(53,222,259)	0.0%	Prescription Drugs	567,923,251	280,984,863	(286,938,388)	(102.1%)
38,593,782	41,403,172	2,809,390	6.8%	MLTSS	416,451,452	443,105,846	26,654,394	6.0%
3,978,621	4,774,436	795,815	16.7%	Medical Management	44,434,914	53,625,708	9,190,794	17.1%
1,174,352	604,006	(570,346)	(94.4%)	Reinsurance & Other	200,774,823	6,644,075	(194,130,748)	(2921.9%)
319,298,218	**240,211,697**	**(79,086,521)**	**(32.9%)**	**Total Medical Expenses**	**3,231,476,564**	**2,868,705,119**	**(362,771,445)**	**(12.6%)**
15,664,634	**803,068**	**14,861,566**	**1850.6%**	**Gross Margin**	**136,679,545**	**76,966,171**	**59,713,374**	**77.6%**
				Administrative Expenses				
7,147,088	6,876,528	(270,560)	(3.9%)	Salaries, Wages & Employee Benefits	75,440,932	76,710,967	1,270,035	1.7%
168,662	320,521	151,859	47.4%	Professional Fees	1,386,084	3,488,591	2,102,507	60.3%
872,654	933,513	60,859	6.5%	Purchased Services	9,096,821	11,533,894	2,437,073	21.1%
162,469	425,725	263,256	61.8%	Printing and Postage	2,728,947	4,907,972	2,179,025	44.4%
411,062	458,500	47,438	10.3%	Depreciation & Amortization	3,666,352	5,043,500	1,377,148	27.3%
1,516,463	1,684,406	167,943	10.0%	Other Operating Expenses	15,046,780	18,452,423	3,405,643	18.5%
(316,841)	(216,971)	99,870	46.0%	Indirect Cost Allocation, Occupancy Expense	(3,117,939)	(2,327,411)	790,528	34.0%
9,961,557	**10,482,222**	**520,665**	**5.0%**	**Total Administrative Expenses**	**104,247,977**	**117,809,936**	**13,561,959**	**11.5%**
				Operating Tax				
13,841,853	15,475,075	(1,633,222)	(10.6%)	Tax Revenue	140,478,148	166,755,571	(26,277,423)	(15.8%)
12,468,750	15,475,075	3,006,325	19.4%	Premium Tax Expense	137,156,250	166,755,571	29,599,321	17.8%
1,373,103	0	1,373,103	**0.0%**	**Total Net Operating Tax**	3,321,898	-	3,321,898	**0.0%**
				Grant Income				
19,046	-	19,046	0.0%	Grant Revenue	307,723	-	307,723	0.0%
-	-	-	0.0%	Grant expense - Service Partner	201,238	-	(201,238)	0.0%
19,046	-	(19,046)	0.0%	Grant expense - Administrative	92,436	-	(92,436)	0.0%
-	-	-	**0.0%**	**Total Grant Income**	14,050	-	14,050	**0.0%**
32	**-**	**32**	**0.0%**	**Other income**	**937**	**-**	**937**	**0.0%**
7,076,212	**(9,679,154)**	**16,755,366**	**173.1%**	**Change in Net Assets**	**35,768,453**	**(40,843,765)**	**76,612,218**	**187.6%**
95.3%	***99.7%***	***4.3%***	***4.4%***	***Medical Loss Ratio***	***95.9%***	***97.4%***	***1.4%***	***1.5%***
3.0%	***4.3%***	***1.4%***	***31.6%***	***Admin Loss Ratio***	***3.1%***	***4.0%***	***0.9%***	***22.6%***

MEDI-CAL INCOME STATEMENT– MAY MONTH:

REVENUES of $335.0 million are favorable to budget $93.9 million driven by:

- Favorable volume related variance of $6.7 million
- Favorable price related variance of $87.2 million
  - $53.5 million of prescription drug revenue due to the Department of Health Care Services (DHCS) postponing pharmacy benefit transition to Fee For Service (FFS)
  - $19.9 million of Proposition 56 risk corridor reserve
  - $6.7 million due to updating revenue from draft calendar year (CY) 2021 capitation rates to final rates
  - $1.7 million of Bridge Period Gross Medical Expenditures (GME) risk corridor

MEDICAL EXPENSES of $319.3 million are unfavorable to budget $79.1 million driven by:

- Unfavorable volume related variance of $6.7 million
- Unfavorable price related variance of $72.4 million
  - Prescription Drugs expense unfavorable variance of $53.2 million due to DHCS postponing pharmacy benefit transition to FFS
  - Provider Capitation expense unfavorable variance of $36.0 million due to $26.2 million of additional accruals for Proposition 56 risk corridor, $6.7 million due to WCM Retroactive Risk Corridor (RRC) and 5% short-term supplemental payments to the networks
  - Reinsurance & Other expense unfavorable variance of $0.6 million
  - Offset by Facilities Claims expense favorable variance of $10.9 million due to Incurred But Not Reported (IBNR) claims and lower utilization
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $4.0 million
  - Professional Claims expense favorable variance of $1.6 million
  - Medical Management expense favorable variance of $0.9 million

ADMINISTRATIVE EXPENSES of $10.0 million are favorable to budget $0.5 million driven by:

- Other Non-Salary expense favorable to budget $0.8 million
- Salaries & Benefit expense unfavorable to budget $0.3 million

CHANGE IN NET ASSETS is $7.1 million for the month, favorable to budget $16.8 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Eleven Months Ending May 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,853	**13,870**	**983**	**7.1%**	**Member Months**	**161,615**	**154,013**	**7,602**	**4.9%**
				Revenues				
2,662,591	2,676,678	(14,087)	(0.5%)	Medi-Cal Capitation Revenue	31,723,898	29,730,032	1,993,866	6.7%
18,700,852	17,321,161	1,379,691	8.0%	Medicare Capitation Revenue Part C	216,740,039	194,578,557	22,161,482	11.4%
5,489,247	5,024,788	464,459	9.2%	Medicare Capitation Revenue Part D	61,290,492	56,522,717	4,767,775	8.4%
-	-	-	0.0%	Other Income	-	-	-	0.0%
26,852,690	**25,022,627**	**1,830,063**	**7.3%**	**Total Operating Revenue**	**309,754,429**	**280,831,306**	**28,923,123**	**10.3%**
				Medical Expenses				
10,667,147	10,562,514	(104,633)	(1.0%)	Provider Capitation	133,795,981	121,716,822	(12,079,159)	(9.9%)
4,658,045	4,014,349	(643,696)	(16.0%)	Facilities Claims	54,752,834	43,773,005	(10,979,829)	(25.1%)
1,158,773	984,300	(174,473)	(17.7%)	Ancillary	11,168,902	10,400,028	(768,874)	(7.4%)
1,223,899	1,510,710	286,811	19.0%	MLTSS	15,189,660	16,689,407	1,499,747	9.0%
4,042,978	6,087,495	2,044,517	33.6%	Prescription Drugs	64,300,401	64,873,959	573,558	0.9%
1,086,609	1,382,529	295,920	21.4%	Medical Management	12,055,381	13,560,446	1,505,065	11.1%
207,436	231,793	24,357	10.5%	Other Medical Expenses	1,509,446	2,415,827	906,381	37.5%
23,044,886	**24,773,690**	**1,728,804**	**7.0%**	**Total Medical Expenses**	**292,772,605**	**273,429,494**	**(19,343,111)**	**(7.1%)**
3,807,804	**248,937**	**3,558,867**	**1429.6%**	**Gross Margin**	**16,981,823**	**7,401,812**	**9,580,011**	**129.4%**
				Administrative Expenses				
723,982	788,781	64,799	8.2%	Salaries, Wages & Employee Benefits	7,687,699	8,768,172	1,080,473	12.3%
66,976	40,083	(26,893)	(67.1%)	Professional Fees	256,825	440,913	184,088	41.8%
76,042	103,412	27,370	26.5%	Purchased Services	996,169	1,137,532	141,363	12.4%
44,408	106,517	62,109	58.3%	Printing and Postage	822,579	1,171,687	349,108	29.8%
235	15,861	15,626	98.5%	Other Operating Expenses	269,568	178,446	(91,122)	(51.1%)
585,999	553,492	(32,507)	(5.9%)	Indirect Cost Allocation	6,445,985	6,088,412	(357,573)	(5.9%)
1,497,642	**1,608,146**	**110,504**	**6.9%**	**Total Administrative Expenses**	**16,478,825**	**17,785,162**	**1,306,337**	**7.3%**
2,310,162	**(1,359,209)**	**3,669,371**	**270.0%**	**Change in Net Assets**	**502,998**	**(10,383,350)**	**10,886,348**	**104.8%**
85.8%	***99.0%***	***13.2%***	***13.3%***	***Medical Loss Ratio***	***94.5%***	***97.4%***	***2.8%***	***2.9%***
5.6%	***6.4%***	***0.8%***	***13.2%***	***Admin Loss Ratio***	***5.3%***	***6.3%***	***1.0%***	***16.0%***

ONECARE CONNECT INCOME STATEMENT– MAY MONTH:

REVENUES of $26.9 million are favorable to budget $1.8 million driven by:

- Favorable volume related variance of $1.8 million
- Favorable price related variance of $0.1 million

MEDICAL EXPENSES of $23.0 million are favorable to budget $1.7 million driven by:

- Unfavorable volume related variance of $1.8 million
- Favorable price related variance of $3.5 million
  - Prescription Drugs expenses favorable variance of $2.5 million due to PY pharmacy rebates
  - Provider Capitation expense favorable variance of $0.6 million
  - Medical Management favorable variance of $0.4 million
  - MLTSS expense favorable variance of $0.4 million
  - Offset by Facilities Claims expense unfavorable variance of $0.4 million

ADMINISTRATIVE EXPENSES of $1.5 million are favorable to budget $0.1 million

CHANGE IN NET ASSETS is $2.3 million, favorable to budget $3.7 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,854	**1,378**	**476**	**34.5%**	**Member Months**	**18,095**	**15,158**	**2,937**	**19.4%**
				Revenues				
1,638,552	1,061,906	576,646	54.3%	Medicare Part C revenue	15,836,448	12,240,706	3,595,742	29.4%
702,392	484,895	217,497	44.9%	Medicare Part D revenue	7,011,106	5,651,100	1,360,006	24.1%
2,340,943	**1,546,801**	**794,142**	**51.3%**	**Total Operating Revenue**	**22,847,554**	**17,891,806**	**4,955,748**	**27.7%**
				Medical Expenses				
615,066	419,747	(195,319)	(46.5%)	Provider Capitation	6,275,247	4,782,883	(1,492,364)	(31.2%)
367,434	442,153	74,719	16.9%	Inpatient	6,351,431	4,925,018	(1,426,413)	(29.0%)
110,821	44,083	(66,738)	(151.4%)	Ancillary	901,857	473,819	(428,038)	(90.3%)
71,186	25,895	(45,291)	(174.9%)	Skilled Nursing Facilities	410,076	279,831	(130,245)	(46.5%)
659,782	511,731	(148,051)	(28.9%)	Prescription Drugs	6,846,150	5,400,596	(1,445,554)	(26.8%)
31,768	64,309	32,541	50.6%	Medical Management	387,453	521,956	134,503	25.8%
17,620	152	(17,468)	(11492.3%)	Other Medical Expenses	20,148	758	(19,390)	(2558.0%)
1,873,678	**1,508,070**	**(365,608)**	**(24.2%)**	**Total Medical Expenses**	**21,192,362**	**16,384,861**	**(4,807,501)**	**(29.3%)**
467,265	**38,731**	**428,534**	**1106.4%**	**Gross Margin**	**1,655,191**	**1,506,945**	**148,246**	**9.8%**
				Administrative Expenses				
72,830	66,530	(6,300)	(9.5%)	Salaries, wages & employee benefits	888,747	742,549	(146,198)	(19.7%)
15,999	16,000	1	0.0%	Professional fees	188,972	176,000	(12,972)	(7.4%)
8,943	9,750	807	8.3%	Purchased services	91,943	107,250	15,307	14.3%
5,451	8,084	2,633	32.6%	Printing and postage	60,358	88,924	28,566	32.1%
-	537	537	100.0%	Other operating expenses	653	5,907	5,254	88.9%
41,437	35,185	(6,252)	(17.8%)	Indirect cost allocation, occupancy expense	455,812	387,035	(68,777)	(17.8%)
144,661	**136,086**	**(8,575)**	**(6.3%)**	**Total Administrative Expenses**	**1,686,486**	**1,507,665**	**(178,821)**	**(11.9%)**
322,605	**(97,355)**	**419,960**	**431.4%**	**Change in Net Assets**	**(31,294)**	**(720)**	**(30,574)**	**(4246.4%)**
80.0%	***97.5%***	***17.5%***	***17.9%***	***Medical Loss Ratio***	***92.8%***	***91.6%***	***(1.2%)***	***(1.3%)***
6.2%	***8.8%***	***2.6%***	***29.8%***	***Admin Loss Ratio***	***7.4%***	***8.4%***	***1.0%***	***12.4%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
393	**465**	**(72)**	**(15.5%)**	**Member Months**	**4,273**	**4,739**	**(466)**	**-9.8%**
				Revenues				
2,475,598	2,927,495	(451,897)	(15.4%)	Medi-Cal Capitation Revenue	26,906,561	29,835,035	(2,928,474)	(9.8%)
595,470	659,098	(63,628)	(9.7%)	Medicare Part C Revenue	6,880,893	6,871,138	9,755	0.1%
166,597	163,719	2,878	1.8%	Medicare Part D Revenue	1,831,765	1,677,933	153,832	9.2%
3,237,665	**3,750,312**	**(512,647)**	**(13.7%)**	**Total Operating Revenue**	**35,619,220**	**38,384,106**	**(2,764,886)**	**(7.2%)**
				Medical Expenses				
844,771	987,124	142,353	14.4%	Medical Management	9,437,321	10,757,939	1,320,618	12.3%
793,795	945,740	151,945	16.1%	Facilities Claims	8,044,576	9,151,003	1,106,427	12.1%
777,475	766,105	(11,370)	(1.5%)	Professional Claims	7,373,270	7,585,263	211,993	2.8%
132,428	294,879	162,451	55.1%	Patient Transportation	1,291,749	2,887,866	1,596,117	55.3%
280,493	315,214	34,721	11.0%	Prescription Drugs	3,140,878	3,116,827	(24,051)	(0.8%)
93,734	81,227	(12,507)	(15.4%)	MLTSS	726,955	745,213	18,258	2.4%
4,913	20,918	16,006	76.5%	Other Expenses	137,772	209,374	71,603	34.2%
2,927,607	**3,411,207**	**483,600**	**14.2%**	**Total Medical Expenses**	**30,152,522**	**34,453,485**	**4,300,963**	**12.5%**
310,058	**339,105**	**(29,047)**	**-8.6%**	**Gross Margin**	**5,466,698**	**3,930,621**	**1,536,077**	**39.1%**
				Administrative Expenses				
128,246	126,697	(1,549)	(1.2%)	Salaries, wages & employee benefits	1,254,115	1,388,845	134,730	9.7%
123	166	43	25.7%	Professional fees	1,397	1,826	429	23.5%
58,274	39,651	(18,623)	(47.0%)	Purchased services	273,870	348,661	74,791	21.5%
13,168	17,325	4,157	24.0%	Printing and postage	128,931	168,075	39,144	23.3%
2,013	2,070	57	2.8%	Depreciation & amortization	22,259	22,770	511	2.2%
2,066	4,537	2,471	54.5%	Other operating expenses	57,422	46,146	(11,276)	(24.4%)
4,226	4,799	573	11.9%	Indirect Cost Allocation, Occupancy Expense	43,747	50,412	6,665	13.2%
208,117	**195,245**	**(12,872)**	**(6.6%)**	**Total Administrative Expenses**	**1,781,741**	**2,026,735**	**244,994**	**12.1%**
				Operating Tax				
5,832	-	5,832	0.0%	Tax Revenue	63,411	-	63,411	0.0%
5,832	-	(5,832)	0.0%	Premium Tax Expense	63,411	-	(63,411)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
101,941	**143,860**	**(41,919)**	**(29.1%)**	**Change in Net Assets**	**3,684,957**	**1,903,886**	**1,781,071**	**93.5%**
90.4%	***91.0%***	***0.5%***	***0.6%***	***Medical Loss Ratio***	***84.7%***	***89.8%***	***5.1%***	***5.7%***
6.4%	***5.2%***	***(1.2%)***	***(23.5%)***	***Admin Loss Ratio***	***5.0%***	***5.3%***	***0.3%***	***5.3%***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
35,740	55,000	19,260	35.0%	Purchase services	417,985	605,000	187,015	30.9%
168,279	177,250	8,971	5.1%	Depreciation & amortization	1,867,447	1,949,750	82,303	4.2%
19,565	18,500	(1,065)	(5.8%)	Insurance expense	204,934	203,500	(1,434)	(0.7%)
103,438	114,917	11,479	10.0%	Repair and maintenance	1,190,535	1,264,084	73,549	5.8%
24,973	41,250	16,277	39.5%	Other Operating Expense	459,628	453,750	(5,878)	(1.3%)
(351,995)	(406,917)	(54,922)	(13.5%)	Indirect allocation, Occupancy	(4,140,528)	(4,476,084)	(335,556)	(7.5%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

OTHER INCOME STATEMENTS – MAY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.3 million, favorable to budget $0.4 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million, unfavorable to budget $41,919

CalOptima
Balance Sheet
May 31, 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$198,835,254	Accounts Payable	$32,520,232
Investments	1,221,832,539	Medical Claims liability	1,107,290,784
Capitation receivable	322,867,241	Accrued Payroll Liabilities	15,629,408
Receivables - Other	49,506,700	Deferred Revenue	57,681,889
Prepaid expenses	13,158,044	Deferred Lease Obligations	130,184
		Capitation and Withholds	164,900,941
Total Current Assets	**1,806,199,778**	**Total Current Liabilities**	**1,378,153,438**
Capital Assets			
Furniture & Equipment	44,476,086		
Building/Leasehold Improvements	6,571,955		
505 City Parkway West	51,646,314		
	102,694,355		
Less: accumulated depreciation	(56,949,650)		
Capital assets, net	45,744,705	Other (than pensions) post employment benefits liability	26,300,608
Other Assets		Net Pension Liabilities	27,462,720
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	(100,000)
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,431,816,767**
Cash and Cash Equivalents	888,352		
Long-term Investments	588,806,644	Deferred Inflows	
Total Board-designated Assets	589,694,996	Excess Earnings	506,547
		OPEB 75 Difference in Experience	804,000
Total Other Assets	646,793,909	Change in Assumptions	3,728,725
		OPEB Changes in Assumptions	1,638,000
TOTAL ASSETS	**2,498,738,392**	Net Position	
		TNE	106,026,339
Deferred Outflows		Funds in Excess of TNE	965,879,084
Contributions	1,047,297	**TOTAL NET POSITION**	1,071,905,423
Difference in Experience	4,280,308		
Excess Earning	-		
Changes in Assumptions	5,060,465		
OPEB 75 Changes in Assumptions	703,000		
Pension Contributions	570,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,510,399,462**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,510,399,462**

CalOptima
Board Designated Reserve and TNE Analysis
as of May 31, 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	161,218,682				
	Tier 1 - MetLife	160,238,703				
	Tier 1 - Wells Capital	160,413,891				
Board-designated Reserve						
		481,871,275	339,675,211	530,690,161	142,196,065	(48,818,885)
TNE Requirement	Tier 2 - MetLife	107,823,721	106,026,339	106,026,339	1,797,382	1,797,382
	Consolidated:	**589,694,996**	**445,701,550**	**636,716,500**	**143,993,446**	**(47,021,503)**
	Current reserve level	*1.85*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
May 31, 2021

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	11,010,162	46,774,126
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	581,354	5,556,058
Changes in assets and liabilities:		
Prepaid expenses and other	(2,532,178)	(6,458,835)
Catastrophic reserves		
Capitation receivable	2,343,193	73,996,084
Medical claims liability	81,370,246	190,138,764
Deferred revenue	16,340,921	34,258,193
Payable to health networks	24,746,762	21,919,914
Accounts payable	12,849,042	(42,136,214)
Accrued payroll	1,425,504	2,823,986
Other accrued liabilities	(102,844)	(130,674)
Net cash provided by/(used in) operating activities	148,032,162	326,741,402
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(225,647,226)	(497,646,226)
Change in Property and Equipment	(607,116)	(4,646,193)
Change in Board designated reserves	(880,874)	(4,811,103)
Change in Homeless Health Reserve	-	400,000
Net cash provided by/(used in) investing activities	(227,135,215)	(506,703,522)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(79,103,053)	(179,962,120)
CASH AND CASH EQUIVALENTS, beginning of period	$277,938,307	378,797,374
CASH AND CASH EQUIVALENTS, end of period	**198,835,254**	**198,835,254**

BALANCE SHEET – MAY MONTH:

ASSETS of $2.5 billion increased $147.6 million from April or 6.2%

- Investments increased $225.6 million due to the receipt of IGT10 funding, along with the timing of cash receipts and month-end requirements for operating cash
- Operating Cash decreased $79.1 million due to the timing of cash transactions and corresponding movements between cash and investments at month-end
- Capitation Receivables decreased $5.0 million due to the timing of cash receipts

LIABILITIES of $1.4 billion increased $136.6 million from April or 10.5%

- Claims Liabilities increased $81.4 million due IGT 10 with planned disbursement to funding entities in June offset by WCM RRC
- Capitation and Withhold increased $24.7 million due to increase in payables for Proposition 56
- Deferred Revenue increased $16.3 million due to timing of capitation payments from Centers for Medicare & Medicaid Services (CMS) and IGT10
- Accounts Payable increased $12.8 million due to the timing of accruals for the quarterly premium tax

NET ASSETS of $1.1billion, increased $11.0 million from April or 1.0%

Summary of Homeless Health Initiatives and Allocated Funds
As of May 31, 2021

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,231,087		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Funds Allocation Total		**$**	**43,201,087**
Program Commitment Balance, available for new initiatives*		**$**	**56,798,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

Budget Allocation Changes
Reporting Changes for May 2021

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Maintenance HW/SW – Corporate Application SW - LexisNexis	Maintenance HW/SW – HR Corporate Application SW - SilkRoad	$12,000	To repurpose funds from LexisNexis renewal to fund shortages in SilkRoad renewal and additional licenses	2021
October	Medi-Cal	Maintenance HW/SW - UPS Maintenance	Maintenance HW/SW - Desktop - Adobe Acrobat	$35,000	To repurpose funds from UPS Maintenance to fund shortages in Desktop - Adobe Acrobat	2021
October	Medi-Cal	Maintenance HW/SW - Microsoft True-Up	Maintenance HW/SW - Desktop - Microsoft Enterprise License Agreement	$91,000	To repurpose funds from Microsoft License True-Up to fund shortages in the new 3-year Microsoft Enterprise License Agreement	2021
November	Medi-Cal	Business Integration - Temporary Help	Process Excellence - Temporary Help	$43,000	To reallocate funds from Business Integration - Temporary Help to Process Excellence - Temporary Help for an Analyst	2021
January	Medi-Cal	Provider Relations - Printing	Sales & Marketing - Member Communication	$10,000	To reallocate funds from Public Relations - Printing to cover shortage in Sales & Marketing - Member Communications	2021
February	Medi-Cal	Human Resources - Food Service Supply	Human Resources - Cert./Cont. Education	$20,000	To reallocate funds from Food Service Supply to Cert./Cont. Education to fund the education reimbursement program	2021
February	Medi-Cal	Purchase Services - HPA Robot Process	Purchase Services - Burgess Group - Facilities Claims Quarterly	$63,000	To repurpose funds from HPA Robot Process to Burgess Group to cover shortfall in quarterly facilities claims fee	2021
March	Medi-Cal	Employee Learning Management System Network - MDF Switch Upgrade Electronic Health Record System	Provider Portal Communication	$99,500	To reallocate funds from capital projects Employee Learning Management System, MDF Switch Upgrade and Electronic Health Record System to pay for TekSystems invoices	2021
May	Medi-Cal	Quality Improvement - Travel	Quality Improvement - Subscriptions	$10,000	To reallocate funds from Travel to Subscriptions to pay for additional credentialing	2021
May	Medi-Cal	IS Infrastructure – Professional Fees	IS Applications Management – Professional Fees	$35,000	To reallocate funds from IS-Infrastructure Professional Fees (Security - CloudSOC CASB E20 Package) to IS-Applications Management to fund shortage in Core Application Support	2021

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

A Public Agency

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Financial Summary

Preliminary Unaudited Financials

June 30, 2021

Board of Directors Meeting

August 5, 2021

Nancy Huang, Chief Financial Officer

Back to Agenda

FY 2020–21: Year-end Highlights*

As of June 30, 2021	Amount (in million)	Notes
Change in Net Assets - Current Year	$ 108	[1]
Prior Year Related Adjustments	180	[2]
Total Change in Net Assets - Reported	**$ 288**	

[1] Current year surplus is primarily due to:

- Updated Calendar Year (CY) 2021 revenue rates from Department of Health Care Services (DHCS) for long-term care and pharmacy benefits
- Lower than anticipated utilization due to the COVID-19 pandemic

[2] Prior years adjustments that were recognized in current year, include:

- $163 million of CY 2015-2017 In-Home Supportive Services (IHSS) expense release based on updated reconciliation result received from DHCS on June 30, 2021
- $25 million related to retroactive eligibility changes for the period between January 2014 to June 2017, and CY 2019 aged receivables
- Offset by $8 million due to refresh of prior year risk corridors and other estimate changes

* Preliminary results, subject to final financial audit

Back to Agenda

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FY 2020–21: Management Summary

- Change in Net Assets (Deficit) or Surplus
  - MTD: $241.2 million, favorable to budget $247.4 million or 4,011.2%
    - Primarily driven by IHSS, Intergovernmental Transfer (IGT) 10, revenue and retroactive eligibility changes
  - YTD: $288.0 million, favorable to budget $329.7 million or 790.0%
- Enrollment
  - MTD: 842,241 members, favorable to budget 25,672 or 3.1%
  - YTD: 9,717,418 member months, favorable to budget 113,793 or 1.2%
- Revenue
  - MTD: $402.2 million, favorable to budget $129.9 million or 47.7% driven by Medi-Cal (MC) line of business (LOB):
    - $54.6 million of prescription drug revenue due to postponement of pharmacy benefits transition to Fee For Service (FFS)
    - $45.4 million of IGT 10 revenue, $29.5 million due to CY 2021 rate update, Prior Year (PY) retroactive eligibility changes, and net of Gross Medical Expenditures (GME) and Proposition 56 risk corridor estimates
    - $7.3 million favorable volume related variance
  - YTD: $4.1 billion, favorable to budget $583.5 million or 16.4% driven by MC LOB:
    - Fiscal Year (FY) 2019 hospital Directed Payments (DP), postponement of pharmacy benefits transition to FFS, IGT 10 and prior year adjustments
    - Offset by the Bridge Period GME risk corridor and Proposition 56 risk corridor reserve

Back to Agenda

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FY 2020–21: Management Summary (cont.)

- Medical Expenses
  - MTD: $143.3 million, favorable to budget $123.4 million or 46.3% driven by MC LOB:
    - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $174.9 million due the release of IHSS estimates for July 2015 through December 2017 based on the reconciliation summary received from DHCS on June 30, 2021
    - Provider Capitation expense favorable variance of $11.7 million due to release of PY Proposition 56 estimates
    - Offset by Prescription Drugs expense unfavorable variance of $56.0 million due to postponement of pharmacy benefits transition to FFS
  - YTD: $3.7 billion, unfavorable to budget $259.2 million or 7.5% driven by:
    - MC LOB FY 2019 hospital DP and postponement of pharmacy benefits transition to FFS, offset by release of IHSS expenses and decreased utilization during COVID-19 pandemic at the start of the FY
    - OCC LOB unfavorable to budget $24.5 million or 8.2% due to higher Provider Capitation and Facilities Claims expenses
- Administrative Expenses
  - MTD: $18.1 million, unfavorable to budget $5.2 million or 40.2% due to the annual adjustment according to CalPERS pension actuarial report as required by GASB 68
  - YTD: $142.3 million, favorable to budget $9.7 million or 6.4%
- Net Investment & Other Income
  - MTD: $0.5 million, unfavorable to budget $0.7 million or 59.0%
  - YTD: $10.7 million, unfavorable to budget $4.3 million or 28.7% due to decrease in long-term bond values that are affected by higher interest rates

Back to Agenda

CalOptima A Public Agency

FY 2020–21: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 35.6% (33.8% excluding DP), Budget 98.0%
  - YTD: Actual 89.9% (89.2% excluding DP), Budget 97.3%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 4.5% (4.5% excluding DP), Budget 4.7%
  - YTD: Actual 3.4% (3.6% excluding DP), Budget 4.3%
- Balance Sheet Ratios
  - Current ratio: 1.6
  - Board-designated reserve funds level: 1.80
  - Net position: $1.3 billion, including required Tangible Net Equity (TNE) of $101.2 million

Back to Agenda

CalOptima
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Enrollment Summary: June 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
117,086	111,207	5,879	5.3%	SPD	1,382,346	1,331,913	50,433	3.8%
516	460	56	12.2%	BCCTP	6,189	5,690	499	8.8%
297,817	320,582	(22,765)	(7.1%)	TANF Child	3,522,896	3,751,361	(228,465)	(6.1%)
107,362	96,336	11,026	11.4%	TANF Adult	1,214,937	1,127,830	87,107	7.7%
3,006	3,527	(521)	(14.8%)	LTC	37,895	42,192	(4,297)	(10.2%)
287,553	256,832	30,721	12.0%	MCE	3,212,396	3,011,858	200,538	6.7%
11,736	11,932	(196)	(1.6%)	WCM	139,611	143,178	(3,567)	(2.5%)
825,076	**800,876**	**24,200**	**3.0%**	**Medi-Cal Total**	**9,516,270**	**9,414,022**	**102,248**	**1.1%**
14,833	**13,843**	**990**	**7.2%**	**OneCare Connect**	**176,448**	**167,856**	**8,592**	**5.1%**
1,934	**1,378**	**556**	**40.3%**	**OneCare**	**20,029**	**16,536**	**3,493**	**21.1%**
398	**472**	**(74)**	**(15.7%)**	**PACE**	**4,671**	**5,211**	**(540)**	**(10.4%)**
842,241	**816,569**	**25,672**	**3.1%**	**CalOptima Total**	**9,717,418**	**9,603,625**	**113,793**	**1.2%**

Back to Agenda

CalOptima
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Financial Highlights: June 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
842,241	816,569	25,672	3.1%	Member Months	9,717,418	9,603,625	113,793	1.2%
402,166,827	272,235,101	129,931,726	47.7%	Revenues	4,138,544,138	3,555,013,609	583,530,529	16.4%
143,333,230	266,727,963	123,394,733	46.3%	Medical Expenses	3,718,927,283	3,459,700,922	(259,226,361)	(7.5%)
18,115,518	12,924,857	(5,190,661)	(40.2%)	Administrative Expenses	142,310,547	152,054,355	9,743,808	6.4%
240,718,079	**(7,417,719)**	**248,135,798**	**3345.2%**	**Operating Margin**	**277,306,308**	**(56,741,668)**	**334,047,976**	**588.7%**
512,041	1,250,000	(737,959)	(59.0%)	Non Operating Income (Loss)	10,697,938	15,000,000	(4,302,062)	(28.7%)
241,230,120	**(6,167,719)**	**247,397,839**	**4011.2%**	**Change in Net Assets**	**288,004,246**	**(41,741,668)**	**329,745,914**	**790.0%**
35.6%	98.0%	62.3%		Medical Loss Ratio	89.9%	97.3%	7.5%	
4.5%	4.7%	0.2%		Administrative Loss Ratio	3.4%	4.3%	0.8%	
59.9%	(2.7%)	62.6%		Operating Margin Ratio	6.7%	(1.6%)	8.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
33.8%	98.0%	64.2%		*MLR (excluding Directed Payments)	89.2%	97.3%	8.1%	
4.5%	4.7%	0.2%		*ALR (excluding Directed Payments)	3.6%	4.3%	0.7%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

Back to Agenda

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Consolidated Performance Actual vs. Budget: June 2021(in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
242.9	(6.6)	249.5	Medi-Cal	275.3	(47.4)	322.8
(1.7)	(0.9)	(0.8)	OCC	(1.2)	(11.3)	10.1
(0.4)	(0.1)	(0.3)	OneCare	(0.4)	(0.1)	(0.4)
(0.0)	0.2	(0.2)	PACE	3.7	2.1	1.6
240.7	**(7.4)**	**248.1**	**Operating**	**277.3**	**(56.7)**	**334.0**
0.5	1.3	(0.7)	Inv./Rental Inc, MCO tax	10.7	15.0	(4.3)
0.5	**1.3**	**(0.7)**	**Non-Operating**	**10.7**	**15.0**	**(4.3)**
241.2	**(6.2)**	**247.4**	**TOTAL**	**288.0**	**(41.7)**	**329.7**

Back to Agenda

CalOptima
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Consolidated Revenue & Expenses: June 2021 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	525,787	287,553	11,736	825,076	14,833	1,934	398	842,241
REVENUES								
Capitation Revenue	176,131,956	$ 156,338,091	$ 33,798,220	$ 366,268,267	$ 29,820,681	$ 2,676,168	$ 3,401,710	$ 402,166,827
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	176,131,956	156,338,091	33,798,220	366,268,267	29,820,681	2,676,168	3,401,710	402,166,827
MEDICAL EXPENSES								
Provider Capitation	34,030,620	45,053,659	5,804,697	84,888,976	14,437,649	753,735		100,080,360
Facilities	21,737,179	21,608,290	3,404,925	46,750,394	3,540,426	959,252	1,033,033	52,283,105
Professional Claims	22,961,818	10,110,597	1,642,645	34,715,059	1,244,086	86,538	592,892	36,638,575
Prescription Drugs	21,365,423	28,766,994	5,887,375	56,019,792	7,381,002	806,141	378,637	64,585,571
MLTSS	(86,762,935)	(48,446,709)	1,687,750	(133,521,894)	1,360,859	73,093	71,546	(132,016,397)
Medical Management	2,706,585	2,065,539	513,402	5,285,526	1,702,185	104,737	929,482	8,021,930
Quality Incentives	(1,736,303)	(1,113,742)	(100,718)	(2,950,763)	(355,427)		4,975	(3,301,215)
Reinsurance & Other	8,509,827	7,755,694	(23,734)	16,241,787	585,504	64,334	149,674	17,041,300
Total Medical Expenses	22,812,214	65,800,320	18,816,342	107,428,877	29,896,284	2,847,830	3,160,239	143,333,230
Medical Loss Ratio	13.0%	42.1%	55.7%	29.3%	100.3%	106.4%	92.9%	35.6%
GROSS MARGIN	**153,319,742**	**90,537,771**	**14,981,878**	**258,839,390**	**(75,602)**	**(171,663)**	**241,472**	**258,833,597**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				12,242,115	718,178	70,811	110,248	13,141,352
Professional fees				221,964	199,880	71,123	233	493,200
Purchased services				1,131,309	180,549	14,108	105,334	1,431,300
Printing & Postage				312,756	69,249	13,305	33,343	428,654
Depreciation & Amortization				429,758			2,013	431,771
Other expenses				1,748,377	32,584	-	4,510	1,785,470
Indirect cost allocation & Occupancy				(134,970)	470,548	64,060	4,132	403,770
Total Administrative Expenses				15,951,310	1,670,988	233,408	259,813	18,115,518
Admin Loss Ratio				4.4%	5.6%	8.7%	7.6%	4.5%
INCOME (LOSS) FROM OPERATIONS				242,888,080	(1,746,590)	(405,070)	(18,342)	240,718,079
INVESTMENT INCOME								(914,691)
TOTAL MCO TAX				1,426,732				1,426,732
CHANGE IN NET ASSETS				**$ 244,314,812**	**$ (1,746,590)**	**$ (405,070)**	**$ (18,342)**	**$ 241,230,120**
BUDGETED CHANGE IN NET ASSETS				(6,593,724)	(929,167)	(65,055)	170,227	(6,167,719)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 250,908,536	$ (817,423)	$ (340,015)	$ (188,569)	$ 247,397,839

Back to Agenda

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Consolidated Revenue & Expenses: June 2021 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	6,164,263	3,212,396	139,611	9,516,270	176,448	20,029	4,671	9,717,418
REVENUES								
Capitation Revenue	1,913,342,631	$ 1,525,558,283	$ 295,523,461	$ 3,734,424,376	$ 339,575,110	$ 25,523,722	$ 39,020,930	$ 4,138,544,138
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,913,342,631	1,525,558,283	295,523,461	3,734,424,376	339,575,110	25,523,722	39,020,930	4,138,544,138
MEDICAL EXPENSES								
Provider Capitation	471,389,064	554,895,207	143,724,785	1,170,009,055	145,854,600	7,028,982		1,322,892,637
Facilities	283,920,498	296,166,694	30,233,870	610,321,063	58,293,261	7,310,682	9,077,609	685,002,615
Professional Claims	243,285,877	112,611,640	14,139,401	370,036,919	12,412,988	988,396	7,966,162	391,404,464
Prescription Drugs	242,319,539	314,936,811	66,686,694	623,943,044	71,681,403	7,652,291	3,519,514	706,796,252
MLTSS	277,726,827	(16,510,831)	21,713,562	282,929,558	16,550,519	483,169	798,501	300,761,747
Medical Management	28,527,084	17,412,060	3,781,297	49,720,440	13,757,565	492,191	10,366,804	74,337,000
Quality Incentives	9,783,204	4,647,845	497,703	14,928,752	2,023,603		142,747	17,095,102
Reinsurance & Other	122,153,296	94,754,630	108,684	217,016,610	2,094,951	84,482	1,441,423	220,637,466
Total Medical Expenses	1,679,105,388	1,378,914,056	280,885,996	3,338,905,441	322,668,889	24,040,193	33,312,760	3,718,927,283
Medical Loss Ratio	87.8%	90.4%	95.0%	89.4%	95.0%	94.2%	85.4%	89.9%
GROSS MARGIN	**234,237,243**	**146,644,227**	**14,637,465**	**395,518,935**	**16,906,221**	**1,483,529**	**5,708,170**	**419,616,855**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				87,683,047	8,405,877	959,559	1,364,363	98,412,845
Professional fees				1,608,048	456,705	260,095	1,630	2,326,479
Purchased services				10,228,130	1,176,718	106,051	379,205	11,890,104
Printing & Postage				3,041,703	891,828	73,663	162,274	4,169,469
Depreciation & Amortization				4,096,111			24,272	4,120,383
Other expenses				16,795,157	302,152	653	61,932	17,159,893
Indirect cost allocation & Occupancy				(3,252,909)	6,916,533	519,872	47,879	4,231,375
Total Administrative Expenses				120,199,287	18,149,813	1,919,893	2,041,555	142,310,547
Admin Loss Ratio				3.2%	5.3%	7.5%	5.2%	3.4%
INCOME (LOSS) FROM OPERATIONS				275,319,649	(1,243,592)	(436,365)	3,666,616	277,306,308
INVESTMENT INCOME								5,934,322
TOTAL MCO TAX				4,748,629				4,748,629
TOTAL GRANT INCOME				14,050				14,050
OTHER INCOME				937				937
CHANGE IN NET ASSETS				**$ 280,083,265**	**$ (1,243,592)**	**$ (436,365)**	**$ 3,666,616**	**$ 288,004,246**
BUDGETED CHANGE IN NET ASSETS				(47,437,489)	(11,312,517)	(65,775)	2,074,113	(41,741,668)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 327,520,754	$ 10,068,925	$ (370,590)	$ 1,592,503	$ 329,745,914

Back to Agenda

CalOptima
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Balance Sheet: As of June 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$281,834,499	Accounts Payable	$46,468,291
Investments	1,065,409,806	Medical Claims liability	942,847,325
Capitation receivable	427,608,293	Accrued Payroll Liabilities	16,216,920
Receivables - Other	48,973,267	Deferred Revenue	13,586,826
Prepaid expenses	11,978,611	Deferred Lease Obligations	127,328
		Capitation and Withholds	142,384,140
Total Current Assets	**1,835,804,476**	**Total Current Liabilities**	**1,161,630,830**
Capital Assets			
Furniture & Equipment	46,251,085		
Building/Leasehold Improvements	5,326,911		
505 City Parkway West	51,777,223		
	103,355,219		
Less: accumulated depreciation	(57,627,344)		
Capital assets, net	45,727,876		
		Other (than pensions) post employment benefits liability	26,339,413
Other Assets		Net Pension Liabilities	30,620,005
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,218,590,248**
Cash and Cash Equivalents	3,345,793		
Long-term Investments	585,534,359	**Deferred Inflows**	
Total Board-designated Assets	588,880,152	Excess Earnings	344,198
		OPEB 75 Difference in Experience	804,000
		Change in Assumptions	2,709,945
Total Other Assets	645,979,065	OPEB Changes in Assumptions	1,638,000
		Net Position	
TOTAL ASSETS	**2,527,511,417**	TNE	101,157,582
		Funds in Excess of TNE	1,211,977,961
Deferred Outflows		**TOTAL NET POSITION**	1,313,135,543
Contributions	1,508,025		
Difference in Experience	3,236,721		
Excess Earning	-		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	703,000		
Pension Contributions	570,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,537,221,934**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,537,221,934**

Back to Agenda

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Board Designated Reserve and TNE Analysis: As of June 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	241,158,321				
	Tier 1 - MetLife	240,141,145				
	Tier 1 - Wells Capital*	-				
Board-designated Reserve		481,299,467	356,633,475	552,829,643	124,665,991	(71,530,176)
TNE Requirement	Tier 2 - MetLife	107,580,680	101,157,582	101,157,582	6,423,098	6,423,098
	Consolidated:	**588,880,146**	**457,791,057**	**653,987,224**	**131,089,089**	**(65,107,078)**
	Current reserve level	*1.80*	*1.40*	*2.00*		

*Investments from Wells Capital were transferrd to Payden & Rygel and MetLife due to Board approved changes to investment managers.

Back to Agenda

CalOptima
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Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Back to Agenda

CalOptima
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UNAUDITED FINANCIAL STATEMENTS

June 2021

Preliminary Report as of July 19, 2021

Final fiscal year report is subject to change following financial audit

Back to Agenda

Table of Contents

Financial Highlights 3
Financial Dashboard 4
Statement of Revenues and Expenses – Consolidated Month to Date 5
Statement of Revenues and Expenses – Consolidated Year to Date 6
Statement of Revenues and Expenses – Consolidated LOB Month to Date 7
Statement of Revenues and Expenses – Consolidated LOB Year to Date 8
Highlights – Overall 9
Enrollment Summary 10
Enrollment Trended by Network Type 11
Highlights – Enrollment 12
Statement of Revenues and Expenses – Medi-Cal 13
Highlights – Medi-Cal 14
Highlights – Medi-Cal (cont.) 15
Statement of Revenues and Expenses – OneCare Connect 16
Highlights – OneCare Connect 17
Statement of Revenues and Expenses – OneCare 18
Statement of Revenues and Expenses – PACE 19
Statement of Revenues and Expenses – 505 City Parkway 20
Highlights – OneCare, PACE & 505 City Parkway 21
Balance Sheet 22
Board Designated Reserve & TNE Analysis 23
Statement of Cash Flow 24
Highlights – Balance Sheet & Statement of Cash Flow 25
Homeless Health Reserve Report 26
Budget Allocation Changes 27

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the Twelve Months Ended June 30, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
842,241	816,569	25,672	3.1%	Member Months	9,717,418	9,603,625	113,793	1.2%
402,166,827	272,235,101	129,931,726	47.7%	Revenues	4,138,544,138	3,555,013,609	583,530,529	16.4%
143,333,230	266,727,963	123,394,733	46.3%	Medical Expenses	3,718,927,283	3,459,700,922	(259,226,361)	(7.5%)
18,115,518	12,924,857	(5,190,661)	(40.2%)	Administrative Expenses	142,310,547	152,054,355	9,743,808	6.4%
240,718,079	**(7,417,719)**	**248,135,798**	**3345.2%**	**Operating Margin**	**277,306,308**	**(56,741,668)**	**334,047,976**	**588.7%**
512,041	1,250,000	(737,959)	(59.0%)	Non Operating Income (Loss)	10,697,938	15,000,000	(4,302,062)	(28.7%)
241,230,120	**(6,167,719)**	**247,397,839**	**4011.2%**	**Change in Net Assets**	**288,004,246**	**(41,741,668)**	**329,745,914**	**790.0%**
35.6%	98.0%	62.3%		Medical Loss Ratio	89.9%	97.3%	7.5%	
4.5%	4.7%	0.2%		Administrative Loss Ratio	3.4%	4.3%	0.8%	
59.9%	(2.7%)	62.6%		Operating Margin Ratio	6.7%	(1.6%)	8.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
33.8%	98.0%	64.2%		*MLR (excluding Directed Payments)	89.2%	97.3%	8.1%	
4.5%	4.7%	0.2%		*ALR (excluding Directed Payments)	3.6%	4.3%	0.7%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Twelve Months Ended June 30, 2021

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	825,076	800,876	24,200	3.0%
OneCare Connect	14,833	13,843	990	7.2%
OneCare	1,934	1,378	556	40.3%
PACE	398	472	(74)	(15.7%)
Total	842,241	816,569	25,672	3.1%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 244,315	$ (6,594)	$ 250,909	3805.1%
OneCare Connect	(1,747)	(929)	(818)	(88.1%)
OneCare	(405)	(65)	(340)	(523.1%)
PACE	(18)	170	(188)	(110.6%)
505 Bldg.	-	-	-	0.0%
Investment Income & Other	(915)	1,250	(2,165)	(173.2%)
Total	$ 241,230	$ (6,168)	$ 247,398	4011.0%

MLR

	Actual	Budget	% Point Var
Medi-Cal	29.3%	98.2%	68.9
OneCare Connect	100.3%	97.1%	(3.1)
OneCare	106.4%	95.3%	(11.1)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 15,951	$ 10,926	$ (5,026)	(46.0%)
OneCare Connect	1,671	1,656	(15)	(0.9%)
OneCare	233	139	(94)	(67.7%)
PACE	260	204	(56)	(27.4%)
Total	$ 18,116	$ 12,925	$ (5,191)	(40.2%)

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,071	1,161	90
OneCare Connect	192	210	17
OneCare	10	9	(1)
PACE	90	116	27
Total	1,363	1,496	133

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	770	690	80
OneCare Connect	77	66	11
OneCare	194	148	45
PACE	4	4	0
Total	1,045	908	137

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	9,516,270	9,414,022	102,248	1.1%
OneCare Connect	176,448	167,856	8,592	5.1%
OneCare	20,029	16,536	3,493	21.1%
PACE	4,671	5,211	(540)	(10.4%)
Total	9,717,418	9,603,625	113,793	1.2%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 280,083	$ (47,437)	$ 327,520	690.4%
OneCare Connect	(1,244)	(11,313)	10,069	89.0%
OneCare	(436)	(66)	(370)	(560.6%)
PACE	3,667	2,074	1,593	76.8%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	5,934	15,000	(9,066)	(60.4%)
Total	$ 288,004	$ (41,742)	$ 329,746	790.0%

MLR

	Actual	Budget	% Point Var
Medi-Cal	89.4%	97.5%	8.1
OneCare Connect	95.0%	97.3%	2.3
OneCare	94.2%	91.9%	(2.3)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 120,199	$ 128,736	$ 8,536	6.6%
OneCare Connect	18,150	19,441	1,291	6.6%
OneCare	1,920	1,647	(273)	(16.6%)
PACE	2,042	2,231	189	8.5%
Total	$ 142,311	$ 152,054	$ 9,744	6.4%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	12,930	13,930	999
OneCare Connect	2,303	2,517	214
OneCare	120	112	(9)
PACE	1,103	1,395	292
Total	16,458	17,953	1,496

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	736	676	60
OneCare Connect	77	67	10
OneCare	167	148	18
PACE	4	4	0
Total	983	894	89

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended June 30, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	842,241		816,569		25,672	
REVENUE						
Medi-Cal	$ 366,268,267	$ 443.92	$ 241,356,570	$ 301.37	$ 124,911,697	$ 142.55
OneCare Connect	29,820,681	2,010.43	25,492,078	1,841.51	4,328,603	168.92
OneCare	2,676,168	1,383.75	1,580,976	1,147.30	1,095,192	236.45
PACE	3,401,710	8,547.01	3,805,477	8,062.45	(403,767)	484.56
Total Operating Revenue	402,166,827	477.50	272,235,101	333.39	129,931,726	144.11
MEDICAL EXPENSES						
Medi-Cal	107,428,877	130.20	237,024,654	295.96	129,595,777	165.76
OneCare Connect	29,896,284	2,015.53	24,765,109	1,789.00	(5,131,175)	(226.53)
OneCare	2,847,830	1,472.51	1,506,862	1,093.51	(1,340,968)	(379.00)
PACE	3,160,239	7,940.30	3,431,338	7,269.78	271,099	(670.52)
Total Medical Expenses	143,333,230	170.18	266,727,963	326.64	123,394,733	156.46
GROSS MARGIN	258,833,597	307.32	5,507,138	6.75	253,326,459	300.57
ADMINISTRATIVE EXPENSES						
Salaries and benefits	13,141,352	15.60	8,362,913	10.24	(4,778,439)	(5.36)
Professional fees	493,200	0.59	376,770	0.46	(116,430)	(0.13)
Purchased services	1,431,300	1.70	1,086,322	1.33	(344,978)	(0.37)
Printing & Postage	428,654	0.51	557,612	0.68	128,958	0.17
Depreciation & Amortization	431,771	0.51	460,570	0.56	28,799	0.05
Other expenses	1,785,470	2.12	1,705,225	2.09	(80,245)	(0.03)
Indirect cost allocation & Occupancy expense	403,770	0.48	375,445	0.46	(28,325)	(0.02)
Total Administrative Expenses	18,115,518	21.51	12,924,857	15.83	(5,190,661)	(5.68)
INCOME (LOSS) FROM OPERATIONS	240,718,079	285.81	(7,417,719)	(9.08)	248,135,798	294.89
INVESTMENT INCOME						
Interest income	43,738	0.05	1,250,000	1.53	(1,206,262)	(1.48)
Realized gain/(loss) on investments	281,140	0.33	-	-	281,140	0.33
Unrealized gain/(loss) on investments	(1,239,569)	(1.47)	-	-	(1,239,569)	(1.47)
Total Investment Income	(914,691)	(1.09)	1,250,000	1.53	(2,164,691)	(2.62)
TOTAL MCO TAX	1,426,732	1.69	-	-	1,426,732	1.69
CHANGE IN NET ASSETS	**241,230,120**	**286.41**	**(6,167,719)**	**(7.55)**	**247,397,839**	**293.96**
MEDICAL LOSS RATIO	**35.6%**		**98.0%**		**62.3%**	
ADMINISTRATIVE LOSS RATIO	**4.5%**		**4.7%**		**0.2%**	

Preliminary

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	9,717,418		9,603,625		113,793	
REVENUE						
Medi-Cal	$ 3,734,424,376	$ 392.43	$ 3,187,027,860	$ 338.54	$ 547,396,516	$ 53.89
OneCare Connect	339,575,110	1,924.51	306,323,384	1,824.92	33,251,726	99.59
OneCare	25,523,722	1,274.34	19,472,782	1,177.60	6,050,940	96.74
PACE	39,020,930	8,353.87	42,189,583	8,096.25	(3,168,653)	257.62
Total Operating Revenue	4,138,544,138	425.89	3,555,013,609	370.17	583,530,529	55.72
MEDICAL EXPENSES						
Medi-Cal	3,338,905,441	350.86	3,105,729,773	329.90	(233,175,668)	(20.96)
OneCare Connect	322,668,889	1,828.69	298,194,603	1,776.49	(24,474,286)	(52.20)
OneCare	24,040,193	1,200.27	17,891,723	1,081.99	(6,148,470)	(118.28)
PACE	33,312,760	7,131.83	37,884,823	7,270.16	4,572,063	138.33
Total Medical Expenses	3,718,927,283	382.71	3,459,700,922	360.25	(259,226,361)	(22.46)
GROSS MARGIN	419,616,855	43.18	95,312,687	9.92	324,304,168	33.26
ADMINISTRATIVE EXPENSES						
Salaries and benefits	98,412,845	10.13	95,973,446	9.99	(2,439,399)	(0.14)
Professional fees	2,326,479	0.24	4,484,100	0.47	2,157,621	0.23
Purchased services	11,890,104	1.22	14,213,659	1.48	2,323,555	0.26
Printing & Postage	4,169,469	0.43	6,894,270	0.72	2,724,801	0.29
Depreciation & Amortization	4,120,383	0.42	5,526,840	0.58	1,406,457	0.16
Other expenses	17,159,893	1.77	20,388,147	2.12	3,228,254	0.35
Indirect cost allocation & Occupancy expense	4,231,375	0.44	4,573,893	0.48	342,518	0.04
Total Administrative Expenses	142,310,547	14.64	152,054,355	15.83	9,743,808	1.19
INCOME (LOSS) FROM OPERATIONS	277,306,308	28.54	(56,741,668)	(5.91)	334,047,976	34.45
INVESTMENT INCOME						
Interest income	10,129,377	1.04	15,000,000	1.56	(4,870,623)	(0.52)
Realized gain/(loss) on investments	5,420,087	0.56	-	-	5,420,087	0.56
Unrealized gain/(loss) on investments	(9,615,143)	(0.99)	-	-	(9,615,143)	(0.99)
Total Investment Income	5,934,322	0.61	15,000,000	1.56	(9,065,678)	(0.95)
TOTAL MCO TAX	4,748,629	0.49	-	-	4,748,629	0.49
TOTAL GRANT INCOME	14,050	-	-	-	14,050	-
OTHER INCOME	937	-	-	-	937	-
CHANGE IN NET ASSETS	**288,004,246**	**29.64**	**(41,741,668)**	**(4.35)**	**329,745,914**	**33.99**
MEDICAL LOSS RATIO	**89.9%**		**97.3%**		**7.5%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.3%**		**0.8%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended June 30, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	525,787	287,553	11,736	825,076	14,833	1,934	398	842,241
REVENUES								
Capitation Revenue	176,131,956	$ 156,338,091	$ 33,798,220	$ 366,268,267	$ 29,820,681	$ 2,676,168	$ 3,401,710	$ 402,166,827
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	176,131,956	156,338,091	33,798,220	366,268,267	29,820,681	2,676,168	3,401,710	402,166,827
MEDICAL EXPENSES								
Provider Capitation	34,030,620	45,053,659	5,804,697	84,888,976	14,437,649	753,735		100,080,360
Facilities	21,737,179	21,608,290	3,404,925	46,750,394	3,540,426	959,252	1,033,033	52,283,105
Professional Claims	22,961,818	10,110,597	1,642,645	34,715,059	1,244,086	86,538	592,892	36,638,575
Prescription Drugs	21,365,423	28,766,994	5,887,375	56,019,792	7,381,002	806,141	378,637	64,585,571
MLTSS	(86,762,935)	(48,446,709)	1,687,750	(133,521,894)	1,360,859	73,093	71,546	(132,016,397)
Medical Management	2,706,585	2,065,539	513,402	5,285,526	1,702,185	104,737	929,482	8,021,930
Quality Incentives	(1,736,303)	(1,113,742)	(100,718)	(2,950,763)	(355,427)		4,975	(3,301,215)
Reinsurance & Other	8,509,827	7,755,694	(23,734)	16,241,787	585,504	64,334	149,674	17,041,300
Total Medical Expenses	22,812,214	65,800,320	18,816,342	107,428,877	29,896,284	2,847,830	3,160,239	143,333,230
Medical Loss Ratio	13.0%	42.1%	55.7%	29.3%	100.3%	106.4%	92.9%	35.6%
GROSS MARGIN	**153,319,742**	**90,537,771**	**14,981,878**	**258,839,390**	**(75,602)**	**(171,663)**	**241,472**	**258,833,597**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				12,242,115	718,178	70,811	110,248	13,141,352
Professional fees				221,964	199,880	71,123	233	493,200
Purchased services				1,131,309	180,549	14,108	105,334	1,431,300
Printing & Postage				312,756	69,249	13,305	33,343	428,654
Depreciation & Amortization				429,758			2,013	431,771
Other expenses				1,748,377	32,584	-	4,510	1,785,470
Indirect cost allocation & Occupancy				(134,970)	470,548	64,060	4,132	403,770
Total Administrative Expenses				15,951,310	1,670,988	233,408	259,813	18,115,518
Admin Loss Ratio				4.4%	5.6%	8.7%	7.6%	4.5%
INCOME (LOSS) FROM OPERATIONS				242,888,080	(1,746,590)	(405,070)	(18,342)	240,718,079
INVESTMENT INCOME								(914,691)
TOTAL MCO TAX				1,426,732				1,426,732
CHANGE IN NET ASSETS				**$ 244,314,812**	**$ (1,746,590)**	**$ (405,070)**	**$ (18,342)**	**$ 241,230,120**
BUDGETED CHANGE IN NET ASSETS				(6,593,724)	(929,167)	(65,055)	170,227	(6,167,719)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 250,908,536	$ (817,423)	$ (340,015)	$ (188,569)	$ 247,397,839

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Twelve Months Ended June 30, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	6,164,263	3,212,396	139,611	9,516,270	176,448	20,029	4,671	9,717,418
REVENUES								
Capitation Revenue	1,913,342,631	$ 1,525,558,283	$ 295,523,461	$ 3,734,424,376	$ 339,575,110	$ 25,523,722	$ 39,020,930	$ 4,138,544,138
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,913,342,631	1,525,558,283	295,523,461	3,734,424,376	339,575,110	25,523,722	39,020,930	4,138,544,138
MEDICAL EXPENSES								
Provider Capitation	471,389,064	554,895,207	143,724,785	1,170,009,055	145,854,600	7,028,982		1,322,892,637
Facilities	283,920,498	296,166,694	30,233,870	610,321,063	58,293,261	7,310,682	9,077,609	685,002,615
Professional Claims	243,285,877	112,611,640	14,139,401	370,036,919	12,412,988	988,396	7,966,162	391,404,464
Prescription Drugs	242,319,539	314,936,811	66,686,694	623,943,044	71,681,403	7,652,291	3,519,514	706,796,252
MLTSS	277,726,827	(16,510,831)	21,713,562	282,929,558	16,550,519	483,169	798,501	300,761,747
Medical Management	28,527,084	17,412,060	3,781,297	49,720,440	13,757,565	492,191	10,366,804	74,337,000
Quality Incentives	9,783,204	4,647,845	497,703	14,928,752	2,023,603		142,747	17,095,102
Reinsurance & Other	122,153,296	94,754,630	108,684	217,016,610	2,094,951	84,482	1,441,423	220,637,466
Total Medical Expenses	1,679,105,388	1,378,914,056	280,885,996	3,338,905,441	322,668,889	24,040,193	33,312,760	3,718,927,283
Medical Loss Ratio	87.8%	90.4%	95.0%	89.4%	95.0%	94.2%	85.4%	89.9%
GROSS MARGIN	**234,237,243**	**146,644,227**	**14,637,465**	**395,518,935**	**16,906,221**	**1,483,529**	**5,708,170**	**419,616,855**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				87,683,047	8,405,877	959,559	1,364,363	98,412,845
Professional fees				1,608,048	456,705	260,095	1,630	2,326,479
Purchased services				10,228,130	1,176,718	106,051	379,205	11,890,104
Printing & Postage				3,041,703	891,828	73,663	162,274	4,169,469
Depreciation & Amortization				4,096,111			24,272	4,120,383
Other expenses				16,795,157	302,152	653	61,932	17,159,893
Indirect cost allocation & Occupancy				(3,252,909)	6,916,533	519,872	47,879	4,231,375
Total Administrative Expenses				120,199,287	18,149,813	1,919,893	2,041,555	142,310,547
Admin Loss Ratio				3.2%	5.3%	7.5%	5.2%	3.4%
INCOME (LOSS) FROM OPERATIONS				275,319,649	(1,243,592)	(436,365)	3,666,616	277,306,308
INVESTMENT INCOME								5,934,322
TOTAL MCO TAX				4,748,629				4,748,629
TOTAL GRANT INCOME				14,050				14,050
OTHER INCOME				937				937
CHANGE IN NET ASSETS				**$ 280,083,265**	**$ (1,243,592)**	**$ (436,365)**	**$ 3,666,616**	**$ 288,004,246**
BUDGETED CHANGE IN NET ASSETS				(47,437,489)	(11,312,517)	(65,775)	2,074,113	(41,741,668)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 327,520,754	$ 10,068,925	$ (370,590)	$ 1,592,503	$ 329,745,914

June 30, 2021 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $241.2 million, $247.4 million favorable to budget
- Operating surplus is $240.7 million, with a surplus in non-operating income of $0.5 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $288.0 million, $329.7 million favorable to budget
- Operating surplus is $277.3 million, with a surplus in non-operating income of $10.7 million
- Investment Income & Other unfavorable variance of $4.3 million due to decrease in long-term bond values that are affected by higher interest rates

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
242.9	(6.6)	249.5	Medi-Cal	275.3	(47.4)	322.8
(1.7)	(0.9)	(0.8)	OCC	(1.2)	(11.3)	10.1
(0.4)	(0.1)	(0.3)	OneCare	(0.4)	(0.1)	(0.4)
(0.0)	0.2	(0.2)	PACE	3.7	2.1	1.6
240.7	**(7.4)**	**248.1**	**Operating**	**277.3**	**(56.7)**	**334.0**
0.5	1.3	(0.7)	Inv./Rental Inc, MCO tax	10.7	15.0	(4.3)
0.5	**1.3**	**(0.7)**	**Non-Operating**	**10.7**	**15.0**	**(4.3)**
241.2	**(6.2)**	**247.4**	**TOTAL**	**288.0**	**(41.7)**	**329.7**

CalOptima - Consolidated
Enrollment Summary
For the Twelve Months Ended June 30, 2021

Month-to-Date					Year-to-Date			
		$	%				$	%
Actual	**Budget**	**Variance**	**Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**Variance**	**Variance**
117,086	111,207	5,879	5.3%	SPD	1,382,346	1,331,913	50,433	3.8%
516	460	56	12.2%	BCCTP	6,189	5,690	499	8.8%
297,817	320,582	(22,765)	(7.1%)	TANF Child	3,522,896	3,751,361	(228,465)	(6.1%)
107,362	96,336	11,026	11.4%	TANF Adult	1,214,937	1,127,830	87,107	7.7%
3,006	3,527	(521)	(14.8%)	LTC	37,895	42,192	(4,297)	(10.2%)
287,553	256,832	30,721	12.0%	MCE	3,212,396	3,011,858	200,538	6.7%
11,736	11,932	(196)	(1.6%)	WCM	139,611	143,178	(3,567)	(2.5%)
825,076	**800,876**	**24,200**	**3.0%**	**Medi-Cal Total**	**9,516,270**	**9,414,022**	**102,248**	**1.1%**
14,833	**13,843**	**990**	**7.2%**	**OneCare Connect**	**176,448**	**167,856**	**8,592**	**5.1%**
1,934	**1,378**	**556**	**40.3%**	**OneCare**	**20,029**	**16,536**	**3,493**	**21.1%**
398	**472**	**(74)**	**(15.7%)**	**PACE**	**4,671**	**5,211**	**(540)**	**(10.4%)**
842,241	**816,569**	**25,672**	**3.1%**	**CalOptima Total**	**9,717,418**	**9,603,625**	**113,793**	**1.2%**
				Enrollment (by Network)				
191,697	177,375	14,322	8.1%	HMO	2,179,606	2,092,902	86,704	4.1%
227,019	230,981	(3,962)	(1.7%)	PHC	2,656,721	2,715,701	(58,980)	(2.2%)
202,098	200,248	1,850	0.9%	Shared Risk Group	2,304,912	2,328,171	(23,259)	(1.0%)
204,262	192,272	11,990	6.2%	Fee for Service	2,375,031	2,277,248	97,783	4.3%
825,076	**800,876**	**24,200**	**3.0%**	**Medi-Cal Total**	**9,516,270**	**9,414,022**	**102,248**	**1.1%**
14,833	**13,843**	**990**	**7.2%**	**OneCare Connect**	**176,448**	**167,856**	**8,592**	**5.1%**
1,934	**1,378**	**556**	**40.3%**	**OneCare**	**20,029**	**16,536**	**3,493**	**21.1%**
398	**472**	**(74)**	**(15.7%)**	**PACE**	**4,671**	**5,211**	**(540)**	**(10.4%)**
842,241	**816,569**	**25,672**	**3.1%**	**CalOptima Total**	**9,717,418**	**9,603,625**	**113,793**	**1.2%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2021

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,536	10,583	10,588	10,639	10,658	10,725	11,756	9,640	10,723	10,691	10,672	10,660	127,871	124,186	3,685
BCCTP	1	1	1	1	1	1	1	1	1	1	1	1	12	12	0
TANF Child	54,644	55,088	55,115	55,276	55,934	56,264	56,566	56,582	56,962	57,177	57,360	57,518	674,486	704,204	(29,718)
TANF Adult	29,033	29,687	30,001	30,679	30,990	31,336	31,677	31,995	32,455	32,764	33,242	33,544	377,403	355,805	21,598
LTC	(1)	402	197	215	239	238	(1,283)					1	8	24	(16)
MCE	74,441	75,955	76,054	78,435	79,490	80,792	82,386	82,587	84,474	85,757	86,843	87,852	975,066	884,131	90,935
WCM	1,721	1,726	2,086	2,507	2,007	2,067	2,109	2,149	2,117	2,065	2,085	2,121	24,760	24,540	220
Total	**170,375**	**173,442**	**174,042**	**177,752**	**179,319**	**181,423**	**183,212**	**182,954**	**186,732**	**188,455**	**190,203**	**191,697**	**2,179,606**	**2,092,902**	**86,704**
PHCs															
SPD	7,145	7,205	6,855	6,760	7,010	7,042	7,103	6,774	6,926	6,945	6,901	6,942	83,608	84,262	(654)
BCCTP													-		0
TANF Child	149,810	151,008	148,874	150,336	152,122	152,428	152,751	152,998	153,502	153,529	154,354	154,969	1,826,681	1,927,620	(100,939)
TANF Adult	11,688	12,097	12,071	12,492	12,728	12,694	12,930	13,071	13,277	13,422	13,587	13,860	153,917	142,251	11,666
LTC		158	81	65	76	80	(456)				1		5	12	(7)
MCE	39,815	40,711	39,935	41,371	41,820	42,350	42,781	42,628	43,255	43,643	43,907	44,041	506,257	475,356	30,901
WCM	5,625	5,716	7,990	8,497	6,957	7,099	7,533	7,208	7,518	7,554	7,349	7,207	86,253	86,200	53
Total	**214,083**	**216,895**	**215,806**	**219,521**	**220,713**	**221,693**	**222,642**	**222,679**	**224,478**	**225,093**	**226,099**	**227,019**	**2,656,721**	**2,715,701**	**(58,980)**
Shared Risk Groups															
SPD	10,264	10,312	10,068	10,117	10,120	10,261	10,927	9,519	10,229	10,143	10,097	10,049	122,106	120,234	1,872
BCCTP													-		0
TANF Child	58,289	58,687	57,269	58,133	58,881	58,952	59,011	58,901	58,985	58,891	58,880	58,961	703,840	788,724	(84,884)
TANF Adult	28,914	29,648	29,235	30,414	30,910	31,050	31,495	31,655	32,014	32,135	32,444	32,762	372,676	361,200	11,476
LTC	1	365	178	209	217	219	(1,185)	(1)			1	1	5	24	(19)
MCE	82,747	84,907	83,063	87,432	88,969	90,268	92,357	92,006	94,565	96,296	97,552	98,933	1,089,095	1,037,676	51,419
WCM	924	1,000	1,954	2,189	1,382	1,408	1,419	1,380	1,357	1,408	1,377	1,392	17,190	20,313	(3,123)
Total	**181,139**	**184,919**	**181,767**	**188,494**	**190,479**	**192,158**	**194,024**	**193,460**	**197,150**	**198,873**	**200,351**	**202,098**	**2,304,912**	**2,328,171**	**(23,259)**
Fee for Service (Dual)															
SPD	74,615	75,198	75,269	76,815	76,628	77,616	85,109	73,178	78,487	78,673	78,981	79,035	929,604	883,928	45,676
BCCTP	12	17	18	18	14	14	16	15	18	17	16	16	191	204	(13)
TANF Child	1	1	1	1	1	1	1	1	1	1	1	1	12	30	(18)
TANF Adult	909	1,266	994	1,107	1,015	1,030	1,064	1,119	1,173	1,205	1,252	1,275	13,409	12,121	1,288
LTC	3,079	4,461	3,855	3,838	3,818	3,817	(2,123)	2,706	2,651	2,681	2,685	2,690	34,158	38,016	(3,858)
MCE	1,658	1,859	1,948	2,077	2,138	2,334	2,430	2,390	2,674	2,914	3,102	3,366	28,890	19,511	9,379
WCM	13	17	16	17	15	14	17	15	16	16	18	20	194	153	41
Total	**80,287**	**82,819**	**82,101**	**83,873**	**83,629**	**84,826**	**86,514**	**79,424**	**85,020**	**85,507**	**86,055**	**86,403**	**1,006,458**	**953,963**	**52,495**
Fee for Service (Non-Dual - Total)															
SPD	9,830	9,822	10,264	9,977	9,304	9,774	10,737	8,838	9,978	10,021	10,212	10,400	119,157	119,303	(146)
BCCTP	497	492	499	506	485	490	515	501	496	503	503	499	5,986	5,474	512
TANF Child	25,494	27,007	28,092	26,150	26,005	25,664	26,404	26,451	26,129	27,020	27,093	26,368	317,877	330,783	(12,906)
TANF Adult	23,028	24,014	24,847	24,196	24,229	24,315	24,823	25,042	25,187	25,904	26,026	25,921	297,532	256,453	41,079
LTC	351	788	580	573	560	580	(1,237)	302	297	310	301	314	3,719	4,116	(397)
MCE	45,498	47,292	52,445	48,625	49,046	49,527	52,810	52,979	53,128	54,271	54,106	53,361	613,088	595,184	17,904
WCM	791	806	974	1,076	896	899	1,014	870	923	988	981	996	11,214	11,972	(758)
Total	**105,489**	**110,221**	**117,701**	**111,103**	**110,525**	**111,249**	**115,066**	**114,983**	**116,138**	**119,017**	**119,222**	**117,859**	**1,368,573**	**1,323,285**	**45,288**
SPD	112,390	113,120	113,044	114,308	113,720	115,418	125,632	107,949	116,343	116,473	116,863	117,086	1,382,346	1,331,913	50,433
BCCTP	510	510	518	525	500	505	532	517	515	521	520	516	6,189	5,690	499
TANF Child	288,238	291,791	289,351	289,896	292,943	293,309	294,733	294,933	295,579	296,618	297,688	297,817	3,522,896	3,751,361	(228,465)
TANF Adult	93,572	96,712	97,148	98,888	99,872	100,425	101,989	102,882	104,106	105,430	106,551	107,362	1,214,937	1,127,830	87,107
LTC	3,430	6,174	4,891	4,900	4,910	4,934	(6,284)	3,007	2,948	2,991	2,988	3,006	37,895	42,192	(4,297)
MCE	244,159	250,724	253,445	257,940	261,463	265,271	272,764	272,590	278,096	282,881	285,510	287,553	3,212,396	3,011,858	200,538
WCM	9,074	9,265	13,020	14,286	11,257	11,487	12,092	11,622	11,931	12,031	11,810	11,736	139,611	143,178	(3,567)
Total Medi-Cal MM	**751,373**	**768,296**	**771,417**	**780,743**	**784,665**	**791,349**	**801,458**	**793,500**	**809,518**	**816,945**	**821,930**	**825,076**	**9,516,270**	**9,414,022**	**102,248**
OneCare Connect	**14,465**	**14,541**	**14,529**	**14,720**	**14,587**	**14,938**	**14,921**	**14,569**	**14,748**	**14,744**	**14,853**	**14,833**	**176,448**	**167,856**	**8,592**
OneCare	**1,525**	**1,523**	**1,594**	**1,627**	**1,625**	**1,609**	**1,615**	**1,645**	**1,714**	**1,764**	**1,854**	**1,934**	**20,029**	**16,536**	**3,493**
PACE	**382**	**381**	**380**	**387**	**393**	**394**	**389**	**391**	**388**	**395**	**393**	**398**	**4,671**	**5,211**	**(540)**
Grand Total	**767,745**	**784,741**	**787,920**	**797,477**	**801,270**	**808,290**	**818,383**	**810,105**	**826,368**	**833,848**	**839,030**	**842,241**	**9,717,418**	**9,603,625**	**113,793**

ENROLLMENT:

Overall, June enrollment was 842,241

- Favorable to budget 25,672 or 3.1%
- Increased 3,211 or 0.4% from Prior Month (PM) (May 2021)
- Increased 83,271 or 11.0% from Prior Year (PY) (June 2020)

Medi-Cal enrollment was 825,076

- Favorable to budget 24,200 or 3.0%
  - Medi-Cal Expansion (MCE) favorable 30,721
  - Seniors and Persons with Disabilities (SPD) favorable 5,879
  - Breast and Cervical Cancer Treatment Program (BCCTP) favorable 56
  - Temporary Assistance for Needy Families (TANF) unfavorable 11,739
  - Long-Term Care (LTC) unfavorable 521
  - Whole Child Model (WCM) unfavorable 196
- Increased 3,146 from PM

OneCare Connect enrollment was 14,833

- Favorable to budget 990 or 7.2%
- Decreased 20 from PM

OneCare enrollment was 1,934

- Favorable to budget 556 or 40.3%
- Increased 80 from PM

PACE enrollment was 398

- Unfavorable to budget 74 or 15.7%
- Increased 5 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
825,076	**800,876**	**24,200**	**3.0%**	**Member Months**	**9,516,270**	**9,414,022**	**102,248**	**1.1%**
				Revenues				
366,268,267	241,356,570	124,911,697	51.8%	Capitation Revenue	3,734,424,376	3,187,027,860	547,396,516	17.2%
-	-	-	0.0%	Other Income	-	-	-	0.0%
366,268,267	**241,356,570**	**124,911,697**	**51.8%**	**Total Operating Revenue**	**3,734,424,376**	**3,187,027,860**	**547,396,516**	**17.2%**
				Medical Expenses				
81,938,213	97,211,378	15,273,165	15.7%	Provider Capitation	1,184,937,808	1,169,261,432	(15,676,376)	(1.3%)
46,750,394	60,269,102	13,518,708	22.4%	Facilities Claims	610,321,063	707,409,916	97,088,853	13.7%
34,715,059	33,782,864	(932,195)	(2.8%)	Professional Claims	370,036,919	398,936,623	28,899,704	7.2%
56,019,792	2	(56,019,790)	(2800989519.0%)	Prescription Drugs	623,943,044	280,984,865	(342,958,179)	(122.1%)
(133,521,894)	40,136,615	173,658,509	432.7%	MLTSS	282,929,558	483,242,461	200,312,903	41.5%
5,285,526	5,020,685	(264,841)	(5.3%)	Medical Management	49,720,440	58,646,393	8,925,953	15.2%
16,241,787	604,008	(15,637,779)	(2589.0%)	Reinsurance & Other	217,016,610	7,248,083	(209,768,527)	(2894.1%)
107,428,877	**237,024,654**	**129,595,777**	**54.7%**	**Total Medical Expenses**	**3,338,905,441**	**3,105,729,773**	**(233,175,668)**	**(7.5%)**
258,839,390	**4,331,916**	**254,507,474**	**5875.2%**	**Gross Margin**	**395,518,935**	**81,298,087**	**314,220,848**	**386.5%**
				Administrative Expenses				
12,242,115	7,321,213	(4,920,902)	(67.2%)	Salaries, Wages & Employee Benefits	87,683,047	84,032,180	(3,650,867)	(4.3%)
221,964	320,509	98,545	30.7%	Professional Fees	1,608,048	3,809,100	2,201,052	57.8%
1,131,309	933,491	(197,818)	(21.2%)	Purchased Services	10,228,130	12,467,385	2,239,255	18.0%
312,756	425,678	112,922	26.5%	Printing and Postage	3,041,703	5,333,650	2,291,947	43.0%
429,758	458,500	28,742	6.3%	Depreciation & Amortization	4,096,111	5,502,000	1,405,889	25.6%
1,748,377	1,684,329	(64,048)	(3.8%)	Other Operating Expenses	16,795,157	20,136,752	3,341,595	16.6%
(134,970)	(218,080)	(83,110)	(38.1%)	Indirect Cost Allocation, Occupancy Expense	(3,252,909)	(2,545,491)	707,418	27.8%
15,951,310	**10,925,640**	**(5,025,670)**	**(46.0%)**	**Total Administrative Expenses**	**120,199,287**	**128,735,576**	**8,536,289**	**6.6%**
				Operating Tax				
13,895,482	15,500,223	(1,604,741)	(10.4%)	Tax Revenue	154,373,629	182,255,794	(27,882,165)	(15.3%)
12,468,750	15,500,223	3,031,473	19.6%	Premium Tax Expense	149,625,000	182,255,794	32,630,794	17.9%
1,426,732	-	1,426,732	**0.0%**	**Total Net Operating Tax**	4,748,629	-	4,748,629	**0.0%**
				Grant Income				
7,564	-	7,564	0.0%	Grant Revenue	315,287	-	315,287	0.0%
-	-	-	0.0%	Grant expense - Service Partner	201,238	-	(201,238)	0.0%
7,564	-	(7,564)	0.0%	Grant expense - Administrative	100,000	-	(100,000)	0.0%
-	-	-	**0.0%**	**Total Grant Income**	14,050	-	14,050	**0.0%**
-	**-**	**-**	**0.0%**	**Other income**	**937**	**-**	**937**	**0.0%**
244,314,812	**(6,593,724)**	**250,908,536**	**3805.3%**	**Change in Net Assets**	**280,083,265**	**(47,437,489)**	**327,520,754**	**690.4%**
29.3%	***98.2%***	***68.9%***	***70.1%***	***Medical Loss Ratio***	***89.4%***	***97.4%***	***8.0%***	***8.3%***
4.4%	***4.5%***	***0.2%***	***3.8%***	***Admin Loss Ratio***	***3.2%***	***4.0%***	***0.8%***	***20.3%***

MEDI-CAL INCOME STATEMENT– JUNE MONTH:

REVENUES of $366.3 million are favorable to budget $124.9 million driven by:

- Favorable volume related variance of $7.3 million
- Favorable price related variance of $117.6 million
  - $54.6 million of prescription drug revenue due to the Department of Health Care Services (DHCS) postponement of pharmacy benefits transition to Fee For Service (FFS)
  - $45.4 million of Intergovernmental Transfer (IGT) 10 revenue
  - $29.5 million due to Calendar Year (CY) 2021 rate update, prior year retroactive eligibility changes, net of Gross Medical Expenditures (GME) and Proposition 56 risk corridor estimates
  - Unfavorable $13.9 million of Behavioral Health Treatment (BHT) write-off for PY receivable

MEDICAL EXPENSES of $107.4 million are favorable to budget $129.6 million driven by:

- Unfavorable volume related variance of $7.2 million
- Favorable price related variance of $136.8 million
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $174.9 million due the release of In Home Supportive Services (IHSS) estimates for July 2015 through December 2017 based on the reconciliation summary received from DHCS on June 30, 2021
  - Provider Capitation expense favorable variance of $18.2 million due to release of prior year Proposition 56 estimates
  - Facilities Claims expense favorable variance of $15.3 million due to Incurred But Not Reported (IBNR) claims and lower utilization
  - Offset by Prescription Drugs expense unfavorable variance of $56.0 million due to DHCS postponement of pharmacy benefits transition to FFS
  - Reinsurance & Other expense unfavorable variance of $15.6 million due to COVID-19 vaccination incentives

MEDI-CAL INCOME STATEMENT– JUNE MONTH: (cont.)

ADMINISTRATIVE EXPENSES of $16.0 million are unfavorable to budget $5.0 million driven by:

- Salaries & Benefit expense unfavorable to budget $4.9 million due to annual true-up to CalPERS actuarial report
- Other Non-Salary expense unfavorable to budget $0.1 million

CHANGE IN NET ASSETS is $244.3 million for the month, favorable to budget $250.9 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Twelve Months Ending June 30, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,833	**13,843**	**990**	**7.2%**	**Member Months**	**176,448**	**167,856**	**8,592**	**5.1%**
				Revenues				
3,046,634	2,671,476	375,158	14.0%	Medi-Cal Capitation Revenue	34,770,532	32,401,508	2,369,024	7.3%
21,216,695	17,771,891	3,444,804	19.4%	Medicare Capitation Revenue Part C	237,956,734	212,350,448	25,606,286	12.1%
5,557,352	5,048,711	508,641	10.1%	Medicare Capitation Revenue Part D	66,847,844	61,571,428	5,276,416	8.6%
-	-	-	0.0%	Other Income	-	-	-	0.0%
29,820,681	**25,492,078**	**4,328,603**	**17.0%**	**Total Operating Revenue**	**339,575,110**	**306,323,384**	**33,251,726**	**10.9%**
				Medical Expenses				
14,082,222	10,798,125	(3,284,097)	(30.4%)	Provider Capitation	147,878,203	132,514,947	(15,363,256)	(11.6%)
3,540,426	3,972,959	432,533	10.9%	Facilities Claims	58,293,261	47,745,964	(10,547,297)	(22.1%)
1,244,086	956,796	(287,290)	(30.0%)	Ancillary	12,412,988	11,356,824	(1,056,164)	(9.3%)
1,360,859	1,455,911	95,052	6.5%	MLTSS	16,550,519	18,145,318	1,594,799	8.8%
7,381,002	5,902,800	(1,478,202)	(25.0%)	Prescription Drugs	71,681,403	70,776,759	(904,644)	(1.3%)
1,702,185	1,452,529	(249,656)	(17.2%)	Medical Management	13,757,565	15,012,975	1,255,410	8.4%
585,504	225,989	(359,515)	(159.1%)	Other Medical Expenses	2,094,951	2,641,816	546,865	20.7%
29,896,284	**24,765,109**	**(5,131,175)**	**(20.7%)**	**Total Medical Expenses**	**322,668,889**	**298,194,603**	**(24,474,286)**	**(8.2%)**
(75,602)	**726,969**	**(802,571)**	**(110.4%)**	**Gross Margin**	**16,906,221**	**8,128,781**	**8,777,440**	**108.0%**
				Administrative Expenses				
718,178	836,775	118,597	14.2%	Salaries, Wages & Employee Benefits	8,405,877	9,604,947	1,199,070	12.5%
199,880	40,087	(159,793)	(398.6%)	Professional Fees	456,705	481,000	24,295	5.1%
180,549	103,418	(77,131)	(74.6%)	Purchased Services	1,176,718	1,240,950	64,232	5.2%
69,249	106,533	37,284	35.0%	Printing and Postage	891,828	1,278,220	386,392	30.2%
32,584	15,829	(16,755)	(105.8%)	Other Operating Expenses	302,152	194,275	(107,877)	(55.5%)
470,548	553,494	82,946	15.0%	Indirect Cost Allocation	6,916,533	6,641,906	(274,627)	(4.1%)
1,670,988	**1,656,136**	**(14,852)**	**(0.9%)**	**Total Administrative Expenses**	**18,149,813**	**19,441,298**	**1,291,485**	**6.6%**
(1,746,590)	**(929,167)**	**(817,423)**	**(88.0%)**	**Change in Net Assets**	**(1,243,592)**	**(11,312,517)**	**10,068,925**	**89.0%**
100.3%	***97.1%***	***(3.1%)***	***(3.2%)***	***Medical Loss Ratio***	***95.0%***	***97.3%***	***2.3%***	***2.4%***
5.6%	***6.5%***	***0.9%***	***13.7%***	***Admin Loss Ratio***	***5.3%***	***6.3%***	***1.0%***	***15.8%***

Preliminary

ONECARE CONNECT INCOME STATEMENT– JUNE MONTH:

REVENUES of $29.8 million are favorable to budget $4.3 million driven by:

- Favorable volume related variance of $1.8 million
- Favorable price related variance of $2.5 million due to the release of CY 2019 Quality Withhold from The Center of Medicare & Medicaid Services (CMS)

MEDICAL EXPENSES of $29.9 million are unfavorable to budget $5.1 million driven by:

- Unfavorable volume related variance of $1.8 million
- Unfavorable price related variance of $3.4 million
  - Provider Capitation expense unfavorable variance of $2.5 million due to CY 2019 Quality Withhold
  - Prescription Drugs expenses unfavorable variance of $1.1 million
  - Other Medical Expenses unfavorable variance of $0.3 million
  - Ancillary Expenses unfavorable variance of $0.2 million
  - Medical Management unfavorable variance of $0.1 million
  - Offset by Facilities Claims expense favorable variance of $0.7 million
  - MLTSS expense favorable variance of $0.2 million

ADMINISTRATIVE EXPENSES of $1.7 million are unfavorable to budget $14,852

CHANGE IN NET ASSETS is ($1.7) million, unfavorable to budget $0.8 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,934	**1,378**	**556**	**40.3%**	**Member Months**	**20,029**	**16,536**	**3,493**	**21.1%**
				Revenues				
1,872,911	1,093,409	779,502	71.3%	Medicare Part C revenue	17,709,358	13,334,115	4,375,243	32.8%
803,257	487,567	315,690	64.7%	Medicare Part D revenue	7,814,363	6,138,667	1,675,696	27.3%
2,676,168	**1,580,976**	**1,095,192**	**69.3%**	**Total Operating Revenue**	**25,523,722**	**19,472,782**	**6,050,940**	**31.1%**
				Medical Expenses				
753,735	432,162	(321,573)	(74.4%)	Provider Capitation	7,028,982	5,215,045	(1,813,937)	(34.8%)
959,252	443,324	(515,928)	(116.4%)	Inpatient	7,310,682	5,368,342	(1,942,340)	(36.2%)
86,538	43,241	(43,297)	(100.1%)	Ancillary	988,396	517,060	(471,336)	(91.2%)
73,093	25,058	(48,035)	(191.7%)	Skilled Nursing Facilities	483,169	304,889	(178,280)	(58.5%)
806,141	496,743	(309,398)	(62.3%)	Prescription Drugs	7,652,291	5,897,339	(1,754,952)	(29.8%)
104,737	66,182	(38,555)	(58.3%)	Medical Management	492,191	588,138	95,947	16.3%
64,334	152	(64,182)	(42225.2%)	Other Medical Expenses	84,482	910	(83,572)	(9183.7%)
2,847,830	**1,506,862**	**(1,340,968)**	**(89.0%)**	**Total Medical Expenses**	**24,040,193**	**17,891,723**	**(6,148,470)**	**(34.4%)**
(171,663)	**74,114**	**(245,777)**	**(331.6%)**	**Gross Margin**	**1,483,529**	**1,581,059**	**(97,530)**	**(6.2%)**
				Administrative Expenses				
70,811	69,611	(1,200)	(1.7%)	Salaries, wages & employee benefits	959,559	812,160	(147,399)	(18.1%)
71,123	16,000	(55,123)	(344.5%)	Professional fees	260,095	192,000	(68,095)	(35.5%)
14,108	9,750	(4,358)	(44.7%)	Purchased services	106,051	117,000	10,949	9.4%
13,305	8,076	(5,229)	(64.8%)	Printing and postage	73,663	97,000	23,337	24.1%
-	543	543	100.0%	Other operating expenses	653	6,450	5,797	89.9%
64,060	35,189	(28,871)	(82.0%)	Indirect cost allocation, occupancy expense	519,872	422,224	(97,648)	(23.1%)
233,408	**139,169**	**(94,239)**	**(67.7%)**	**Total Administrative Expenses**	**1,919,893**	**1,646,834**	**(273,059)**	**(16.6%)**
(405,070)	**(65,055)**	**(340,015)**	**(522.7%)**	**Change in Net Assets**	**(436,365)**	**(65,775)**	**(370,590)**	**(563.4%)**
106.4%	***95.3%***	***(11.1%)***	***(11.6%)***	***Medical Loss Ratio***	***94.2%***	***91.9%***	***(2.3%)***	***(2.5%)***
8.7%	***8.8%***	***0.1%***	***0.9%***	***Admin Loss Ratio***	***7.5%***	***8.5%***	***0.9%***	***11.1%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
398	**472**	**(74)**	**(15.7%)**	**Member Months**	**4,671**	**5,211**	**(540)**	**-10.4%**
				Revenues				
2,772,684	2,973,027	(200,343)	(6.7%)	Medi-Cal Capitation Revenue	29,679,245	32,808,062	(3,128,817)	(9.5%)
426,452	666,541	(240,089)	(36.0%)	Medicare Part C Revenue	7,307,346	7,537,679	(230,334)	(3.1%)
202,575	165,909	36,666	22.1%	Medicare Part D Revenue	2,034,340	1,843,842	190,498	10.3%
3,401,710	**3,805,477**	**(403,767)**	**(10.6%)**	**Total Operating Revenue**	**39,020,930**	**42,189,583**	**(3,168,653)**	**(7.5%)**
				Medical Expenses				
929,482	1,038,943	109,461	10.5%	Medical Management	10,366,804	11,796,882	1,430,078	12.1%
1,033,033	935,332	(97,701)	(10.4%)	Facilities Claims	9,077,609	10,086,335	1,008,726	10.0%
592,892	753,911	161,019	21.4%	Professional Claims	7,966,162	8,339,174	373,012	4.5%
149,674	290,980	141,306	48.6%	Patient Transportation	1,441,423	3,178,846	1,737,423	54.7%
378,637	310,432	(68,205)	(22.0%)	Prescription Drugs	3,519,514	3,427,259	(92,255)	(2.7%)
71,546	81,193	9,647	11.9%	MLTSS	798,501	826,406	27,905	3.4%
4,975	20,547	15,572	75.8%	Other Expenses	142,747	229,921	87,175	37.9%
3,160,239	**3,431,338**	**271,099**	**7.9%**	**Total Medical Expenses**	**33,312,760**	**37,884,823**	**4,572,063**	**12.1%**
241,472	**374,139**	**(132,667)**	**-35.5%**	**Gross Margin**	**5,708,170**	**4,304,760**	**1,403,410**	**32.6%**
				Administrative Expenses				
110,248	135,314	25,066	18.5%	Salaries, wages & employee benefits	1,364,363	1,524,159	159,796	10.5%
233	174	(59)	(34.1%)	Professional fees	1,630	2,000	370	18.5%
105,334	39,663	(65,671)	(165.6%)	Purchased services	379,205	388,324	9,119	2.3%
33,343	17,325	(16,018)	(92.5%)	Printing and postage	162,274	185,400	23,126	12.5%
2,013	2,070	57	2.8%	Depreciation & amortization	24,272	24,840	568	2.3%
4,510	4,524	14	0.3%	Other operating expenses	61,932	50,670	(11,262)	(22.2%)
4,132	4,842	710	14.7%	Indirect Cost Allocation, Occupancy Expense	47,879	55,254	7,375	13.3%
259,813	**203,912**	**(55,901)**	**(27.4%)**	**Total Administrative Expenses**	**2,041,555**	**2,230,647**	**189,092**	**8.5%**
				Operating Tax				
5,906	-	5,906	0.0%	Tax Revenue	69,318	-	69,318	0.0%
5,906	-	(5,906)	0.0%	Premium Tax Expense	69,318	-	(69,318)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
(18,342)	**170,227**	**(188,569)**	**(110.8%)**	**Change in Net Assets**	**3,666,616**	**2,074,113**	**1,592,503**	**76.8%**
92.9%	***90.2%***	***(2.7%)***	***(3.0%)***	***Medical Loss Ratio***	***85.4%***	***89.8%***	***4.4%***	***4.9%***
7.6%	***5.4%***	***(2.3%)***	***(42.5%)***	***Admin Loss Ratio***	***5.2%***	***5.3%***	***0.1%***	***1.0%***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
36,784	55,000	18,216	33.1%	Purchase services	454,768	660,000	205,232	31.1%
197,611	177,250	(20,361)	(11.5%)	Depreciation & amortization	2,065,057	2,127,000	61,943	2.9%
19,565	18,500	(1,065)	(5.8%)	Insurance expense	224,499	222,000	(2,499)	(1.1%)
109,842	114,916	5,074	4.4%	Repair and maintenance	1,300,377	1,379,000	78,623	5.7%
53,458	41,250	(12,208)	(29.6%)	Other Operating Expense	513,086	495,000	(18,086)	(3.7%)
(417,259)	(406,916)	10,343	2.5%	Indirect allocation, Occupancy	(4,557,788)	(4,883,000)	(325,212)	(6.7%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

OTHER INCOME STATEMENTS – JUNE MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($0.4) million, unfavorable to budget $0.3 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is ($18,342), unfavorable to budget $0.2 million

CalOptima
Balance Sheet
June 30, 2021

ASSETS			**LIABILITIES & NET POSITION**		
Current Assets			Current Liabilities		
	Operating Cash	$281,834,499		Accounts Payable	$46,468,291
	Investments	1,065,409,806		Medical Claims liability	942,847,325
	Capitation receivable	427,608,293		Accrued Payroll Liabilities	16,216,920
	Receivables - Other	48,973,267		Deferred Revenue	13,586,826
	Prepaid expenses	11,978,611		Deferred Lease Obligations	127,328
				Capitation and Withholds	142,384,140
	Total Current Assets	**1,835,804,476**	**Total Current Liabilities**		**1,161,630,830**
Capital Assets					
	Furniture & Equipment	46,251,085			
	Building/Leasehold Improvements	5,326,911			
	505 City Parkway West	51,777,223			
		103,355,219			
	Less: accumulated depreciation	(57,627,344)			
	Capital assets, net	45,727,876	Other (than pensions) post		
				employment benefits liability	26,339,413
Other Assets			Net Pension Liabilities		30,620,005
	Restricted Deposit & Other	300,000	Bldg 505 Development Rights		-
	Homeless Health Reserve	56,798,913			
	Board-designated assets:				
	Cash and Cash Equivalents	3,345,793	**TOTAL LIABILITIES**		**1,218,590,248**
	Long-term Investments	585,534,359			
	Total Board-designated Assets	588,880,152	Deferred Inflows		
				Excess Earnings	344,198
				OPEB 75 Difference in Experience	804,000
	Total Other Assets	645,979,065		Change in Assumptions	2,709,945
				OPEB Changes in Assumptions	1,638,000
			Net Position		
TOTAL ASSETS		**2,527,511,417**		TNE	101,157,582
				Funds in Excess of TNE	1,211,977,961
Deferred Outflows			**TOTAL NET POSITION**		1,313,135,543
	Contributions	1,508,025			
	Difference in Experience	3,236,721			
	Excess Earning	-			
	Changes in Assumptions	3,692,771			
	OPEB 75 Changes in Assumptions	703,000			
	Pension Contributions	570,000			
	TOTAL ASSETS & DEFERRED OUTFLOWS	**2,537,221,934**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**		**2,537,221,934**

CalOptima
Board Designated Reserve and TNE Analysis
as of June 30, 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	241,158,321				
	Tier 1 - MetLife	240,141,145				
	Tier 1 - Wells Capital*	-				
Board-designated Reserve		481,299,467	356,633,475	552,829,643	124,665,991	(71,530,176)
TNE Requirement	Tier 2 - MetLife	107,580,680	101,157,582	101,157,582	6,423,098	6,423,098
	Consolidated:	**588,880,146**	**457,791,057**	**653,987,224**	**131,089,089**	**(65,107,078)**
	Current reserve level	*1.80*	*1.40*	*2.00*		

*Investments from Wells Capital were transferrd to Payden & Rygel and MetLife due to Board approved changes to investment managers.

CalOptima
Statement of Cash Flows
June 30, 2021

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	241,230,120	288,004,246
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	629,382	6,185,440
Changes in assets and liabilities:		
Prepaid expenses and other	1,179,433	(5,279,402)
Catastrophic reserves		
Capitation receivable	(104,207,619)	(30,211,535)
Medical claims liability	(164,443,459)	25,695,305
Deferred revenue	(44,095,064)	(9,836,871)
Payable to health networks	(22,516,802)	(596,888)
Accounts payable	13,948,059	(28,188,155)
Accrued payroll	3,783,601	6,607,587
Other accrued liabilities	97,145	(33,529)
Net cash provided by/(used in) operating activities	(74,395,204)	252,346,198
GASB 68 CalPERS Adjustments	769,424	769,424
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	156,422,732	(341,223,494)
Change in Property and Equipment	(612,552)	(5,258,745)
Change in Board designated reserves	814,844	(3,996,259)
Change in Homeless Health Reserve	-	400,000
Net cash provided by/(used in) investing activities	156,625,024	(350,078,498)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	82,999,244	(96,962,876)
CASH AND CASH EQUIVALENTS, beginning of period	$198,835,254	378,797,374
CASH AND CASH EQUIVALENTS, end of period	**281,834,499**	**281,834,499**

BALANCE SHEET – JUNE MONTH:

ASSETS of $2.5 billion increased $26.8 million from May or 1.1%

- Capitation Receivables increased $104.7 million due to reclassification of overpayments from DHCS, recognition of retroactive eligible changes, and CY 2021 rate updates
- Operating Cash and Investments net decrease of $73.4 million due to the disbursement of IGT 10
  - Investments decreased $156.4 million
  - Operating cash increased $83.0 million

LIABILITIES of $1.2 billion decreased $213.2 million from May or 14.9%

- Claims Liabilities decreased $164.4 million due disbursement of IGT 10, prior year retroactive eligible changes and overpayments
- Deferred Revenue decreased $44.1 million due to timing of capitation payments from CMS and IGT 10
- Capitation and Withhold decreased $22.5 million due to decrease Proposition 56 estimates
- Accounts Payable increased $13.9 million due to the timing of accruals for the quarterly premium tax
- Net Pension Liabilities increased $3.2 million

NET ASSETS of $1.3 billion, increased $241.2 million from May or 22.5%

Summary of Homeless Health Initiatives and Allocated Funds
As of June 30, 2021

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,231,087		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Funds Allocation Total		**$**	**43,201,087**
Program Commitment Balance, available for new initiatives*		**$**	**56,798,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

Budget Allocation Changes
Reporting Changes for June 2021

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	Maintenance HW/SW – Corporate Application SW - LexisNexis	Maintenance HW/SW – HR Corporate Application SW - SilkRoad	$12,000	To repurpose funds from LexisNexis renewal to fund shortages in SilkRoad renewal and additional licenses	2021
October	Medi-Cal	Maintenance HW/SW - UPS Maintenance	Maintenance HW/SW - Desktop - Adobe Acrobat	$35,000	To repurpose funds from UPS Maintenance to fund shortages in Desktop - Adobe Acrobat	2021
October	Medi-Cal	Maintenance HW/SW - Microsoft True-Up	Maintenance HW/SW - Desktop - Microsoft Enterprise License Agreement	$91,000	To repurpose funds from Microsoft License True-Up to fund shortages in the new 3-year Microsoft Enterprise License Agreement	2021
November	Medi-Cal	Business Integration - Temporary Help	Process Excellence - Temporary Help	$43,000	To reallocate funds from Business Integration - Temporary Help to Process Excellence - Temporary Help for an Analyst	2021
January	Medi-Cal	Provider Relations - Printing	Sales & Marketing - Member Communication	$10,000	To reallocate funds from Public Relations - Printing to cover shortage in Sales & Marketing - Member Communications	2021
February	Medi-Cal	Human Resources - Food Service Supply	Human Resources - Cert./Cont. Education	$20,000	To reallocate funds from Food Service Supply to Cert./Cont. Education to fund the education reimbursement program	2021
February	Medi-Cal	Purchase Services - HPA Robot Process	Purchase Services - Burgess Group - Facilities Claims Quarterly	$63,000	To repurpose funds from HPA Robot Process to Burgess Group to cover shortfall in quarterly facilities claims fee	2021
March	Medi-Cal	Employee Learning Management System Network - MDF Switch Upgrade Electronic Health Record System	Provider Portal Communication	$99,500	To reallocate funds from capital projects Employee Learning Management System, MDF Switch Upgrade and Electronic Health Record System to pay for TekSystems invoices	2021
May	Medi-Cal	Quality Improvement - Travel	Quality Improvement - Subscriptions	$10,000	To reallocate funds from Travel to Subscriptions to pay for additional credentialing	2021
May	Medi-Cal	IS Infrastructure – Professional Fees	IS Applications Management – Professional Fees	$35,000	To reallocate funds from IS-Infrastructure Professional Fees (Security - CloudSOC CASB E20 Package) to IS-Applications Management to fund shortage in Core Application Support	2021
June	Medi-Cal	Strategic Development - Professional Fees	Communications - Professional Fees	$23,000	To reallocate funds from Professional Fees in Strategic Development to Professional Fees in Communications to fund additional consulting fees needed for acquiring market research data for strategic planning purposes.	2021
June	Medi-Cal	Infrastructure - Infrastructure for DMZ Scaling	Infrastructure - Server 2016 Upgrade	$35,000	To reallocate funds from capital project, Infrastructure for DMZ scaling, to capital project, Server 2016 Upgrade to cover the shortage in HW.	2021

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
August 5, 2021

Monthly Compliance Report

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

A. Updates on Regulatory Audits

1. OneCare
   - Contract Year (CY) 2019 Medical Loss Ratio (MLR) Desk Review:

     On April 28, 2021, CalOptima received notification from Actuarial Research Corporation (ARC) that they will be facilitating the review of CY 2019 MLR Reports for OneCare on behalf of the Centers for Medicare & Medicaid Services (CMS). Regulatory Affairs & Compliance (RAC) is awaiting details and instructions from ARC and will work with Finance on deliverables, as needed.

   - 2021 CMS Program Audit Engagement (applicable to OneCare and OneCare Connect):

     On June 7, 2021, CalOptima was formally engaged by the Centers for Medicare & Medicaid Services (CMS) for a full-scope program audit of OneCare (OC) and OneCare Connect (OCC). The audit will be conducted virtually via webinar.

     The following program areas are included in the scope of the audit:
     - CPE: Compliance Program Effectiveness [OC and OCC, 6/7/2020-6/7/2021]
     - FA: Part D Formulary and Benefit Administration [OC and OCC, various 3-month lookback periods, range is from 09/01/2020 to 6/7/2021]
     - CDAG: Part D Coverage Determinations, Appeals and Grievances [OC and OCC, 3/7/2021-6/7/2021]
     - ODAG: Part C Organization Determinations, Appeals and Grievances [OC only, 3/7/2021-6/7/2021]
     - SNP-MOC: Special Needs Plan Model of Care [OC only, 5/1/2020-6/7/2021]
     - MMP-SARAG: Medicare-Medicaid Plan – Service Authorization Request, Appeals and Grievances [OCC only, 3/7/2021 -6/7/2021]
     - MMP-CCQIPE: Medicare-Medicaid Plan – Care Coordination Quality Improvement Program Effectiveness [OCC only, 5/1/2020 – 6/7/2021]

     Impacted stakeholders, health networks and other delegates are expected to directly participate in audit, as needed:

Back to Agenda

- Preparing data audit universes and supporting documents
- Providing case complete case files in support of file review
- Participating in webinars
- Answering technical questions or providing background information
- Assist with other deliverables and audit documentation, as needed

The following are key dates for this audit:

- 6/9/21: CMS Engagement Letter Follow-Up Call
- 6/28/21: Universe and Supporting Documentation due
- 6/28/21- 7/9/21: Universe Integrity Webinars
- 7/19/21: Entrance Conference
- 7/19/21 - 8/6/21: Webinar Audit Sessions
- 8/6/21: Exit Conference

- 2021 Medicare Parts C and D Data Validation Audit (applicable to OneCare and OneCare Connect):

  On an annual basis, CMS requires all plan sponsors to engage an independent auditor to validate all Medicare Parts C and D data reported for the prior calendar year. The data validation audit season takes place from March through June each year. The audit includes a webinar validation and source documentation review of Medicare Parts C and D reporting data submitted for the prior calendar year. The following reporting measures were reviewed:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medicare Therapy Management (MTM) Program
  - Special Needs Plan (SNP) Care Management
  - Improving Drug Utilization Review (IDUR) Controls

  On April 6, 2021, CalOptima participated in the 2021 Medicare Parts C and D Data Validation Audit. Following the webinar validation, CalOptima's independent auditor Advent requested sample selections for each of the reporting measures. CalOptima submitted the requested documents to Advent between April 16 and June 8, 2021. On June 23, 2021, Advent informed CalOptima that it received a final score of 100% for the audit of both its OneCare and OneCare Connect programs.

- CY 2015 Medicare Part C National Risk Adjustment Data Validation (CON15 RADV) Audit:

  On November 21, 2019, CMS notified CalOptima that its OneCare program was selected to participate in the CY 2015 RADV audit. On January 10, 2020, CMS released the enrollee list and opened the submission window. CMS selected a total of thirty-three (33) members for this audit.

  After suspending audit activities on March 30, 2020 due to the public health emergency, CMS resumed audit activities on September 14, 2020. The submission window closed on

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Back to Agenda

April 23, 2021. CalOptima has concluded its submission for this audit and is awaiting results from CMS.

2. OneCare Connect

- Performance Measure Validation (PMV) Requirement:

On May 20, 2021, CMS provided MMPs initial notification of upcoming PMV efforts for the 2020 measurement of the following core measures:

- MMP Core 2.1: Members with an assessment completed within 90 days of enrollment
- MMP Core 3.2: Members with a care plan completed within 90 days of enrollment

MMPs are required to report various monitoring and performance measures as articulated in the MMP Core Reporting Requirements and MMP State-Specific Reporting Requirements. In order to ensure MMPs' reported data are reliable, valid, complete, and comparable, CMS has subcontracted with Health Services Advisory Group (HSAG) to conduct this validation.

On June 25, 2021, CMS notified CalOptima it was not selected to participate in the 2021 PMV.

- Part D Transition Requirement Analysis (TRA):

On 5/24/21, CalOptima's OneCare Connect contract was selected for inclusion in the CY 2021 TRA, which investigates whether Part D sponsors are administering transition requirements appropriately.

On 6/8/21, CMS shared that CalOptima will now be excluded from the CY 2021 TRA due to CalOptima's engagement in the CMS 2021 Program Audit.

- CY2019 Part D Improper Payment Measure (IPM) Pilot Study for Prescription Drug Event (PDE) Review:

On May 7, 2021, CMS informed CalOptima that its OneCare Connect program has been selected to participate in the Part D IPM 19 Pilot. CMS conducts the Part D IPM activity to validate the accuracy of PDE data submitted by Medicare Part D Sponsors to CMS for payments. CMS is undertaking this pilot to explore a more efficient method for sampling and calculation of the Part D IPM. This study will sample all of the PDEs associated with sampled beneficiaries, rather than the current method of sampling by single PDEs. The results of this study will inform whether CMS will alter the current sampling and calculation methodology for the Part D IPM. This pilot is being conducted in addition to CY 2019 Part D IPM, for which CalOptima submitted documentation for its OneCare and OneCare Connect program between January 29, 2021, and April 23, 2021.

On May 20, 2021, CMS held a training teleconference. During the teleconference, CMS reviewed roles and expectations for the Part D IPM process, demonstrate the HPMS Part D IPM Module, and hosted a question and answer session. The submission window opened,

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Back to Agenda

and contract specific documentation was made available on May 21, 2021. CalOptima has set an internal deadline of July 7, 2021, to submit requested documents to CMS.

3. PACE

- 2019 CMS Financial Audit:

On August 13, 2020, CMS notified CalOptima PACE that it has been selected for the 2019 CMS Financial Audit. By way of background, at least one-third of Medicare plan sponsors are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CalOptima was notified that the Certified Public Accountant (CPA) firm, Myers & Stauffer, will be leading this audit. Myers & Stauffer will audit and inspect any books and records from CalOptima 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.

On December 4, 2020, Myers & Stauffer notified CalOptima of the selection of the prescription drug event (PDE) samples and associated documentation request. CalOptima submitted the full set of requested PDE samples to Myers & Stauffer ahead of the February 2, 2021, deadline. CalOptima has completed submission of all deliverables and is pending feedback from the auditor.

On April 1, 2021, Myers & Stauffer notified CalOptima they have provided a new documentation request list and will be conducting two sets of interviews during the week of April 12, 2021. On April 12, 2021 and April 15, 2021, Myers & Stauffer hosted a series of interview/conference calls to discuss CalOptima's oversight of delegated entities, policies and procedures related to fraud, waste, and abuse (FWA), and reporting of shared and/or intercompany expenses as they relate to PACE.

On June 15, 2021, Myers & Stauffer provided CalOptima with the Draft Report in advance of the Exit Conference scheduled for June 18, 2021. The draft report informs of one (1) finding and one (1) observation as a result of this audit activity.

- Finding: The Plan was unable to substantiate the reclassification of certain expenses between patient care and non-patient care and the related allocation methodologies used to report non-benefit expenses on Worksheet 1 of the 2021 Part D bid. The total exposure to these reclassified expenses on Worksheet 1 of the Part D bid is $370,034.12, or $179.19 per-member per month (PMPM). There is no known beneficiary impact associated with this issue.
- Observation: Out of two P2P payments included in the 2019 P2P universe, one payment was not made within 30 days of CMS' notification. The total amount of the untimely P2P payments is $5.25. There is no known beneficiary impact associated with this issue.

On June 18, 2021, CalOptima attended the exit conference held by Myers & Stauffer. During the call, the draft report was reviewed along with next steps regarding agreeing and/or disagreeing with the findings and observations. On June 25, 2021, CalOptima

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Back to Agenda

submitted the Agree/Disagree letter to Myers & Stauffer rebutting the finding and agreeing with the observation noted within the draft report. The final report is expected from CMS in August 2021. *At that time, CalOptima will learn whether CMS accepted CalOptima's rebuttal of the finding. If it is determined the finding is not moved to an observation status, CMS will have the discretion to impose a Civil Monetary Penalty for that finding. Until then, it is unknown how large the potential fiscal impact might be for CalOptima to pay CMS, given there is no known beneficiary impact associated with this finding.*

3. Medi-Cal

- Nothing to Report for the months of May and June 2021

B. Regulatory Notices of Non-Compliance

- CalOptima did not receive any notices of non-compliance from its regulators for the months of May and June 2021.

- On June 10, 2021, CMS confirmed that the OneCare and OneCare Connect Warning Notices issued to CalOptima on January 15, 2021, for formulary submission violations were valid and not misdirected. As such, a corrective action plan has been requested from the Pharmacy team. For context, CMS "Warning Notice" would typically be issued following a "Notice of Non-Compliance". However, CMS has the discretion to issue a Warning Notice without a prior Notice of Non-Compliance, when it considers the initial non-compliance to be significant enough to warrant issuing the more severe notice. In this instance, CalOptima only received the CMS Warning letter for the formulary submission violations, and had not received prior notices of non-compliance. Due to not having received a prior notice of non-compliance, CalOptima originally believed these may have been misdirected. However, upon further follow-up with CMS between January and June, it was confirmed that the warning notices for the formulary violations were indeed valid.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring Dashboard: Medi-Cal Grievance & Appeals Resolution Services (GARS) [a\]

- As part of its monitoring process, CalOptima's Audit & Oversight department, in collaboration with business areas, maintains a dashboard to monitor key performance metrics for internal and external operations on a monthly basis. Dashboard results are presented to CalOptima's Audit & Oversight Committee and Compliance Committee for oversight. Below are the dashboard results for the months of March 2021 – May 2021 for Medi-Cal GARS. CalOptima's GARS department continues to not meet resolution timeliness requirements for eight (8) consecutive months for Medi-Cal standard appeals and for (3) three consecutive months for Medi-Cal expedited appeals.

Month	Compliance Goal	Standard Appeals Resolved within ≤ 30 Calendar Days of Receipt
March 2021	98%	52%

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Back to Agenda

Month	Compliance Goal	Standard Appeals Resolved within ≤ 30 Calendar Days of Receipt
April 2021	98%	56%
May 2021	98%	74%

Month	Compliance Goal	Expedited Appeals Resolved within ≤ 72 Hours of Receipt
March 2021	98%	43%
April 2021	98%	75%
May 2021	98%	90%

- CalOptima's Audit & Oversight (A&O) department escalated the corrective action plan (CAP) that was previously issued to an immediate corrective action plan (ICAP), as issues with non-timely processing of Medi-Cal standard appeals appear to be systemic, may have the potential to cause member harm, and have been ongoing for at least three (3) months. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard appeals. In addition, CalOptima's Audit & Oversight department has increased its monitoring of the GARS department by requiring case status reports twice a day and weekly updates on staffing and remediation activities.

- CalOptima's Audit & Oversight (A&O) department will issue a request for a corrective action plan (CAP) for deficiencies identified during the department's file review of Medi-Cal expedited appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of expedited appeals.

2. Internal Monitoring: Medi-Cal[a\]

   - Medi-Cal GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
March 2021	100%	100%	100%	85.71%	42.86%
April 2021	100%	100%	100%	100%	0%
May 2021	100%	100%	100%	100%	0%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- Based on a focused review of sixteen (16) Medi-Cal standard appeals for April 2021, the lower compliance scores of 0% was due to untimely resolution of sixteen (16) standard appeals.

- Based on a focused review of ten (10) Medi-Cal standard appeals for May 2021, the lower compliance scores of 0% was due to untimely resolution of ten (10) standard appeals.

- Medi-Cal GARS: Expedited Appeals

Month(s)	Classification Score	Expedited Appeals Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Resolution of Expedited Appeals within 72 Hours of Receipt
March 2021	100%	100%	100%	92.30%	7.69%
April 2021	100%	N/A	100%	100%	75%
May 2021	100%	N/A	100%	100%	90%

- Based on a focused review of four (4) Medi-Cal expedited appeals for April 2021, the lower compliance score of 75% was due to untimely resolution of one (1) expedited appeal.

- Based on a focused review of ten (10) Medi-Cal expedited appeals for May 2021, the lower compliance score of 90% was due to untimely resolution of one (1) expedited appeal.

- Medi-Cal GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievances Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Standard Resolution of Grievances within ≤ 30 Calendar Days of Receipt
March 2021	100%	100%	100%	90%	95%
April 2021	90.90%	100%	100%	90.90%	81.81%
May 2021	100%	100%	100%	85.71%	64.28%

- Based on a focused review of eleven (11) Medi-Cal standard grievances for April 2021, the lower compliance score of 90.90% was due to incorrect classification of one (1) standard grievance.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- Based on a focused review of eleven (11) Medi-Cal standard grievances for April 2021, the lower compliance score of 90.90% was due to the member resolution letter not addressing all member grievances in one (1) standard grievance.

- Based on a focused review of eleven (11) Medi-Cal standard grievances for April 2021, the lower compliance score of 81.81% was due to untimely resolution of two (2) standard grievances.

- Based on a focused review of fourteen (14) Medi-Cal standard grievances for May 2021, the lower compliance score of 85.71% was due to the Spanish acknowledgment letter not including the phone number of the plan representative who may be contacted about the grievance for one (1) standard grievance and due to an incomplete resolution letter for one (1) standard grievance.

- Based on a focused review of fourteen (14) Medi-Cal standard grievances for May 2021, the lower compliance score of 64.28% was due to resolution letters being issued past the 30-calendar day timeframe for four (4) standard grievances and due to the oral notification of resolution to the member occurring past the 72 hours timeframe for one (1) standard grievance.

- Medi-Cal GARS: Expedited Grievances

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
March 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
April 2021	100%	N/A	100%	77.77	88.88%
May 2021	100%	100%	100%	83.33%	83.33%

- Based on a focused review of nine (9) Medi-Cal expedited grievances for April 2021, the lower compliance score of 77.77% was due to incomplete resolution of two (2) expedited grievances.

- Based on a focused review of nine (9) Medi-Cal expedited grievances for April 2021, the lower compliance score of 88.88% was due to one (1) expedited grievance with an untimely verbal resolution.

- Based on a focused review of six (6) Medi-Cal expedited grievances for May 2021, the lower compliance score of 83.33% was due to one (1) resolution letter not addressing the actual complaint made for the actual expedited grievance.

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Back to Agenda

- Based on a focused review of six (6) Medi-Cal expedited grievances for May 2021, the lower compliance score of 83.33% was due to one (1) oral notification of resolution to the member occurring past the 72 hours timeframe.

- Medi-Cal Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
March 2021	78%	67%	100%	89%	67%	100%	89%
April 2021	100%	81.81%	81.81%	90.90%	100%	100%	90.90%
May 2021	100%	85%	100%	92%	100%	100%	100%

- Based on a focused review of eleven (11) Medi-Cal standard prior authorizations for April 2021, the lower compliance score of 81.81% for resolution timeliness was due to two (2) files not meeting the TAT for processing standard authorization request.

- Based on a focused review of eleven (11) Medi-Cal standard prior authorizations for April 2021, the lower compliance score of 81.81% for Provider and Member Notification Timeliness was due to two (2) standard prior authorization requests not having evidence of member notification sent to the member.

- Based on a focused review of eleven (11) Medi-Cal standard prior authorizations for April 2021, the lower compliance score of 90.90% for clinical decision-making review was due to one (1) standard prior authorization request not following the hierarchy for the Medi-Cal LOB.

- Based on a focused review of eleven (11) Medi-Cal standard prior authorizations for April 2021, the lower compliance score of 90.90% for accuracy of member notice content was due to one (1) Notice of Action letter not being written in lay terms.

- Based on a focused review of thirteen (13) Medi-Cal standard prior authorizations for May 2021, the lower compliance score of 85% for resolution timeliness was due to two (2) files not meeting the TAT for processing standard authorization requests.

- Based on a focused review of thirteen (13) Medi-Cal standard prior authorizations for May 2021, the lower compliance score of 92% for clinical decision-making review was due to one (1) standard prior authorization request not following the hierarchy for the Medi-Cal LOB.

- Medi-Cal Utilization Management: Urgent Prior Authorizations

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Back to Agenda

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
March 2021	100%	100%	82%	100%	100%	100%	100%
April 2021	100%	66.67%	44.44%	100%	100%	100%	100%
May 2021	100%	28.57%	57.14%	71.42%	100%	100%	100%

- Based on a focused review of nine (9) Medi-Cal urgent prior authorizations for April 2021, the lower compliance score of 66.67% for resolution timeliness was due to three (3) files' decisions not being made within 72 hours from receipt of request.

- Based on a focused review of nine (9) Medi-Cal urgent prior authorizations for April 2021, the lower compliance score of 44.44% for provider and member notification timeliness was due to three (3) files failing to notify the member of the decision made and two (2) files containing written notification to the member that exceeded the 72-hour turnaround time.

- Based on a focused review of seven (7) Medi-Cal urgent prior authorizations for May 2021, the lower compliance score of 28.57% for resolution timeliness was due to five (5) files not meeting the TAT for processing expedited requests.

- Based on a focused review of seven (7) Medi-Cal urgent prior authorizations for May 2021, the lower compliance score of 57.14% for provider and member notification timeliness was due to two (2) files not containing the provider fax confirmation within RightFax and one (1) file exceeding the member notification TAT for expedited requests and exceeding the oral or electronic TAT guidelines for provider notification.

- Based on a focused review of seven (7) Medi-Cal urgent prior authorizations for May 2021, the lower compliance score of 71.42% for clinical decision-making review was due to one (1) one approval following the incorrect guidelines and one (1) approval decision made by a UM nurse not a doctor.

3. Internal Monitoring: OneCare [a\]

- OneCare GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
March 2021	100%	100%	100%	66%	66%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
April 2021	100%	100%	100%	66.67%	100%
May 2021	100%	100%	100%	100%	100%

- Based on a focused review of three (3) OneCare standard appeals for April 2021, the lower compliance score of 66.67% was due to one (1) file exceeding the sixth (6^{th}) grade reading level.
- No significant trends to report in May 2021.

- OneCare GARS: Payment Reconsiderations (PREC)

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
March 2021	NTR	NTR	NTR	NTR	NTR
April 2021	NTR	NTR	NTR	NTR	NTR
May 2021	100%	100%	N/A	N/A	100%

- No significant trends to report in May 2021.

- OneCare GARS: Standard Grievances

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
March 2021	100%	100%	100%	100%	100%
April 2021	100%	100%	100%	66.67%	100%
May 2021	100%	100%	100%	100%	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- Based on a focused review of six (6) OneCare standard grievances for April 2021, the lower compliance score of 66.67% was due to one (1) file containing an incomplete resolution letter and one (1) resolution letter was issued on the wrong letterhead.

- No significant trends to report in May 2021.

- OneCare Utilization Management: Standard Pre-Service Organization Determinations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
March 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
April 2021	100%	100%	50%	100%	100%	100%	100%
May 2021	100%	100%	100%	100%	100%	100%	100%

- Based on a focused review of four (4) OneCare standard pre-service organization determination for April 2021, the lower compliance score of 50% for provider and member notification timeliness was due to two (2) files not containing evidence of a mailed member notification letter.

- No significant trends to report in May 2021.

4. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
March 2021	100%	100%	100%	28.57%	85.71%
April 2021	100%	100%	100%	80%	80%
May 2021	100%	91.67%	100%	66.67%	100%

- Based on a focused review of ten (10) OneCare Connect standard appeals for April 2021, the lower compliance score of 80% for member notice content was due to two (2) files exceeding sixth (6^{th}) grade reading level.

- Based on a focused review of ten (10) OneCare Connect standard appeals for April 2021, the lower compliance scores of 80% for resolution of appeals within ≤ 30

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Back to Agenda

calendar days of receipt was due to not issuing the effectuation within 72 hours of the doctor's decision in one (1) file and one (1) standard appeal was not processed in 30 calendar days.

- Based on a focused review of twelve (12) OneCare Connect standard appeals for May 2021, the lower compliance score of 91.67% for standard appeals acknowledged within ≤ 5 Calendar days of receipt was due to one (1) untimely acknowledgement letter.

- Based on a focused review of twelve (12) OneCare Connect standard appeals for May 2021, the lower compliance score of 66.67% for member notice content was due to three 93) files exceeding sixth (6^{th}) grade reading level and one (1) file not showing a notice of compliance that was not sent to the member.

- OneCare Connect GARS: Expedited Appeals

Month(s)	Classification Score	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within 72 Hours of Receipt
March 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
April 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
May 2021	100%	100%	100%	100%	100%

- No significant trends to report in April and May 2021.

- OneCare Connect GARS: Standard Grievances

Month(s)	Classification Score	Standard Grievance Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievance within ≤ 30 Calendar Days of Receipt
March 2021	100%	100%	100%	93.33%	100%
April 2021	100%	100%	100%	93.33%	100%
May 2021	100%	100%	100%	86.67%	100%

- Based on a focused review of fifteen (15) OneCare Connect standard grievances for April 2021, the lower compliance score of 93.33% was due to the member resolution letter not addressing all member grievances in one (1) standard grievance.

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Back to Agenda

- Based on a focused review of fifteen (15) OneCare Connect standard grievances for May 2021, the lower compliance score of 86.67% was due to incomplete resolution letters that did not address the member's complaints in two (2) standard grievances.

- OneCare Connect GARS: Expedited Grievances

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
March 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
April 2021	100%	100%	100%	100%	100%
May 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- No significant trends to report in April and May 2021.

- OneCare Connect Utilization Management: Standard Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
March 2021	100%	90%	90%	70%	90%	70%	90%
April 2021	100%	100%	100%	90%	100%	60%	100%
May 2021	100%	100%	90%	90%	100%	60%	80%

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for April 2021, the lower compliance score of 90% for clinical decision-making review was due to one (1) file request for additional information was not made within two business days of receipt of requests.

- Based on a focused review of ten (10) OneCare standard prior authorizations for April 2021, the lower compliance score of 60% for written response in member's preferred language was due to four (4) Notice of Actions that were not fully translated in the member's preferred language.

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for May 2021, the lower compliance score of 90% for provider and member notification timeliness was due to one (1) UM file not meeting the provider notification TAT.

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Back to Agenda

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for May 2021, the lower compliance score of 90% for clinical decision-making review was due to one (1) UM file that did not follow the hierarchy for the OCC LOB.

- Based on a focused review of ten (10) OneCare standard prior authorizations for May 2021, the lower compliance score of 60% for written response in member's preferred language was due to four (4) Notice of Actions that were not fully translated in the member's preferred language.

- Based on a focused review of ten (10) OneCare standard prior authorizations for May 2021, the lower compliance score of 80% for written response in accuracy of member notice content was due to one (1) UM file that did not write the NOA letter to the member in lay terms and one (1) Notice of Action letter exceeding the sixth grade reading level.

- OneCare Connect Utilization Management: Expedited Prior Authorizations

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Processing Accuracy	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
March 2021	100%	100%	80%	100%	100%	90%	100%
April 2021	100%	100%	100%	90%	100%	60%	100%
May 2021	100%	100%	100%	100%	100%	80%	100%

- Based on a focused review of ten (10) OneCare Connect standard prior authorizations for April 2021, the lower compliance score of 90% for clinical decision-making review was due to one (1) file not following the medical hierarchy guidelines for OneCare Connect.

- Based on a focused review of ten (10) OneCare standard prior authorizations for April 2021, the lower compliance score of 60% for written response in member's preferred language was due to four (4) Notice of Actions that were not fully translated in the member's preferred language.

- Based on a focused review of ten (10) OneCare standard prior authorizations for May 2021, the lower compliance score of 80% for written response in member's preferred language was due to two (2) Notice of Actions that were not fully translated in the member's preferred language.

5. Internal Audits: [a\]

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- During the fourth quarter of 2020, CalOptima's Audit & Oversight (A&O) department conducted a full-scope audit of CalOptima's Case Management department to ensure compliance with timeliness and accuracy requirements for care coordination for the review period of January 2020-September 2020.

- 2020 Internal Audit: Case Management (Medi-Cal)

Area Assessed	Universe Validation	Policy Review	Data Integrity	File Classification	Member Consent Timeliness	Risk Stratification Timeliness	Assessment Timeliness	Assessment Accuracy	Care Plan Timeliness	Care Plan Accuracy	Interdisciplinary Care Team	Care Transitions
Non-SPD	100%	100%	100%	100%	100%	N/A	100%	100%	67%	100%	100%	100%
WCM	100%	100%	100%	75%	N/A	N/A	100%	100%	100%	100%	100%	100%
SPD	100%	100%	83%	100%	N/A	100%	100%	100%	100%	100%	100%	100%

Medi-Cal Non-SPD Initial Assessment
- Individual Care Plan Timeliness
  - 1 out 3 samples had an untimely initial assessment.

Medi-Cal Whole Childe Model (WCM) Health Needs Assessment (HNA)
- File Classification
  - 1 out 4 samples was misclassified.

Medi-Cal Seniors and Persons with Disabilities (SPD) Health Risk Assessment (HRA)
- Data Integrity Finding:
  - 1 out 6 samples reviewed had incorrect data in the universe. The data in the universe did not match the data in the documentation.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the audit of CalOptima's Case Management department universe, timeliness, and accuracy. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

  - During the fourth quarter of 2020, CalOptima's Audit & Oversight (A&O) department conducted a full-scope audit of CalOptima's Case Management department to ensure

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Back to Agenda

compliance with timeliness and accuracy requirements for care coordination for the review period of September 2019-September 2020.

- 2020 Internal Audit: Case Management (Care Coordination) (OneCare, OneCare Connect)

Area Assessed	Universe Validation	Policy Review	Data Integrity	File Classification	Health Risk Assessment Timeliness	Health Risk Assessment Accuracy	Individual Care Plan Timeliness	Individual Care Plan Accuracy	Interdisciplinary Care Team	Care Transitions	Administrative Processes & Training/Credentialing
OneCare	100%	100%	97%	100%	97%	97%	93%	93%	93%	100%	97%
OneCare Connect	100%	100%	93%	100%	100%	100%	92%	92%	100%	100%	N/A

- There were no corrective action plans (CAPs) issued for the OneCare / OneCare Connect Case Management (Care Coordination) internal audit, as all audit measures met their compliance goal of 90%.

- During the fourth quarter of 2020, CalOptima's Audit & Oversight (A&O) department conducted a full-scope audit of CalOptima's Quality Improvement department to ensure compliance with universe and policy accuracy for facility site review for the review period of January 2020-September 2020.

- 2020 Internal Audit: Quality Improvement- Facility Site Review (Medi-Cal)

Area Assessed	Universe Validation	Policy Review
Quality Improvement (Facility Site Review)	100%	100%

- No significant trends to report during the Quality Improvement- Facility Site Review (Medi-Cal) audit.

6. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
February 2021	89%	95%	98%	94%	93%	93%	99%	92%	95%	100%	95%	89%	97%
March 2021	87%	95%	100%	92%	84%	78%	86%	99%	94%	100%	77%	89%	99%
April 2021	87%	82%	89%	81%	97%	92%	91%	90%	85%	93%	50%	84%	86%

- Based on a focused review of select files, seven (7) health networks drove the lower compliance score for timeliness during the month April 2021. Of the ninety-five (95) files submitted in the aggregate by seven (7) health networks, twenty-two (22) files were deficient for timeliness. The deficiency for the lower scores for timeliness were due to the following:
  - Failure to meet timeframe for decision (Routine – 5 business days, and Extended– 14 calendar days)
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for member notification (2 business days)

- Based on a focused review of select files, four (4) health networks drove the lower compliance score for clinical decision making (CDM) during the month of April 2021. Of the forty-one (41) files submitted in the aggregate by four (4) health networks, thirty-six (36) files were deficient for CDM. The deficiency for the lower scores for CDM were due to the following:
  - Failure to obtain adequate clinical information
  - Failure to include appropriate professional that makes decision
  - Failure to cite criteria for decision

- Based on a focused review of select files, six (6) health networks drove the lower compliance score for letter criteria during the month of April 2021. Of the eighty-seven (87) files submitted in the aggregate by six (6) health networks, thirty-seven (37) files were deficient for letter criteria. The deficiency for the lower scores for letter criteria were due to the following:
  - Failure to provide information on how to file appeal and grievance
  - Failure to provide letter in member preferred language
  - Failure to provide why the request did not meet the criteria in lay language
  - Failure to provide description of service in lay language
  - Failure to provide name and contact information for health care professional responsible for the decision to deny or modify

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Back to Agenda

- Failure to provide Language Assistance Taglines insert with approved threshold languages
- Failure to provide referral back to primary care provider (PCP) on denial letter
- Failure to provide peer-to-peer discussion of the decision with medical reviewer

➢ Based on the overall universe of Medi-Cal authorizations for April 2021, CalOptima's health networks received an aggregate compliance score of 99.93% for timely processing of routine authorization requests and a compliance score of 99.51% for timely processing of expedited authorization requests.

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2021	94%	98%	98%	96%
March 2021	86%	97%	97%	90%
April 2021	91%	99%	95%	92%

➢ Based on a focused review of select files, three (3) health networks drove the lower compliance score for Denied Claims Timeliness during the month of April 2021. Of the ninety-two (92) files submitted in the aggregate by three (3) health networks, thirteen (13) files were deficient due to the failure to meet non-contracted denied claim timeliness (30 calendar day from date of claim receipt).

➢ Based on the overall universe of Medi-Cal claims for April 2021, CalOptima's health networks received an overall compliance score of 75% for timely processing of claims.

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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Back to Agenda

7. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
February 2021	98%	100%	93%	100%	89%	100%	88%	100%
March 2021	93%	100%	89%	100%	93%	100%	97%	98%
April 2021	83%	84%	85%	88%	94%	75%	100%	99%

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for timeliness during the month of April 2021. Of the twelve (12) files submitted by the (2) health networks, twelve (12) files were deficient for timeliness. The deficiency for the lower scores for timeliness were due to the following:
  - Failure to meet timeframe for decision (Routine – 14 calendar days)
  - Failure to meet timeframe for member notification (Routine – 14 calendar days)
  - Failure to meet timeframe for provider notification (Routine – 14 calendar days)
  - Failure to meet timeframe for decision (Expedited –72 hours)
  - Failure to meet timeframe for provider notification (72 hours)
  - Failure to meet timeframe for member written notification (72 hours)
  - Failure to meet timeframe for member oral notification (72 hours)

- Based on a focused review of select files, one (1) health network drove the lower compliance score for clinical decision making (CDM) during the month of April 2021. Of the one (1) file submitted in the aggregate by the one (1) health network, one (1) file was deficient for CDM. The lower scores for CDM were due to the following:
  - Failure to cite criteria for decision
  - Failure to include appropriate professional that makes decision
  - Failure to obtain adequate clinical information

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for letter criteria during the month of April 2021. Of the thirty-nine (39) files submitted in the aggregate by two (2) health networks, seventeen (17) files were deficient for letter criteria. The deficiency for the lower scores for letter criteria were due to the following:
  - Failure to utilize CMS approved letter template
  - Failure to provide letter with CalOptima logo
  - Failure to provide description of service in lay language
  - Failure to describe why the request did not meet criteria in lay language

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Back to Agenda

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for April 2021 CalOptima's health networks received an overall compliance score 93% for timely processing of standard Part C authorization requests and 99% for timely processing of expedited Part C authorization requests**.**

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2021	96%	96%	100%	94%
March 2021	89%	100%	100%	100%
April 2021	95%	99%	100%	100%

- Based on a focused review of select files, one (1) health network drove the lower compliance score for paid claims accuracy during the month of April 2021. Of the ten (10) files submitted by the one (1) health network, one (1) file was deficient due to the failure accurately process paid claim.

- Based on the overall universe of OneCare claims for CalOptima's health networks for April 2021, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
  - 93.29% for non-contracted clean claims paid or denied within 30 calendar days of receipt
  - 99.31% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and

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Back to Agenda

policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

8. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timeliness for Routine Requests	Letter Score for Routine Requests	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests
February 2021	95%	87%	96%	88%	94%	81%	83%	90%	85%	95%	97%
March 2021	99%	92%	95%	93%	95%	93%	94%	93%	98%	100%	100%
April 2021	98%	100%	93%	99%	94%	100%	89%	94%	97%	99%	100%

- Based on a focused review of select files, three (3) health networks drove the lower compliance score for timeliness during the month of April 2021. Of the fifty-two (52) files submitted in the aggregate by three (3) health networks, twenty-eight (28) files were deficient for timeliness. The deficiency for the lower score for timeliness were due to the following:
  - Failure to meet timeframe for decision (Urgent – 72 hours)
  - Failure to meet timeframe for provider written notification (Urgent – 72 hours)
  - Failure to meet timeframe for provider decision (5 business days)
  - Failure to meet timeframe for initial notification (24 hours)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for member written notification (2 business days)

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for clinical decision making (CDM) during the month of April 2021. Of the twenty-four (24) files submitted in the aggregate by two (2) health networks, sixteen (16) files were deficient for CDM. The deficiency for the lower scores for CDM were due to the following:
  - Failure to cite criteria for decision
  - Failure to include appropriate professional that makes decision
  - Failure to obtain adequate clinical information

- Based on a focused review of select files, three (3) health networks drove the lower compliance score for letter criteria during the month of April 2021. Of the seventy-six (76) files submitted in the aggregate by three (3) health networks, forty-three (43) files were deficient for letter criteria. The deficiency for the lower scores for letter criteria were due to the following:
  - Failure to provide description of service in lay language
  - Failure to provide letter in the member preferred language

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Back to Agenda

- Failure to provide Language Assistance Taglines insert with approved threshold languages
- Failure to describe why the request did not meet criteria in lay language
- Failure to provide peer-to-peer discussion of the decision with medical reviewer
- Failure to include contact information for health care professional responsible for the decision to deny or modify

➢ Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for April 2021, CalOptima's health networks received an overall compliance score of 100% for timely processing of routine authorization requests and 97.9 % for timely processing of expedited authorization requests.

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of authorizations within regulatory requirements.

- <u>OneCare Connect Claims</u>: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2021	85%	94%	100%	96%
March 2021	68%	84%	99%	88%
April 2021	93%	93%	100%	95%

➢ Overall scores for OneCare Connect claims increased in the aggregate for the April 2021 file review month.

➢ Based on the overall universe of OneCare Connect claims for CalOptima's health networks for April 2021, CalOptima's health networks received the following overall compliance scores:
  – 97.18% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  – 91.95% for non-contracted and contracted unclean claims paid or denied within 60 calendar days of receipt
  – 99.77% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of

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Back to Agenda

claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

First Tier Entities (FTE):

- CalOptima's Audit & Oversight department conducted annual audits of five (5) first-tier entities (FTE) to ensure compliance with applicable laws, regulations, contractual requirements, and CalOptima policies. FTEs included, but may not be limited to, printing and fulfillment vendors, translation and interpreter vendors, enrollment and eligibility verification vendor, home health and hospice service vendors, over-the-counter benefit vendor, pharmacy formulary services vendor, timely access survey vendor, and personal emergency response services vendor. The audit areas assessed included the contractual, compliance, information systems, insurance, and sub-contractual obligations of the FTE.

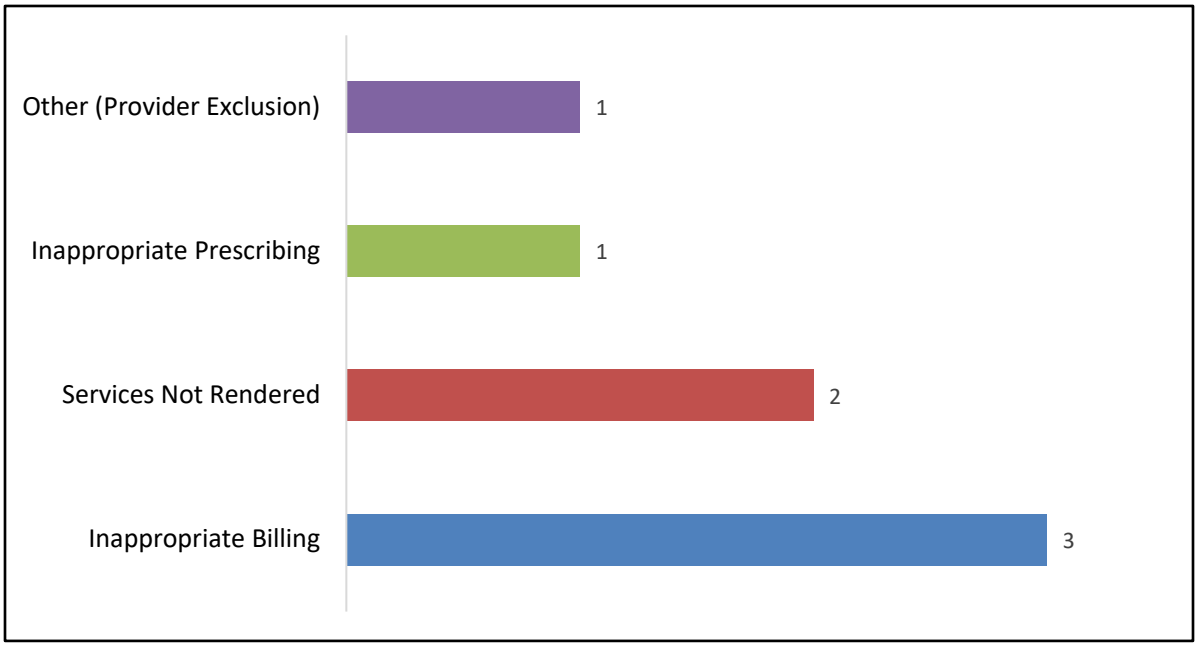
Audit Area	Contractual Obligations	Compliance	Information Systems	Sub-Contractual
Overall Average Score	99.88%	100%	100%	100%

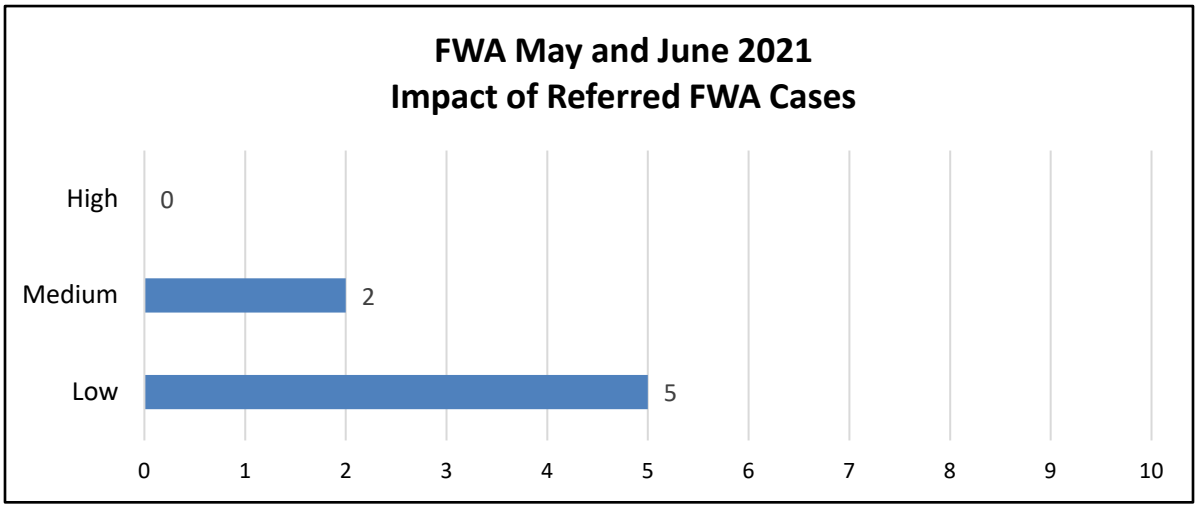
a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Referred in May and June 2021)



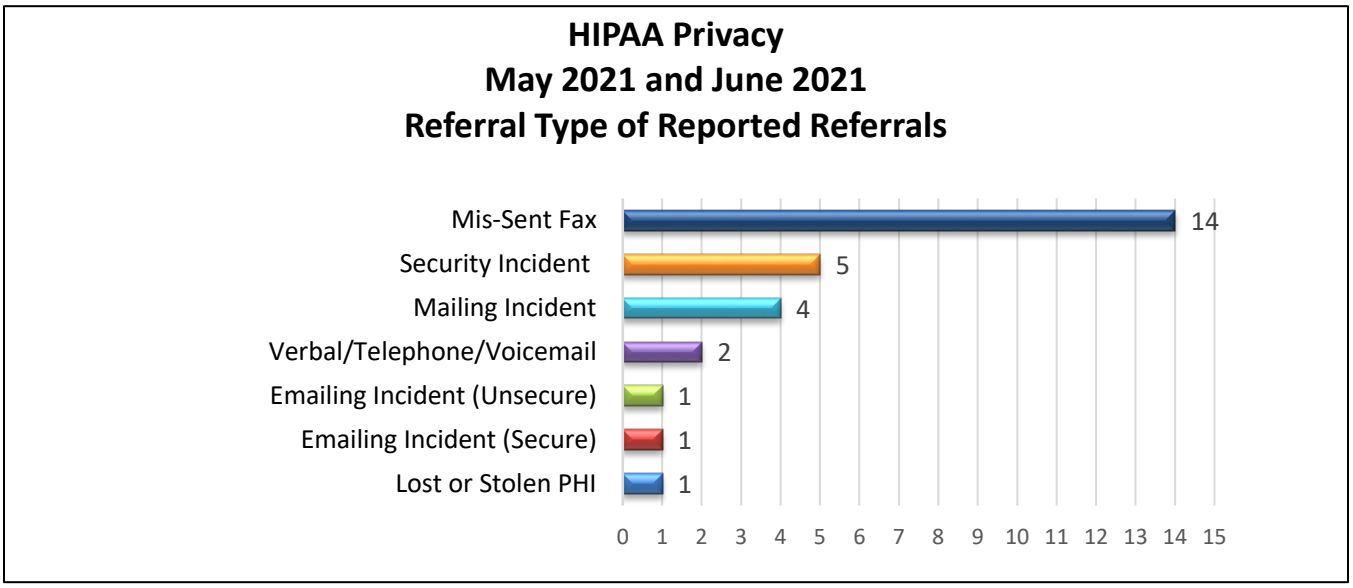


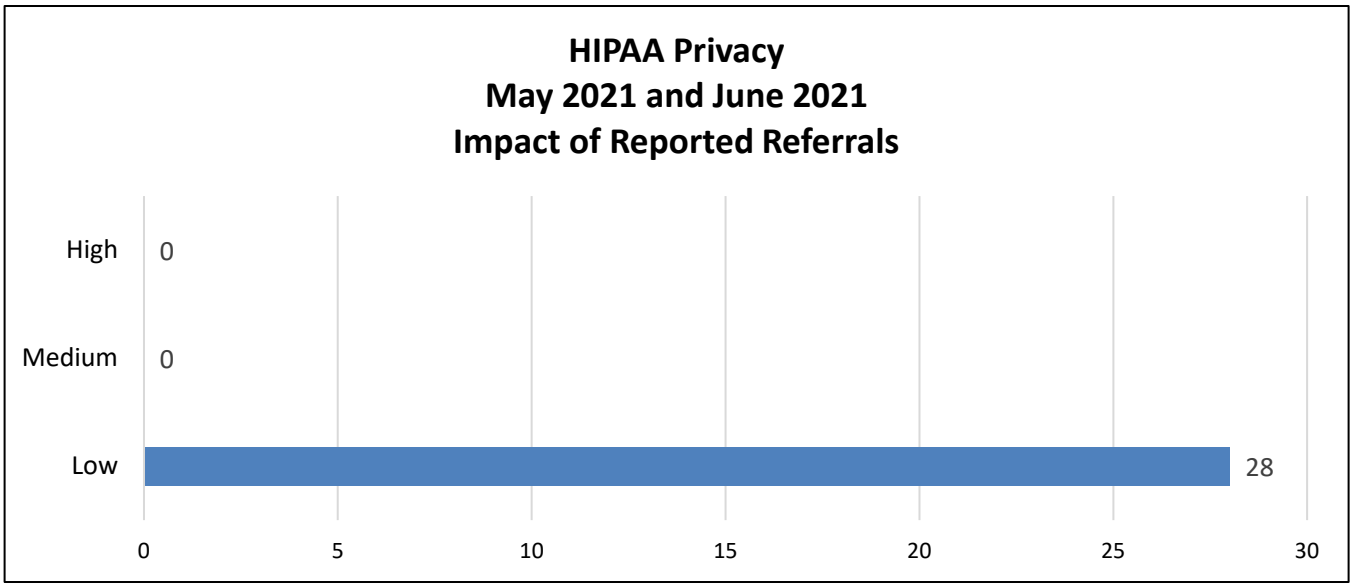
Total Number of New Cases Referred to DHCS (State)	4
Total Number of Closed Cases Referred to I-MEDIC (CMS)	3
Total Number of Referrals Reported	**7**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

E. Privacy Update: (May and June 2021)





Total Number of Referrals Reported to DHCS (State)	28
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**28**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

MEMORANDUM

July 9, 2021

To: CalOptima

From: Potomac Partners DC & Strategic Health Care

Re: July Board of Directors Report

The House and Senate were in session most of the month of June, recessing the week of July 4th. In the House, the primary focus was Fiscal Year 2022 Appropriations markups, committee hearings on a number of health and health equity bills, and transportation legislation. The Senate meanwhile focused on Executive Branch nominations.

CONGRESSIONAL MEETINGS

As part of the Association for Community Affiliated Plan's (ACAP) virtual fly-ins last month, Potomac Partners DC (PPDC) and Strategic Health Care (SHC) facilitated virtual meetings for CalOptima CEO Richard Sanchez with Orange County Delegation Reps. Michelle Steel (R-CA), Young Kim (R-CA), and senior staff in the offices of Senator Dianne Feinstein and Rep Linda Sanchez (D-CA). The purpose of these meetings was to provide the Members with current information on CalOptima's operations, responsibilities, and legislative needs for the 117th Session of Congress. Each meeting was efficient and productive, covering a number of issues to include new funding for innovative Social Determinants of Health (SDOH) programs, vaccination rates by age in the County, Medicaid access and expansion, and support for allowing audio-only telehealth encounters to be included in MA and PACE risk adjustment payments.

FISCAL YEAR 2022 (FY22) APPROPRIATIONS

The House Appropriations Committee has begun marking-up the first of its Fiscal Year 2022 (FY22) appropriations bills, approving 6 of the 12 appropriations bills in subcommittee and full committee markups. The Labor, Health and Human Services, Education bill's subcommittee markup is scheduled for July 12th, followed by full committee consideration on July 15th. As of this report, the draft Labor-HHS-Edu bill has not been unveiled. It is likely to be released shortly before the subcommittee markup. The Labor-HHS-Edu bill's spending cap has been set by the House Appropriations Committee at $237.47 billion, a 36.4% increase compared to FY21 enacted spending.

In the Senate, Budget Committee Chairman Bernie Sanders (I-VT) circulated a draft FY22 budget resolution blueprint to Committee members that contains reconciliation instructions allowing for nearly $6 trillion in new spending over 10 years, approximately $1.6 billion more than included in

Back to Agenda

the Administration's proposals for infrastructure and care economy. Chairman Sanders told members that the committee will focus on drafting a resolution that includes long-term spending increases, while borrowing for "one-time" infrastructure projects that on net could add roughly $3 trillion to the deficit over a decade. Sanders also indicated that his plan could go beyond the nearly $2.4 trillion in tax increases over a decade included in the Administration's plans, supplemented by over $600 billion in potential drug pricing savings. Revenue sources, changes to the tax code, and other mechanisms to pay for new spending would fall under the jurisdiction of the Senate Finance Committee. Senate Majority Leader Chuck Schumer (D-NY) has indicated he wants to bring an FY22 budget resolution with reconciliation instructions to the floor in July prior to adjourning for August recess, setting up consideration of a massive reconciliation package this fall.

MEDICAID UPDATE

On June 28th, the Biden Administration announced Daniel Tsai as Deputy Administrator and Director for the Center for Medicaid and CHIP Services (CMCS). Mr. Tsai was previously Assistant Secretary for MassHealth and Medical Director.

Medicaid enrollment currently tops 80 million, ten million more than a year ago. Despite the increase, millions of individuals and families fall into the ACA coverage gap or are eligible but unenrolled. Additionally, the program's provider networks are significantly narrower than commercial counterparts and nearly one-third of providers do not accept Medicaid patients. The Administration's Medicaid and Medicare reform interests largely concern coverage expansion. For example, the American Rescue Plan included enhanced FMAP (at 85%) for optional state community mobile crisis intervention services for five years beginning April 2022, and a two year 5% FMAP incentive for the now eleven states that have not yet expanded Medicaid. This is on top of the 6.2% FMAP Public Health Emergency (PHE) increase.

President Biden's American Families and Jobs plans would include related provisions. The former would seek to expand Medicaid home and community-based waivers by $400 billion. These proposals would also provide stronger benefits, opportunities to unionize and develop registered apprenticeships, raise caregiver wages, make the Money Follows the Person program permanent, and either make permanent the child tax credit or extend it through 2025. The administration has also expressed support for Medicaid state wavier approvals to extend Medicaid coverage for post-partum women for one year and provide coverage for inmates with behavioral health diagnoses and undocumented immigrants.

Rep. Lloyd Doggett (D-TX), Chair of the Ways and Means Health Subcommittee, introduced H.R. 3961 - *COVER Now Act* in June that would allow counties, cities, and other political subdivisions to expand Medicaid coverage in the 11 remaining non-ACA expansion states. Rep. Debbie Dingell (D-MI) and Senator Bob Casey (D-PA) recently introduced the Better Care Better Jobs Act that would facilitate statewide planning for Home and Community Based Services (HBCS) infrastructure development plans and permanently increase FMAP if states expanded access to HCBS and strengthened HCBS workforces.

SURPRISE BILLING

The first set of surprise billing regulations are out and will pose new challenges to providers. The Requirements Related to Surprise Billing; Part I, an interim final rule, was released by HHS along with the Departments of Labor and Treasury. The rule will:

- Ban surprise billing for emergency services stating that regardless of where they are provided, they must be treated on an in-network basis without requirements for prior authorization.

- Ban high out-of-network cost-sharing for emergency and non-emergency services specifying that patient cost-sharing, such as co-insurance or a deductible, cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network provider rates.

- Ban out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances.

- Ban other out-of-network charges without advance notice by requiring health care providers and facilities provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

Additionally, the UnitedHealthcare proposal to deny emergency room claims it later deemed to not be actual emergencies would be disallowed under both the surprise billing ban and the broader Affordable Care Act.

TELEHEALTH

There have been a number of new telehealth bills introduced in June, possibly signaling growing support for expanding and streamlining telehealth capabilities. One of these bills is H.R. 3447 - *Permanency for Audio-Only Telehealth Act,* sponsored by Rep. Jason Smith (R-MO). This bill aims to make telehealth services available to Medicare recipients who cannot access the video component during telehealth visits. Allowable services would include evaluation and management, mental and behavioral health, substance use disorder, or any other service specified by the Secretary of HHS.

Another bill, sponsored by Reps. Doris Matsui (D-CA) and Bill Johnson (R-OH), was introduced as the *Telemental Health Care Access Act*. This legislation seeks to remove barriers to high-quality, virtual mental and behavioral health care for Medicare beneficiaries. Specifically, the bill removes the statutory requirement that Medicare beneficiaries be seen in-person within six months of being treated for mental and behavioral health services through telehealth. Eliminating this arbitrary requirement will ensure that patients can fully leverage telehealth to get the care they need from home.

We have been closely monitoring Rep. Terri Sewell's (D-AL) telehealth legislation, H.R. 2166 - *Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021*, which would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for Medicare Advantage (MA) and PACE plans during the COVID-19 public health emergency. Rep. Young Kim (R-CA) cosponsored this legislation in June.

AFFORDABLE CARE ACT SUPREME COURT DECISION

On June 17th, the US Supreme Court ruled that a coalition of states led by Texas did not have the legal standing to challenge the law saying that the plaintiffs "have not shown a past or future injury fairly traceable to defendants' conduct enforcing the specific statutory provision they attack as unconstitutional." The 7-2 decision, written by Justice Breyer, will leave the Affordable Care Act intact for the third time since enactment.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

July 9, 2021

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

On June 28, Governor Newsom signed California's $267 billion budget. However, as we've reported previously, the signed budget contains the appropriations to spend state funds, but much work continues to finalize the budget behind the scenes. The annual Budget Act is always accompanied by a number of "trailer bills" which enact policy changes needed to implement the budget. In recent years, the number of trailer bills has increased and the scope of policy changes made in these bills has expanded.

In 2021, negotiations on these trailer bills and the finer points of the budget are moving slowly. Very few trailer bills have been put into print let alone considered by the Legislature. In the meantime, several appropriations within the budget are contingent upon enactment of these trailer bills, meaning the money can't move until the details are worked out.

Negotiations will continue in the coming weeks, and we expect much of the work to get done during the month-long summer recess which begins on July 14. There is no final deadline for the Legislature to adopt trailer bills or amend the current Budget Act, so work can continue right through the end of Session on September 10.

Meanwhile, Governor Newsom will be facing the unwanted distraction of a recall election. We continue to think there is little chance the Governor will be recalled, but with the election set for September 14, we have a few observations.

The Governor May not be Designated as a Democrat, Does it Matter?
Historically, elected officials who are facing recall have not had their party affiliation listed on the ballot. However, the candidates who hope to replace them do. In 2019, the Legislature passed and the Governor signed legislation allowing officials facing recall to have their party affiliation designated on the ballot, but they had to file a request to do so at the same time that they filed their response to the recall petition.

Governor Newsom's attorneys failed to submit this request and the Secretary of State has ruled that he cannot be noted as a Democrat on the recall ballot. The Governor is suing the Secretary of State to overturn this decision and one of his opponents, Caitlyn Jenner, has filed a motion to intervene in the suit in the hopes of keeping the Governor from being successful.

The issue has received a decent amount of attention in part because the Governor recently appointed the current Secretary of State and because he signed the law that

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Back to Agenda

his attorneys failed to comply with. It's an interesting story but in our opinion it probably will not matter much for the outcome of the election.

In a regular election, ballots are full of federal, state, and local candidates as well as numerous statewide and local ballot measures. Some voters get overwhelmed by the sheer number of choices they are asked to make. In these elections, party affiliation is significant for down ballot candidates because some of those exhausted voters will simply vote based on their party preference.

The recall election is quite different. It poses only two questions to voters. Should the Governor be recalled and if so, who should replace him? If you don't know who the Governor is or have an opinion about whether he should be recalled, it's hard to imagine you'll show up to the polls at all. If you do, it's hard to imagine that knowing his party affiliation will change your mind.

Bottom line, for the September 14 election, the only thing to show up for in the first place is the recall and if you do show up, you're going to know if you're a yes or no. On that note, we think who shows up is a much more important question.

Turnout

As we've said before, with roughly 46% of voters registered as Democrats, Governor Newsom will approach the September 14 election with a tremendous registration and fundraising advantage. The problem is whether Democrats will be motivated to show up to the election. A May survey by the UC Berkeley Institute for Governmental Studies found 75% of Republicans reported a high level of interest in the recall, compared to just 36% of Democrats and 35% of No Party Preference voters. A recent analysis by the PPIC found similar results that showed that voters who supported the recall were following news related to the recall more closely.

At the end of the day, we think the risk is pretty low for the Governor. To start out with, no matter how motivated Republican voters are, only 24.1% of voters are Republicans. His opponents are not as well known to voters and lack experience in statewide office. Moreover, the Governor has the cash to drown his opponents in advertisements and bombard registered Democrats with pleas for turnout in the next two months. Nevertheless, turnout is the biggest problem the Governor can run into in the recall election.

Bill Signing

As we noted above the Legislature will adjourn for the year on September 10. At that point, the Governor will have until October 10 to sign or veto the hundreds of bills that will land on his desk. Most of these bills will be run of the mill and will be of little interest to the public. However, some will be controversial and some will advance the Governor's agenda.

Back to Agenda

A September 14 election date is pretty good timing for the Governor in this regard. Many mail-in ballots will be sent well before the Governor has to take action on bills. Those voters who wait could see the Governor advance his agenda in a very public way just days before the election by signing the right bills. On the flip side, he will have time for the more controversial items after September 14.

Wildfire

With over 60% of Californians having received at least one dose of a vaccine, it seems like the disaster that is most likely to coincide with the recall is a catastrophic wildfire.

Sadly, wildfire season has already started in California. CalFire is working to contain several blazes in the north state which have burned structures and forced evacuations. Exacerbated by extreme heat and extreme drought conditions, the fire season can only get worse going forward.

A large wildfire is a serious problem that is largely out of the Governor's control. A wildfire which results in mass evacuations and property damage is the kind of event that, fair or not, can frustrate voters.

We will keep you apprised of further developments.

Back to Agenda

2021–22 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 510 Pan	**Disease Testing and Vaccination Coverage:** Would require a health plan to cover COVID-19 testing and vaccinations provided by an in-network or out-of-network provider, without cost sharing or prior authorization requirements, during a public health emergency. This bill would also apply these requirements to any future diseases causing a public health emergency. ***Potential CalOptima Impact:*** *Reimbursement for all in-network and out-of-network provider claims for testing and vaccinations related to a disease causing a public health emergency.*	**06/01/2021** Passed Senate floor; referred to Assembly	CalOptima: Watch CAHP: Oppose Unless Amended
SB 242 Newman	**Provider Reimbursement for Medically Necessary Expenses:** Would allow physicians and dental providers to be reimbursed for medically necessary business expenses, in compliance with a public health order, to treat and reduce the spread of COVID-19 or other infectious diseases in the workplace during a public health emergency. Reimbursable expenses would include personal protective equipment, infection control supplies, testing supplies and processing, and related information technology expenses. ***Potential CalOptima Impact:*** *Additional payments to contracted providers for medically necessary business expenses.*	**06/01/2021** Passed Senate floor; referred to Assembly	CalOptima: Watch CAHP: Oppose LHPC: Oppose

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
S. 764 Wyden	**Crisis Assistance Helping Out On The Streets (CAHOOTS) Act:** Similar to H.R. 1914, would allow State Medicaid programs to provide 24/7 community-based mobile crisis intervention services — under a State Plan Amendment or waiver — for those experiencing a mental health or substance use disorder crisis. Would provide states a 95% Federal Medical Assistance Percentage (FMAP) to cover such services for three years as well as a total of $25 million in planning grants. ***Potential CalOptima Impact:*** *Subject to further action by the California Department of Health Care Services (DHCS), increased behavioral health and substance use disorder services to CalOptima's Medi-Cal members.*	**03/16/2021** Introduced; referred to Senate Finance Committee	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1914 DeFazio	**Crisis Assistance Helping Out On The Streets (CAHOOTS) Act:** Similar to S. 764, would allow State Medicaid programs to provide 24/7 community-based mobile crisis intervention services — under a State Plan Amendment or waiver — for those experiencing a mental health or substance use disorder crisis. Would provide states a 95% FMAP to cover such services for three years as well as a total of $25 million in planning grants. ***Potential CalOptima Impact:*** *Subject to further DHCS action, increased access to behavioral health and substance use disorder services for CalOptima's Medi-Cal members.*	**03/16/2021** Introduced; referred to House Energy and Commerce Committee	CalOptima: Watch
AB 563 Berman	**Office of School-Based Health Programs:** Would establish the Office of School-Based Health Programs within the California Department of Education (CDE), no later than July 1, 2022, to administer current health programs, including the Local Education Agency (LEA) Medi-Cal Billing Option Program, and Early and Periodic Screening, Diagnostic, and Treatment (ESPDT) services. Would also require the CDE to coordinate with DHCS and LEAs to increase access to and expand the scope of school-based Medi-Cal programs. ***Potential CalOptima Impact:*** *Increased number of LEAs that enter into agreements or contracts with CalOptima.*	**05/27/2021** Passed Assembly floor; referred to Senate	CalOptima: Watch
AB 586 O'Donnell	**School Health Demonstration Project:** Would establish the School Health Demonstration Project, as a two-year program, to expand comprehensive physical and mental health access to students. The CDE would provide support, technical assistance and $500,000 in annual grants to LEAs to participate in additional Medi-Cal funding opportunities and build partnerships with Medi-Cal managed care plans (MCPs), county mental health plans (MHPs) and private health plans. ***Potential CalOptima Impact:*** *Increased number of LEAs that enter into agreements or contracts with CalOptima.*	**06/01/2021** Passed Assembly floor; referred to Senate	CalOptima: Watch
SB 221 Wiener	**Timely Access to Behavioral Health Follow-Up Care:** Would codify current timely access standards requiring health plans to ensure that contracted providers and health networks schedule initial appointments within specified time frames of a beneficiary's request. Would expand current standards to also require follow-up appointments with a non-physician mental health or substance use disorder provider to be scheduled within 10 business days of a previous appointment related to an ongoing course of treatment — in alignment with the current time frame for the initial appointment. ***Potential CalOptima Impact:*** *Increased monitoring of behavioral health appointments; arrangement and payment of out-of-network coverage when timely access is not ensured; additional contracting with behavioral health providers.*	**06/01/2021** Passed Senate floor; referred to Assembly	CalOptima: Watch CAHP: Oppose

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 293 Limon	**Standardized Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT) Forms:** Would require DHCS to develop standardized forms for specialty mental health services provided under EPSDT after January 1, 2022. Consistent with the California Advancing and Innovating Medi-Cal (CalAIM) proposal, the forms would address medical necessity criteria, screening tools and transition of care tools, which would impact coordination and referrals with Medi-Cal MCPs. ***Potential CalOptima Impact:*** *Implementation and use of new forms and processes by Behavioral Health Integration staff.*	**06/01/2021** Passed Senate floor; referred to Assembly	CalOptima: Watch
SB 562 Portantino	**Autism Spectrum Disorder (ASD) Treatment:** Would revise and expand the definitions of those providing care and support to individuals with ASD and redefine the minimum qualifications of autism service professionals. Additionally, ASD treatment such as the Developmental, Individual-differences and Relationship-based model (DIR), or "DIRFloortime," not currently covered by Medi-Cal, would be authorized to be provided at any time or location, in an unscheduled and unstructured setting, by a qualified autism provider. The authorization of ASD treatment services will not been denied or limited if a parent or caregiver is unable to participate. ***Potential CalOptima Impact:*** *New Medi-Cal covered benefit; expansion of provider types for ASD treatment services.*	**06/22/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/01/2021** Passed Senate floor	CalOptima: Watch CAHP: Oppose
SB 773 Roth	**Medi-Cal Incentive Payments for School-Based Behavioral Health:** Would require DHCS to make incentive payments to Medi-Cal MCPs for the 2022–24 rating period if plans increase access to preventive and behavioral health services for K–12 students through targeted interventions by school-based behavioral health providers. Of note, Gov. Newsom included $400 million of one-time funding in the proposed state budget for this initiative. ***Potential CalOptima Impact:*** *Administration of incentive payments to behavioral health providers; increased coordination and partnerships with LEAs in Orange County; increased tracking and reporting of provider and member metrics.*	**06/01/2021** Passed Senate floor; referred to Assembly	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
RN 21 14789 Trailer Bill	**Children and Youth Behavioral Health Initiative:** Would allow DHCS to award competitive grants to counties, Medi-Cal MCPs, LEAs colleges, community-based organizations (CBOs) and behavioral health providers to build partnerships and infrastructure supporting school-based behavioral health services for students ages 25 years or younger. Would require DHCS to provide incentive payments to Medi-Cal MCPs that increase access to preventive, early intervention and behavioral health services by school-based providers for K–12 students. Would also require Medi-Cal MCPs to reimburse providers who deliver outpatient mental health or substance use disorder services at a school, regardless of network status. No sooner than July 1, 2022, would add dyadic behavioral health visits as a covered Medi-Cal benefit. These services would be provided to the whole family during a medical visit to facilitate early identification and preventive services regarding behavioral health problems and social determinants of health (SDOH). Would require DHCS to establish a virtual platform to provide direct behavioral health screenings and short-term services to youth ages 25 years or younger. ***Potential CalOptima Impact:*** *Administration of incentive payments to behavioral health providers; increased coordination and partnerships with LEAs in Orange County; increased tracking and reporting of provider and member metrics; new Medi-Cal covered benefit.*	**06/18/2021** Published on the Department of Finance website	CalOptima: Watch

BUDGET**

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 128 Ting	**Budget Act of 2021:** Makes appropriations for the government of the State of California for Fiscal Year (FY) 2021–22. Total spending is $261.4 billion, of which $195.5 billion is from the General Fund. Key initiatives related to health care with an impact to CalOptima include: ■ Behavioral health services for youth ■ CalAIM proposal ■ COVID-19 response ■ Homelessness ■ Medi-Cal eligibility expansion to adults ages 50 and older, regardless of immigration status ■ Medi-Cal Rx ■ New Medi-Cal covered benefits ■ Telehealth	**06/28/2021** Signed into law	CalOptima: Watch
AB 133 Committee on Budget	**Health:** Would consolidate and enact certain health care trailer bill language to implement the FY 2021–22 state budget. Key initiatives with an impact to CalOptima include: ■ CalAIM proposal ■ Medi-Cal eligibility expansion to adults ages 50 years and older, regardless of immigration status ■ Medi-Cal eligibility extension for postpartum individuals ■ New Medi-Cal covered benefits ■ Proposition 56 supplemental payments ■ Telehealth	**06/27/2021** Referred to Senate Budget and Fiscal Review Committee	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 129 Skinner	**Budget Act of 2021:** Would amend AB 128 to modify appropriations for the government of the State of California for FY 2021–22. Total spending would be adjusted to $262.6 billion, of which $196.4 billion would be from the General Fund. Key initiatives related to health care with an impact to CalOptima include: ■ Behavioral health services for youth ■ CalAIM proposal ■ COVID-19 response ■ Homelessness ■ Medi-Cal eligibility expansion to adults ages 50 and older, regardless of immigration status ■ Medi-Cal Rx ■ New Medi-Cal covered benefits ■ Telehealth	**06/28/2021** Passed Assembly and Senate floors; presented to the Governor	CalOptima: Watch

**The potential CalOptima impacts of budget legislation will be included in a forthcoming detailed analysis.

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)**

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1132 Wood	**CalAIM Proposal:** Would require Medi-Cal MCPs to operate a D-SNP in Coordinated Care Initiative (CCI) counties by January 1, 2023, and in non-CCI counties by January 1, 2025. Would standardize benefits provided by Medi-Cal MCPs statewide, including the carve-out of the Multipurpose Senior Services Program (MSSP) and the carve-in of organ transplants by January 1, 2022, and the carve-in of institutional long-term care services by January 1, 2023. Would require DHCS to implement alternate criteria for medical necessity regarding behavioral health services, as well as mandatory screening and transition of care tools for Medi-Cal behavioral health benefits no sooner than January 1, 2022. Additionally, as of January 1, 2027, the bill would require a county/counties to administer behavioral health benefits under a single Medi-Cal behavioral health delivery system contract. No later than January 1, 2023, would require Medi-Cal MCPs to coordinate with county jails, juvenile facilities and county MHPs to provide continued behavioral health services to former inmates who received the same services while incarcerated.	**06/01/2021** Passed Assembly floor; referred to Senate	CalOptima: Watch
SB 256 Pan	**CalAIM Proposal:** Would authorize DHCS to implement the CalAIM proposal, including the following provisions: ■ Enhanced Care Management ■ In Lieu of Services ■ Incentive payments to Medi-Cal MCPs ■ Mandatory managed care enrollment populations ■ Population Health Management (PHM) Program ■ Regional capitation rates	**06/01/2021** Passed Senate floor; referred to Assembly	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
RN 21 08858 Trailer Bill	**CalAIM Proposal:** Would codify various provisions of the CalAIM Proposal as revised by DHCS on January 8, 2021, as well as authorize additional CalAIM initiatives included in the Governor's May Revise, released on May 14, 2021. Additional initiatives would include: ■ Providing Access and Transforming Health (PATH) Supports ■ Targeted Pre-Release Medi-Cal Benefits for Qualified Inmates ■ Behavioral Health Quality Improvement Program ■ Centralized PHM service ■ Augmented incentive payments to Medi-Cal MCPs	**05/19/2021** Republished on the Department of Finance website	CalOptima: Watch

**The potential CalOptima impacts of CalAIM legislation are included in the CalAIM Legislative Analysis that follows the Legislative Tracking Matrix.

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 56 Biggs	**Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, Children's Health Insurance Program (CHIP) and Medicaid, as a mandatory benefit. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima's lines of business.*	**01/04/2021** Introduced; referred to House Committees on Energy and Commerce, Ways and Means and Armed Services	CalOptima: Watch
H.R. 1118 Dingell	**Medicare Hearing Aid Coverage Act of 2021:** Effective January 1, 2022, would require Medicare Part B coverage of hearing aids and related examinations. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE).*	**02/18/2021** Introduced; referred to House Energy and Commerce Committee and House Ways and Means Committee	CalOptima: Watch
AB 114 Maienschein	**Rapid Whole Genome Sequencing:** Would add rapid Whole Genome Sequencing as a covered Medi-Cal benefit for any beneficiary who is at least one year of age and is receiving inpatient services in an intensive care unit. The benefit would include individual sequencing, trio sequencing for one or more parent and their baby, and ultra-rapid sequencing. ***Potential CalOptima Impact:*** *New Medi-Cal covered benefit.*	**06/16/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **5/27/2021** Passed Assembly floor	CalOptima: Watch
AB 342 Gipson	**Colorectal Cancer Screenings and Colonoscopies:** Effective January 1, 2022, would require health plans to provide no-cost coverage for a colorectal cancer screening recommended by the U.S. Preventive Services Task Force and Medicare. Additionally, when such a test produces a positive result, health plans would be required to provide no-cost coverage for a colonoscopy. Health plans would not be required to comply with these provisions when the service was delivered by an out-of-network provider. ***Potential CalOptima Impact:*** *New Medi-Cal covered benefit.*	**06/30/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **5/27/2021** Passed Assembly floor	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 245 Gonzalez	**Abortion Services:** Would prohibit a health plan from imposing Medi-Cal cost-sharing on all abortion services, including any pre-abortion or follow-up care, no sooner than January 1, 2022. Likewise, a health plan may not require a prior authorization or impose an annual or lifetime limit on such coverage. ***Potential CalOptima Impact:*** *Modified utilization management (UM) procedures for a covered Medi-Cal benefit.*	**06/22/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/01/2021** Passed Senate floor	CalOptima: Watch CAHP: Oppose
SB 306 Pan	**Sexually Transmitted Disease (STD) Home Test Kits:** Would require health plans to provide coverage and reimbursement for at-home STD test kits and any associated laboratory fees. Would also authorize Medi-Cal reimbursement for STD-related services at the same rate as comprehensive family planning services, even when the patient is not at risk of becoming pregnant or in need of contraception ***Potential CalOptima Impact:*** *New Medi-Cal covered benefit.*	**06/22/2021** Passed Assembly Health Committee; referred to Assembly Business and Professions Committee **06/02/2021** Passed Senate floor	CalOptima: Watch CAHP: Oppose
SB 523 Leyva	**Contraceptive Equity Act of 2021:** Effective January 1, 2022, would require health plans to provide coverage of all Food and Drug Administration-approved over-the-counter contraceptive drugs, devices, and products, including vasectomies, without a prescription and regardless of gender. Would also require coverage of related examinations, procedures, and consultations. ***Potential CalOptima Impact:*** *New Medi-Cal covered benefit.*	**06/22/2021** Passed Assembly Labor and Employment Committee; referred to Assembly Health Committee **06/01/2021** Passed Senate floor	CalOptima: Watch CAHP: Oppose
RN 21 13505 Trailer Bill	**Eliminate Suspension of Optional Adult Medi-Cal Benefits:** Would permanently extend certain optional adult Medi-Cal benefits, which are currently set to expire on December 31, 2021. Extended optional benefits include podiatric services, audiology services, speech therapy, optician and optical services, and incontinence creams and washes. ***Potential CalOptima Impact:*** *Continuation of current optional adult Medi-Cal benefits.*	**05/25/2021** Published on the Department of Finance website	CalOptima: Watch

MEDI-CAL ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	**Medi-Cal Eligibility for All Undocumented Adults:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. ***Potential CalOptima Impact:*** *Projected increase of approximately 75,000–80,000 CalOptima Medi-Cal members.*	**06/16/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/01/2021** Passed Assembly floor	CalOptima: Watch CAHP: Support LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 470 Carrillo	**Elimination of Asset Consideration:** Would prohibit the consideration of any assets or property in determining Medi-Cal eligibility under any aid category, subject to federal approval. ***Potential CalOptima Impact:*** *Increased number of CalOptima's Medi-Cal members.*	**06/30/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/27/2021** Passed Assembly floor	CalOptima: Watch LHPC: Support
SB 56 Durazo	**Medi-Cal Eligibility for Undocumented Older Adults 60+:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 60 years or older, regardless of their immigration status. ***Potential CalOptima Impact:*** *Projected increase of approximately 5,000–6,000 CalOptima Medi-Cal members.*	**06/22/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/02/2021** Passed Senate floor	CalOptima: Watch CAHP: Support LHPC: Support
RN 21 13777 Trailer Bill	**Medi-Cal Eligibility Extension for Postpartum Individuals:** Would permanently extend and expand Medi-Cal postpartum eligibility, which is currently set to expire on December 31, 2021, to all pregnant individuals and targeted low-income children. Would allow all Medi-Cal beneficiaries who receive pregnancy-related services and their newborns to remain eligible for Medi-Cal postpartum care for up to 12 months after the last day of pregnancy. ***Potential CalOptima Impact:*** *Increased number of CalOptima's Medi-Cal members.*	**05/19/2021** Published on the Department of Finance website	CalOptima: Watch
RN 21 14089 Trailer Bill	**Medi-Cal Eligibility for Undocumented Older Adults 60+:** No sooner than May 1, 2022, would extend eligibility for full-scope Med-Cal benefits to eligible individuals ages 60 years or older, regardless of their immigration status. ***Potential CalOptima Impact:*** *Projected increase of approximately 5,000–6,000 CalOptima Medi-Cal members.*	**05/24/2021** Published on the Department of Finance website	CalOptima: Watch

MEDI-CAL OPERATIONS AND ADMINISTRATION

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1738 Dingell	**Stabilize Medicaid and CHIP Coverage Act of 2021:** Similar to S. 646, would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary. ***Potential CalOptima Impact:*** *Increased number of CalOptima's Medi-Cal members.*	**03/10/2021** Introduced; referred to House Energy and Commerce Committee	CalOptima: Watch ACAP: Support
S. 646 Brown	**Stabilize Medicaid and CHIP Coverage Act of 2021:** Similar to H.R. 1738, would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary. ***Potential CalOptima Impact:*** *Increased number of CalOptima's Medi-Cal members.*	**03/09/2021** Introduced; referred to Senate Finance Committee	CalOptima: Watch ACAP: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1082 Waldron	**California Health Benefits Review Program (CHBRP) Extension:** Would extend current authorization for the University of California to administer CHBRP, which provides independent analyses of proposed states legislation regarding new health benefits, from July 1, 2022, until July 1, 2027. To fully fund CHBRP, the bill would also increase the total annual fee charged to health plans and insurers from $2 million to $2.2 million, beginning July 1, 2022. ***Potential CalOptima Impact:*** *Increased annual fee assessed to CalOptima; continued availability of CHBRP analyses.*	**06/16/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/27/2021** Passed Assembly floor	CalOptima: Watch CAHP: Support In Concept
SB 250 Pan	**Prior Authorization "Deemed Approved" Status:** Beginning January 1, 2023, would require a health plan to review a provider's prior authorization requests to determine eligibility for "deemed approved" status, which would exempt the provider from prior authorization requirements for any plan benefit for two years. A provider would qualify if their number of denied prior authorizations requests (which were not successfully appealed) are both within a certain range of the average numbers for the same specialty in the same region. ***Potential CalOptima Impact:*** *Implementation of new UM procedures to assess provider appeals rates and exempt certain providers from UM requirements.*	**06/01/2021** Passed Senate floor; referred to Assembly	CalOptima: Watch CAHP: Oppose
SB 371 Caballero	**Health Information Technology and Interconnected Exchanges:** Would require DHCS to apply for federal funding to create a unified data exchange between the state government, health records systems, other data exchange networks and health care providers, including for the Medi-Cal program. Funds would also be used to provide grants and technical support to small provider practices, community health centers, safety net hospitals, social service entities and CBOs to expand the use of health information technology and connect to exchanges. ***Potential CalOptima Impact:*** *Connection of CalOptima's electronic health record system to a health information network (HIN); coordination with contracted providers to connect to the same HIN.*	**05/28/2021** Passed Senate floor; referred to Assembly	CalOptima: Watch
RN 21 13435 Trailer Bill	**Eliminate Suspension of Proposition 56 Supplemental Payments:** Would permanently extend the value-based payment (VBP) programs authorized under Proposition 56, which are currently set to expire on July 1, 2021. For VBP programs aimed at improving behavioral health integration, incentive payments would instead be earned by Medi-Cal MCPs rather than by providers. ***Potential CalOptima Impact:*** *Continuation of VBP programs administered through CalOptima; increase in incentive payments that may be retained by CalOptima.*	**05/14/2021** Published on the Department of Finance website	CalOptima: Watch

OLDER ADULT SERVICES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1868 Yarmuth	**Extension of Medicare Sequestration Moratorium:** Extends the moratorium on automatic, across-the-board 2% spending cuts to Medicare payments. The moratorium, which was set to expire on March 31, 2021, now ends on December 31, 2021. ***CalOptima Impact:*** *Continued federal capitation payments to CalOptima OneCare, OneCare Connect and PACE.*	**04/14/2021** Signed into law	CalOptima: Watch
H.R. 4131 Dingell	**Better Jobs Better Care Act:** Similar to S. 2210, would make permanent the enhanced 10% FMAP for Medicaid home- and community-based services (HCBS) enacted by the American Rescue Plan Act of 2021. Would also provide states with $100 million in planning grants to develop HCBS infrastructure and workforces. Additionally, would make permanent spousal impoverishment protections for those receiving HCBS. ***Potential CalOptima Impact:*** *Continuation of current federal funding rate for HCBS; expansion of HCBS opportunities.*	**06/24/2021** Introduced; referred to House Energy and Commerce Committee	CalOptima: Watch NPA: Support
S. 1162 Casey	**PACE Plus Act:** Would increase the number of PACE programs nationally by making it easier for states to adopt PACE as a model of care and providing grants to organizations to start PACE centers or expand existing PACE centers. Would incentivize states to expand the number of seniors and people with disabilities eligible to receive PACE services beyond those deemed to require a nursing home level of care. Would provide states a 90% FMAP to cover the expanded eligibility. ***Potential CalOptima Impact:*** *Subject to further DHCS authorization, expanded eligibility for CalOptima PACE; additional federal funding to expand the service area of a current PACE center or to establish a new PACE center(s).*	**04/15/2021** Introduced; referred to Senate Finance Committee	CalOptima: Watch NPA: Support
S. 2210 Casey	**Better Jobs Better Care Act:** Similar to H.R. 4131, would make permanent the enhanced 10% FMAP for Medicaid HCBS enacted by the American Rescue Plan Act of 2021. Would also provide states with $100 million in planning grants to develop HCBS infrastructure and workforces. Additionally, would make permanent spousal impoverishment protections for those receiving HCBS. ***Potential CalOptima Impact:*** *Continuation of current federal funding rate for HCBS; expansion of HCBS opportunities.*	**06/24/2021** Introduced; referred to Senate Finance Committee	CalOptima: Watch NPA: Support
AB 523 Nazarian	**Permanent PACE Flexibilities:** Would permanently extend most flexibilities granted to PACE organizations during the COVID-19 public health emergency. This includes flexibilities relating to telehealth services, verbal agreements followed with in-person signatures, Adult Day Health Center home-based services and discharge planning. ***Potential CalOptima Impact:*** *Continuation of most flexibilities adopted by CalOptima PACE during the COVID-19 pandemic.*	**06/23/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/27/2021** Passed Assembly floor	CalOptima: Support CalPACE: Support/ Sponsor

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 540 Petrie-Norris	**Modification of PACE Enrollment Process:** Would seek to increase enrollment into PACE organizations by: ■ Listing PACE as a Medi-Cal/Medicare plan choice in areas where a PACE center is available and there is more than one Medi-Cal MCP ■ Delaying mandatory or passive enrollment into Medi-Cal MCPs by up to 60 days for new Medi-Cal beneficiaries who express interest in being assessed for PACE ■ Requiring DHCS to establish an auto-referral program for those who may be eligible for PACE upon Medi-Cal enrollment based on age, residence and prior use of services ***Potential CalOptima Impact:*** *Increased awareness of PACE.*	**06/02/2021** Passed Assembly floor; referred to Senate	CalOptima: Watch CalPACE: Support/ Sponsor

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
RN 21 12969 Trailer Bill	**Medication Therapy Management (MTM) Reimbursement for Qualified Specialty Drugs:** Would add MTM as a covered Medi-Cal fee-for service (FFS) pharmacist service for beneficiaries who are prescribed certain specialty drugs. MTM services would be designed to address noncompliance in drug therapy and would be subject to different DHCS reimbursement rates in comparison with other pharmacist services. ***Potential CalOptima Impact:*** *Increased care coordination for new Medi-Cal FFS benefit.*	**05/20/2021** Published on the Department of Finance website	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 365 Caballero	**Medi-Cal Provider Electronic Consultation (E-Consult) Service:** Would allow provider-to-provider e-consult services to be reimbursable to all requesting and consulting Medi-Cal providers, including Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) providers. The e-consult may include assessing health records, providing feedback and/or recommending a further course of action. ***Potential CalOptima Impact:*** *Expanded reimbursable service for all Medi-Cal providers and FQHC providers.*	**05/28/2021** Passed Senate floor; referred to Assembly	CalOptima: Watch LHPC: Support

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 316 Eggman	**FQHC Reimbursement for Same-Day Visits:** Would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. This bill would distinguish a medical visit (through the member's primary care provider) and a mental health or dental visit as two separate visits, regardless of whether the visits were at the same location on the same day. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC. ***Potential CalOptima Impact:*** *Timelier access to services at CalOptima's contracted FQHCs.*	**06/22/2021** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/01/2021** Passed Senate floor	CalOptima: Support CAHP: Support LHPC: Support

SOCIAL DETERMINANTS OF HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 379 Barragan	**Improving Social Determinants of Health Act of 2021:** Similar to S. 104, would require the Centers for Disease Control and Prevention (CDC) to establish an SDOH program to coordinate SDOH activities to improve health outcomes and reduce health inequities. CDC would be required to consider SDOH in all relevant grant awards and other activities, as well as issue new grants of up to $50 million to health agencies, nonprofit organizations and/or institutions of higher education to address or study SDOH. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address SDOH.*	**01/21/2021** Introduced; referred to House Energy and Commerce Committee	CalOptima: Watch
S. 104 Smith	**Improving Social Determinants of Health Act of 2021:** Similar to H.R. 379, would require the CDC to establish an SDOH program to coordinate SDOH activities to improve health outcomes and reduce health inequities. CDC would be required to consider SDOH in all relevant grant awards and other activities, as well as issue new grants of up to $50 million to health agencies, nonprofit organizations and/or institutions of higher education to address or study SDOH. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address SDOH.*	**01/28/2021** Introduced; referred to Senate Health, Education, Labor, and Pensions Committee	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 369 Kamlager	**Presumptive Eligibility and Street Medicine for Homeless Individuals:** Would apply presumptive Medi-Cal eligibility — with full-scope benefits and without share of cost — to individuals experiencing homelessness. Would allow any Medi-Cal provider to determine presumptive eligibility and issue a temporary Medi-Cal card to such individuals. Would also allow Medi-Cal providers to receive reimbursement for any covered Medi-Cal benefit delivered to a homeless individual outside of a medical facility, including primary, specialist and laboratory services, without a referral or prior authorization. Finally, would add a field on the Medi-Cal application form to indicate homelessness. ***Potential CalOptima Impact:*** *Increased number of CalOptima's Medi-Cal members; increased access to services for homeless members, but may negatively impact care coordination; increased payments to providers; implementation of modified UM procedures for homeless members.*	**05/27/2021** Passed Assembly floor; referred to Senate	CalOptima: Watch
SB 17 Pan	**Office of Racial Equity:** Would establish the independent Office of Racial Equity and position of Chief Equity Officer to develop a Racial Equity Framework containing guidelines and strategies for advancing racial equity across the state government by January 1, 2023. Each state agency, including DHCS, would be required to implement a Racial Equity Plan by July 1, 2023, in alignment with the goals of the framework, and the office and each agency would prepare annual reports outlining progress toward achieving those goals. ***Potential CalOptima Impact:*** *Increased reporting requirements to DHCS.*	**06/30/2021** Passed Assembly Accountability and Administrative Review Committee; referred to Assembly Appropriations Committee **6/02/2021** Passed Senate floor	CalOptima: Watch

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 366 Thompson (CA)	**Protecting Access to Post-COVID-19 Telehealth Act of 2021:** Would permit the U.S. Secretary of Health and Human Services to waive or modify any telehealth service requirements in the Medicare program during a national disaster or public health emergency and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by an FQHC or RHC, as well as allow patients to receive telehealth services in the home without restrictions. ***Potential CalOptima Impact:*** *Continuation and expansion of certain Medicare telehealth flexibilities allowed during the COVID-19 pandemic.*	**01/19/2021** Introduced; referred to House Energy and Commerce Committee and House Ways and Means Committee	CalOptima: Watch
H.R. 2166 Sewell	**Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021:** Similar to S. 150, would require the Centers for Medicare & Medicaid Services to include audio-only telehealth diagnoses in the determination of risk adjustment payments for Medicare Advantage (MA) and PACE plans during the COVID-19 public health emergency. ***Potential CalOptima Impact:*** *For CalOptima OneCare, OneCare Connect and PACE, members' risk scores and risk adjustment payments would accurately reflect diagnoses.*	**03/23/2021** Introduced; referred to House Energy and Commerce Committee and House Ways and Means Committee	CalOptima: Watch ACAP: Support NPA: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
S. 150 Cortez Masto	**Ensuring Parity in MA for Audio-Only Telehealth Act of 2021:** Similar to H.R. 2166, would require the Centers for Medicare & Medicaid Services to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA plans during the COVID-19 public health emergency. ***Potential CalOptima Impact:*** *For CalOptima OneCare and OneCare Connect, members' risk scores and risk adjustment payments would accurately reflect diagnoses.*	**02/02/2021** Introduced; referred to Senate Finance Committee	CalOptima: Watch ACAP: Support NPA: Support
AB 32 Aguiar-Curry	**Telehealth Payment Parity and Flexibilities:** Would expand current law to require Medi-Cal MCPs, including County Organized Health Systems, to reimburse their contracted providers for telehealth services at the same rate as equivalent in-person health services. This requirement would also apply to any delegated entities of a Medi-Cal MCP, such as contracted health networks. Likewise, clinics must be reimbursed by Medi-Cal for telehealth services at the same rate as in-person services. Would also allow providers to determine eligibility and enroll patients into Medi-Cal programs through audio-visual or audio-only telehealth services. Additionally, would require DHCS to indefinitely continue all telehealth flexibilities implemented during the COVID-19 pandemic. ***Potential CalOptima Impact:*** *Extension of all Medi-Cal telehealth flexibilities allowed during the COVID-19 pandemic.*	**06/01/2021** Passed Assembly floor; referred to Senate	CalOptima: Watch
RN 21 08267 Trailer Bill	**Medi-Cal Telehealth Proposal:** Would require DHCS to specify Medi-Cal-covered benefits that may be delivered through telehealth services. DHCS and Medi-Cal MCPs would be required to reimburse audio-visual telehealth services at the same rate as in-person services, while audio-only, remote patient monitoring and other modalities may be reimbursed at different rates. Audio-only telehealth would be reimbursed by DHCS at 65% of the in-person service rate. However, a provider may not establish a new Medi-Cal patient relationship using audio-only telehealth. Would allow FQHCs and RHCs to establish a patient within its service area through audio-visual telehealth. Audio-only telehealth delivered at an FQHC or RHC would be reimbursed by DHCS at a separate rate from its per-visit PPS rate. Additionally, would allow Medi-Cal MCPs to include telehealth services when determining compliance with network adequacy standards without the use of alternative access standard requests. ***Potential CalOptima Impact:*** *Extension of certain Medi-Cal telehealth flexibilities allowed during the COVID-19 pandemic; restricted scope of telehealth services; modified reimbursement rates for audio-only telehealth services.*	**05/18/2021** Republished on the Department of Finance website	CalOptima: Watch

YOUTH SERVICES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 66 Buchanan	**CARING for Kids Act:** Would permanently extend authorization and funding of CHIP and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs. ***Potential CalOptima Impact:*** *Continuation of current federal funding and eligibility requirements for CalOptima's Medi-Cal members eligible under CHIP.*	**01/04/2021** Introduced; referred to House Energy and Commerce Committee	CalOptima: Watch
S. 453 Casey	**Children's Health Insurance Program Pandemic Enhancement and Relief (CHIPPER) Act:** Would retroactively extend CHIP's temporary 11.5% FMAP increase, enacted by the HEALTHY KIDS Act (2018), from September 30, 2020, until September 30, 2022, to meet increased health care needs during the COVID-19 public health emergency. ***Potential CalOptima Impact:*** *Increased federal funds for CalOptima's Medi-Cal members eligible under CHIP.*	**02/25/2021** Introduced; referred to Senate Finance Committee	CalOptima: Watch
SB 428 Hurtado	**Adverse Childhood Experiences (ACEs) Screenings Coverage:** Would require a health plan to provide coverage for ACEs screenings. ***Potential CalOptima Impact:*** *Continuation or expansion of a current Medi-Cal covered benefit.*	**06/01/2021** Passed Senate floor; referred to Assembly	CalOptima: Watch
SB 682 Rubio	**Childhood Chronic Health Conditions:** Would require the California Health and Human Services Agency, the Governor's office and other departments to develop and implement a plan that reduces racial disparities in children with chronic health conditions by 50% by 2030. Chronic conditions may include asthma, diabetes, depression and vaping-related diseases. ***Potential CalOptima Impact:*** *Increased reporting requirements to DHCS.*	**06/02/2021** Passed Senate floor; referred to Assembly	CalOptima: Watch

Two-Year Bills

The following bills did not meet the deadline to be passed out of their originating house. These are now considered two-year bills and are eligible for reconsideration in 2022:

- AB 58 (Salas)
- AB 71 (Rivas, Luz)
- AB 112 (Holden)
- AB 393 (Reyes)
- AB 454 (Rodriguez)
- AB 552 (Quirk-Silva)
- AB 671 (Wood)
- AB 685 (Maienschein)
- AB 797 (Wicks)
- AB 822 (Rodriguez)
- AB 862 (Chen)
- AB 875 (Wood)
- AB 882 (Gray)
- AB 935 (Maienschein)
- AB 942 (Wood)
- AB 1050 (Gray)
- AB 1083 (Nazarian)
- AB 1107 (Boerner Horvath)
- AB 1117 (Wicks)
- AB 1131 (Wood)
- AB 1160 (Rubio)
- AB 1162 (Villapadua)
- AB 1254 (Gipson)
- AB 1372 (Muratsuchi)
- AB 1400 (Kalra, Lee, Santiago)
- SB 279 (Pan)
- SB 508 (Stern)

*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: July 2, 2021

2021 Federal Legislative Dates

January 3	117th Congress, First Session convenes
March 29–April 9	Spring recess
August 2–27	Summer recess for House
August 9–September 10	Summer recess for Senate
December 10	First Session adjourns

2021 State Legislative Dates*

**Due to COVID-19, 2021 State Legislative dates have been modified*

January 11	Legislature reconvenes
February 19	Last day for legislation to be introduced
March 25–April 4	Spring recess
April 30	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in their house
May 7	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in their house
May 21	Last day for fiscal committees to hear and report to the floor any bills introduced in their house
June 1–4	Floor session only
June 4	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 to fiscal committees or the floor
July 16–August 15	Summer recess
August 27	Last day for fiscal committees to report bills to the floor
August 30–September 10	Floor session only
September 3	Last day to amend bills on the floor
September 10	Last day for bills to be passed; final recess begins upon adjournment
October 10	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2021 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

CalOptima 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 provide members with access to quality health care services delivered in a cost-effective and compassionate manner. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan) and the Program of All-Inclusive Care for the Elderly (PACE).

California Advancing and Innovating Medi-Cal (CalAIM) Legislative Analysis

Table of Contents

Overview

CalAIM

- Population Health Management
- Enhanced Care Management
- In Lieu of Services
- Shared Risk, Shared Savings and Incentive Payments
- Full Integration Plans
- Long-Term Plan for Foster Care
- Managed Care Benefit Standardization
- Mandatory Managed Care Enrollment
- Transition to Statewide Long-Term Services and Supports, Long-Term Care, and Dual Eligible Special Needs Plans
- NCQA Accreditation of Medi-Cal Managed Care Plans
- Regional Managed Care Capitation Rates
- Behavioral Health: Medical Necessity Criteria
- Enhancing County Oversight and Monitoring: California Children's Services and Child Health Disability Prevention

Next Steps

Overview

The ambitious proposal, known as California Advancing and Innovating Medi-Cal (CalAIM), was suspended in early 2020 due to the COVID-19 pandemic. Recognizing the need to further efforts of coordinated care for Medi-Cal beneficiaries, on January 8, 2021, Governor Newsom announced CalAIM's return with a proposed budget of $1.1 billion ($531.9 million General Fund) in FY 2021–22, growing to $1.5 billion ($755.5 million GF) in FY 2023–24. The revised CalAIM proposal, effective no sooner than January 1, 2022, focuses on transforming the Medi-Cal program, targeting those with complex health needs, addressing high health care costs and implementing payment reform. This memo includes a high-level overview of segments within the CalAIM proposal that may have a direct impact on CalOptima.

CalAIM

Population Health Management

The Population Health Management (PHM) program seeks to improve overall health outcomes and efficiency of care management by assessing individual member health risks and by creating wellness, prevention, case management and care transition programs. All Medi-Cal managed care plans (MCPs) shall develop and maintain a whole system, person-centered PHM program, where the plan will partner with contracted health care providers and community-based partners to identify and address members' health and health-related social needs. Within the PHM program, the following CalAIM elements will help magnify the anticipated positive impact the program has on member outcomes:

- National Committee for Quality Assurance (NCQA) Accreditation
- Enhanced Care Management
- In Lieu of Services
- Shared Risk Savings and Incentive Payments[2]

Timeline: Effective no sooner than January 1, 2023.

Enhanced Care Management

The Department of Health Care Services (DHCS) proposed the implementation of a single, comprehensive Enhanced Care Management (ECM) benefit within Medi-Cal managed care. The ECM proposal replaces the current Health Homes Program (HHP) and Whole Person Care (WPC) pilot program by merging them into one comprehensive program. The overarching goals of ECM are:

- Improving care coordination
- Integrating services
- Facilitating community resources
- Improving health outcomes
- Addressing social determinants of health
- Decreasing inappropriate utilization

Additionally, the ECM proposal suggests the following populations be eligible to receive ECM services:

- Children or youth with complex physical, behavioral, developmental and/or oral health needs
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays or emergency room visits
- Individuals at risk for institutionalization who are eligible for long-term care services
- Nursing facility residents who want to transition to the community
- Individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community[3]

Timeline: Medi-Cal MCPs currently operating an HHP *or* operating in a county with a WPC pilot are required to submit a transition and coordination plan to DHCS by July 1, 2021. Those Medi-Cal MCPs will then be required to implement ECM on January 1, 2022. Draft contract provisions will be shared with plans in February 2021.

In Lieu of Services

CalAIM also builds upon WPC and HHP programs through In Lieu of Services (ILOS). According to federal Medicaid programs rules, ILOS are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. If approved, ILOS will operate in conjunction with PHM and ECM in order to focus on addressing combined medical and social determinants of health needs to avoid higher levels of care. Furthermore, DHCS proposed to include 14 distinct services as ILOS under Medi-Cal managed care:

In Lieu of Services Options

- Housing transition/navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Short-term post-hospitalization housing
- Recuperative care
- Respite services
- Day habilitation programs
- Nursing facility transition/diversion to assisted living facilities
- Community transition services/nursing facility transition to a home
- Personal care and homemaker services
- Environmental accessibility adaptations
- Meals/medically tailored meals
- Sobering centers
- Asthma remediation

Each service will have defined eligible populations, code sets, potential providers, restrictions and limitations. Additionally, the provision of ILOS is voluntary for Medi-Cal MCPs, and beneficiaries have to option to accept or decline ILOS. Of note, CalOptima staff are collaborating with community stakeholders to gather data and provide recommendations on which ILOS options CalOptima should provide.

Timeline: Medi-Cal MCPs currently operating an HHP and WPC pilot program are required to submit a transition and coordination plan to DHCS by July 1, 2021. Those Medi-Cal MCPs will then be required to implement ILOS on January 1, 2022.[4]

Shared Risk, Shared Savings and Incentive Payments

The proposal to combine PHM, ECM and ILOS, in addition to Long-Term Care, provides an opportunity to encourage MCPs and providers to be fully engaged in these CalAIM proposals. Therefore, DHCS proposed to create a series of incentives through a multipronged risk strategy. Potential incentives include:

- A blended capitation rate to account for the addition of seniors and persons with disabilities and long-term care beneficiaries into managed care
- A time-limited, tiered and retrospective shared savings/risk financial calculation performed by DHCS
- A prospective payment model of shared risk or shared savings incorporated via capitation rate development[5]

Timeline: DHCS will engage and collaborate with Medi-Cal MCPs and make future refinements as determined appropriate.

- January–December 2021: Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input.
- January 1, 2022: Begin implementation of managed care plan incentives.
- No sooner than January 1, 2023: Begin implementation of a seniors and persons with disabilities/long-term care blended rate.

Full Integration Plans

Currently, Medi-Cal beneficiaries are required to navigate several managed care and fee-for-service Medi-Cal systems to receive comprehensive care. DHCS proposed the full integration of physical health, behavioral health and oral health under one contracted entity: DHCS. This requires multiple Medi-Cal delivery systems, including Medi-Cal managed care, county mental health plans, county Drug Medi-Cal and Drug Medi-Cal Organized Delivery System programs, to be consolidated under one contract with DHCS.[6]

Timeline: No sooner than January 2027.

Long-Term Plan for Foster Care

DHCS is exploring the option of a single, statewide managed care plan for foster youth. Under the Medi-Cal program, beneficiaries receive services through various delivery systems, including Medi-Cal managed care, fee-for-service, California Children's Services, regional centers, county mental health plans and Drug Medi-Cal programs. However, many challenges remain in navigating Medi-Cal delivery systems, especially if there are multiple placements that may result in the child moving from one county to another or between homes in a single county. In June 2020, DHCS reconvened a stakeholder workgroup to consider this proposal.[7]

Timeline: Pending stakeholder engagement and feedback and state budget recommendations.

Managed Care Benefit Standardization

Under CalAIM, DHCS proposed to standardize benefits that are provided through Medi-Cal MCPs statewide, regardless of the beneficiary's county of residence or the plan they are enrolled in. This supports CalAIM's goal for a regional standardized set of benefits delivered by MCPs, no matter which county the beneficiary resides in. Therefore, CalAIM proposed four changes to the Medi-Cal program, including the highly anticipated pharmacy carve-out, by carving in and carving out specific covered benefits.

Carved-Out Benefits: Managed by DHCS

Program	Timeline
Pharmacy benefits	No sooner than April 1, 2021
Multipurpose Senior Services Program (MSSP)	January 1, 2022

Carved-In Benefits: Managed by the MCP

Program	Timeline
Major organ transplants	January 1, 2022
Long-term care (LTC) services*	January 1, 2023

*LTC services are already managed by CalOptima and propose no major operational changes.

Of note, the managed care benefit standardization proposal paves a path for the state to propose regional rate setting.[8]

Timeline: By January 1, 2023.

Mandatory Managed Care Enrollment

Medi-Cal beneficiaries currently receive coverage either through fee-for-service or managed care. To increase enrollment into managed care, DHCS proposed to standardize which aid code groups require mandatory managed care enrollment versus fee-for-service, statewide. This would require Medi-Cal beneficiaries to choose a Medi-Cal MCP, and they would no longer be permitted to remain in fee-for-service. Mandatory enrollment from fee-for-service into an MCP affects populations such as individuals participating in accelerated enrollment, pregnancy-related Medi-Cal and American Indians, to name a few.[9]

Timeline: DHCS proposed a two-phase implementation timeline, transitioning non-dual eligible populations on January 1, 2022, and dual eligible populations on January 1, 2023.

Transition to Statewide Long-Term Services and Supports, Long-Term Care, and Dual Eligible Special Needs Plans

Returning to the CalAIM proposal is the transition of Cal MediConnect (CMC) and the Coordinated Care Initiative (CCI) to a statewide Managed Long-Term Services and Supports (MLTSS) and Dual Eligible Special Needs Plan (D-SNP) structure. This CalAIM proposal leverages best practices from the seven counties that implemented CMC and CCI, including Orange County, to develop policies and to promote integrated care thorough D-SNPs and MLTSS across the state. Of note, when CalOptima joined the CMC and CCI programs, CalOptima's D-SNP, OneCare, continued as one of CalOptima's lines of

business. Therefore, CalOptima will not have to reinstate the program.[10]

Timeline: All existing D-SNPs had to meet new regulatory integration standards by January 1, 2021, to support the following timeline scheduled to take place over the next six years:

Implementation Date	Operational Changes
January 1, 2022	• Voluntary ILOS in all MCPs and CMC plans • MSSP carved out of MCPs in CCI counties
December 31, 2022	• Discontinue CMC and CCI
January 1, 2023	• Statewide mandatory enrollment of full- and partial-benefit dual eligible beneficiaries into MCPs for Medi-Cal benefits, including dual and non-dual eligible LTC residents • Statewide integration of LTC • Aligned enrollment begins in CCI counties • All CMC members cross-walked to matching D-SNPs and MCPs
January 1, 2025	• Aligned enrollment begins in CCI counties • All MCPs required to operate D-SNPs
January 1, 2027	• Implement MLTSS statewide in Medi-Cal managed care

NCQA Accreditation of Medi-Cal Managed Care Plans

The NCQA is a private, nonprofit organization that offers accreditation to health plans and other health care-related entities in the areas of quality improvement, PHM, network management, utilization management, credentialing and recredentialing, and member experience. To streamline MCP oversight and to increase standardization across plans, DHCS recommended requiring all Medi-Cal MCPs and their subcontractors to be NCQA accredited. Of note, at this time, DHCS is not requiring that MCPs ensure any non-health plan subcontractors to whom certain contractual elements are delegated are NCQA accredited for that specific function.[11]

Timeline: January 1, 2026

Regional Managed Care Capitation Rates

Currently, DHCS develops managed care capitation rates for each contracted MCP based on county, region and population. To reduce the number of distinct rating components DHCS develops on an annual basis, and as a way to incentivize MCPs to operate efficiently, DHCS proposed a regional rate setting methodology.[12]

Timeline: No sooner than January 1, 2026, to fully implement regional rates statewide.

Behavioral Health: Medical Necessity Criteria

CalAIM seeks to improve access to medically necessary behavioral health (BH) services by ensuring the beneficiary receives the right care in the right place and at the right time. DHCS proposed the following actions to address beneficiaries' needs across the continuum of care:

- Update and clarify the medical necessity criteria for specialty mental health services for both adults and children
- Clarify the Early and Periodic Screenings, Diagnosis and Treatment (EPSDT) protections for beneficiaries under the age of 21, and create criteria for children to access specialty mental health services
- Develop a standardized screening tool to facilitate accurate determinations of when care would be better delivered in the specialty mental health delivery system or in the Medi-Cal managed care/fee-for-service system
- Implement a "no wrong door" policy
- Simplify and streamline mental health documentation requirements
- Update the criteria for psychiatric inpatient and medical necessity currently provided in Title 9 of the California Code of Regulations
- Modify the current Section 1115 waiver to allow Substance Use Disorder treatment services to be provided and be reimbursed prior to the determination of a diagnosis
- Update overall medical necessity criteria and processes.[13]

Of note, BH care and services shall be coordinated between the specialty mental health plan and the Medi-Cal MCP, and services shall not be duplicated.

Timeline: January 1, 2022, with the approval of the Section 1115 and 1915(b) waivers.

Enhancing County Oversight and Monitoring: California Children's Services and Child Health Disability Prevention

As of July 1, 2019, CalOptima members' needs related to California Children's Services (CCS) became a part of CalOptima's Medi-Cal plan. Within the CalAIM proposal, DHCS intends to provide enhanced monitoring and oversight of all 58 counties and three cities (Berkeley, Pasadena and Long Beach) to ensure continuous optimal care for children.[14]

Timeline: The proposal includes a phased timeline approach.

Phase: Date	Action
Phase I: August 2020–June 2021	• Review of current standards, policies and guidelines • Development of goals, performance measures and metrics • Revision of current Plan and Fiscal Guidelines guidance document • Continuation of the establishment of an electronic submission portal for the annual county/city budgets
Phase II: July–September 2021	• Development of auditing tools
Phase III: October 2021–September 2022	• Shift to an electronic automated submission by the counties/cities • Develop training documents • Evaluate and analyze findings and trends • Identify gaps and vulnerabilities
Phase IV: October 2022–Ongoing	• Initiate Memorandum of Understanding between state and counties • Continuous monitoring and oversight • Continuous updates to standards, policies and guidelines

Next Steps

Although the CalAIM proposal is included in the governor's proposed budget, this is only the first step in the state's legislative process. Many of the proposals within CalAIM will require additional stakeholder engagement, legislation and trailer bill language over several years in order to implement. CalOptima will continue to closely follow these ongoing CalAIM discussions and provide updates regarding any issues that support the advancement of CalOptima's legislative priorities. Additionally, CalOptima will work collaboratively with our provider, member, county and community stakeholders to better understand the impact of the proposed CalAIM initiatives as we move forward with implementation.

About CalOptima

CalOptima, a county organized health system (COHS), is the single plan providing guaranteed access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions regarding the above information, please contact:

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Endnotes

[1] 2021-22 Governor's Budget Summary, January 8, 2021, Pg. 105
[2] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 43
[3] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 45
[4] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 54
[5] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 57
[6] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 61
[7] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 62
[8] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 65
[9] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 67
[10] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 70-73
[11] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 74
[12] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 76
[13] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 82
[14] Department of Health Care Services: California Advancing & Innovating Medi-Cal (CalAIM) Proposal, Pg. 105

Board of Directors Meeting
August 5, 2021

CalOptima Community Outreach Summary — July and August 2021

Background
CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. CalOptima accomplishes this by participating in community coalitions, collaborative meetings and advisory groups, supporting our community partners' public activities and sharing information with current and potential members.

CalOptima's participation in public activities supports:

- Member interaction/enrollment in a CalOptima program
- Branding that promotes community awareness of CalOptima
- Partnerships that increase positive visibility and relationships with community organizations

CalOptima is reviewing recent updates to local, state, and federal guidelines to prevent the spread of COVID-19. In the interim, CalOptima continues to participate in public activities via virtual meetings and events, providing CalOptima Medi-Cal educational materials and, if criteria are met, providing financial support and/or CalOptima-branded items.

CalOptima Highlights
CalOptima collaborated with the Orange County Health Care Agency (HCA) to host vaccine events at CalOptima's main office on May 15 and 22, June 5, 12 and 19, and July 10. In addition to offering vaccinations for up to 1,200 people per day, the events also featured a resource fair with health screenings and information about supportive services. CalOptima members were invited via a personal text, and an event flier was emailed to more than 1,200 community partners. Members and the community could call the OC COVID-19 Hotline at 714-834-2000 or visit www.othena.com to register, or walk-in. Transportation was also available to CalOptima members who expressed the need.

CalOptima eligible members also received the COVID-19 Vaccine Member Health Rewards $25 gift card, on-site, after their vaccination(s). During the events, the County of Orange Social Services Agency was available to assist with CalFresh, and Medi-Cal applications. 2-1-1 OC was also available to provide information for food, housing, rental assistance, financial assistance and more. On May 15 and 22, the Community Action Partnership of Orange County distributed free diapers and small food items such as raisin boxes, juice boxes, fruit and more.

To serve individuals with special needs, CalOptima collaborated with the State Council on Developmental Disabilities, the Center for Autism & Neurodevelopmental Disorders, Regional Center of Orange County and the Dayle McIntosh Center to promote the June 19 and July 10 events. When families arrived at the event, they could use the Americans With Disabilities Act (ADA) lane to receive the vaccine in their cars. **As of June 21, 4,578 vaccines were administered with 1,993 vaccines administered to CalOptima members**. For additional information or questions, please contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities
As of June 21, 2021, CalOptima planned to participate in, organize or convene 48 public activities in July and August. For July, these include 29 public activities: 23 virtual community/collaborative meetings; 2 virtual community events; 1 in-person event with financial support but no staff participation; 1 CalOptima COVID-19 vaccine clinic; 1 community-based organization presentation; and 1 CalOptima Health Network Forum.

For August, these include 19 public activities: 17 virtual community/collaborative meetings; 1 Cafecito; and 1 CalOptima Health Network Forum.

Below are more details about CalOptima's expected participation in these community and CalOptima-hosted events:

July 2021

* CalOptima Hosted
† Exhibitor/Attendee

Updated 2021-06-21

Back to Agenda

Date/Time	Event Title/Location	Expected Staff/Volunteer/Financial Participation	Event Type/Audience
7/01 11 a.m.–1:30 p.m.	**Service Provider Resource Fair hosted by Regional Center of Orange County†** Virtual	1 staff member attended and presented	• Health/resource fair • Open to the public
7/07 11:30 a.m.–12:30 p.m.	**Vendor Fair hosted by UCI Health Center†** Virtual	1 staff member attended and presented	• Health/resource fair • Open to the staff
7/10 9 a.m.–5 p.m.	**CalOptima Community Vaccine Clinic hosted in partnership with Orange County Health Care Agency*** CalOptima 505 City Parkway West Orange, CA	40+ staff members worked at the event	• Health/resource fair • Open to the public
7/15 9 a.m. –11 a.m.	**Health Network Forum*** Virtual	10+ staff members attended	• Forum • Open to health and human services providers
7/24 11 a.m.–1 p.m.	**Back to School Fest hosted by Advance OC†** 4 locations: Station/Garden Grove, Santa Ana, Fullerton/Anaheim, and San Juan Capistrano	0 staff members attended Sponsorship fee: $1,000 included: recognition of CalOptima in event flyers and organization's website; and event organizer distributed CalOptima's tote bags with educational materials and branded items	• Health/resource fair • Open to the public
7/27 9 a.m. –10:30 a.m.	**CalOptima Medi-Cal Presentation for Clinic in the Park Collaborative** Virtual	1 staff member presented	• Community-based organization presentation • Open to collaborative members
August 2021			
8/19 9 a.m. –11 a.m.	**Health Network Forum*** Virtual	10+ staff members attended	• Forum • Open to health and human services providers
8/25 9 a.m. –10:30 a.m.	**Cafecito Meeting*** Virtual	3+ staff members attended	• Steering committee meeting • Open to collaborative members

CalOptima's participation in community meetings throughout Orange County can be found at: https://www.caloptima.org/en/About/CommunityRelations/UpcomingEventsAndMeetings.aspx.

These sponsorship request(s) and community event(s) meet the requirements of CalOptima Policy AA.1223: Participation in Community Events Involving External Entities. More information about our policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

Endorsements
CalOptima provided one endorsement since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). The Endorsement(s) align with the requirements of CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo. More information about our policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Use of CalOptima's name or logo for UC Irvine Health Center's online Orange County Nursing Home Infection COVID-19 Prevention toolkit.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Adoption of Resolution Approving and Adopting Updated CalOptima Policy GA.8058: Salary Schedule, Appropriation of Funds and Authorization of Unbudgeted Expenditures

Contacts

Richard Sanchez, Chief Operating Officer, (657) 900-1481
Brigette Hoey, Executive Director, Human Resources, (714) 246-8405

Recommended Actions

1. Adopt Resolution Approving Updated CalOptima Policy GA.8058: Salary Schedule and Attachment A; and
2. Appropriate funds and authorize unbudgeted expenditures of up to $488,000 from existing reserves to fund the proposed new Chief of Staff position and pay grade change for the Director of Behavioral Health position through June 30, 2022

Background/Discussion

On November 1, 1994, the Board of Directors delegated authority to the Chief Executive Officer to promulgate employee policies and procedures, and to amend these policies from time to time, subject to annual presentation of the policies and procedures, with specific emphasis on any changes thereto, to the Board or to a committee appointed for that purpose. On December 6, 1994, the Board adopted CalOptima's Bylaws, which requires, pursuant to section 13.1, 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.

Pursuant to the California Code of Regulations, Title 2, Section 570.5, CalOptima is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees' Retirement System (CalPERS) to reflect recent changes, including the addition or deletion of positions and revisions to wage grades for certain positions.

The following table lists the existing CalOptima policy that has been updated and is being presented for review and approval.

Back to Agenda

Policy No./Name	Summary of Changes	Reason for Change	Impact
GA.8058: Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment A – Salary Schedule has been revised to reflect the addition of three new position titles, the modification of five job titles and two pay grade adjustments based on review of current market data and internal evaluation of job responsibilities for two department director positions. A summary of the changes to the Salary Schedule Attachment A is included for reference.	- Pursuant to CalPERS requirement, 2 CCR §570.5 CalOptima periodically updates the salary schedule to reflect current job titles and pay rates for each job position. New Position: Creation of a new job title or a revised job title may be due to a regulatory requirement, a change in the scope of a current position or the addition of a new level in a job family.	Meets CalPERS requirements, 2 CCR §570.5 The addition of three (3) new titles will allow staff to recruit for the Chief of Staff position in this fiscal year, and the Director of Community Relations and the Graphic Designer Sr. in next fiscal year. The pay grade changes will align the two (2) job titles to the current market data and internal evaluation of job responsibilities and enhance recruitment efforts when filling vacancies. The revisions to five (5) job titles will better align the job titles with the job duties.

Proposed revisions to Attachment A of CalOptima Policy GA.8058: Salary Schedule include:

- The addition of three (3) new job titles:
  - Chief of Staff
  - Director Community Relations
  - Graphic Designer Sr.
- Pay grade changes for two (2) job titles:
  - Director Behavioral Health Services
  - Director Population Health Management; and
- Five (5) job title changes.

Staff is requesting that the Board appropriate the funds and authorize unbudgeted expenditures to fill the Chief of Staff position as well as fund the pay grade changes for the Director Behavioral Health Services position. Funding for the new Director Community Relations, and Graphic Designer Sr. positions and the pay grade changes for the Director, Population Health Management positions is not requested at this time.

Back to Agenda

The Chief of Staff position is intended to provide support to the Chief Executive Officer in the research, development, and implementation of Board-driven objectives. This new position was not included in the Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021, and has an annual fiscal impact of $382,000.

The Director Community Relations job title was removed from the Salary Schedule in March 2021. Given the initiatives currently underway that require extensive community engagement, such as CalAIM, there will be a need for this leadership position to drive the community engagement strategy and implementation. The job title is being returned to allow staff to fill the position in a future fiscal year.

The Graphic Designer Sr. job title is intended to allow job progression in the Graphic Designer job class series. This position was not included in the FY 2021-22 Operating Budget approved by the Board on June 3, 2021 and is not intended to be filled in this FY.

Currently, there are two (2) Director Behavioral Health Services positions vacant. Both positions were budgeted items in the FY 2021-22 Operating Budget and intended to be filled through the current recruitment.

The Director Population Health Management position is currently filled and budgeted in the FY 2021-22 Operating Budget.

Staff is requesting funding in an amount up to $106,000 to account for the increase in pay grades through June 30, 2022.

Fiscal Impact

Funding for the new position Chief of Staff, and the pay grade changes for the two (2) vacant Director Behavioral Health Services positions is unbudgeted. An appropriation of the funds and authorization of expenditures of up to $488,000 from existing reserves will fund this proposed action through June 30, 2022.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 21-0805-01, Approve Updated Human Resources Policy
2. Revised CalOptima Policy: GA.8058: Salary Schedule (redlined and clean copies) with revised Attachment A
3. Summary of Changes to Salary Schedule

/s/ Richard Sanchez *07/28/2021*
Authorized Signature **Date**

Back to Agenda

RESOLUTION NO. 21-0805-01

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

APPROVE UPDATED CALOPTIMA POLICY GA 8058: SALARY SCHEDULE

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

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

WHEREAS, California Code of Regulations, Title 2, Section 570.5, requires CalOptima to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima regularly reviews CalOptima's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated CalOptima Policy:

a. GA.8058: Salary Schedule with Attachment to be Implemented August 5, 2021

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this August 5, 2021.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

Back to Agenda

Back to Item

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	08/05/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20210805 BOD Review Only

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

Back to Agenda

Back to Item

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of ~~03/04~~08/05/2021)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors

For 2021 0805 BOD Review Only

Date	Meeting
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
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11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	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	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
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Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
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For 20210805 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative

For 20210805 BOD Review Only

GLOSSARY

Not Applicable

For 20210805 BOD Review Only

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	08/05/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20210805 BOD Review Only

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

Back to Agenda

Back to Item

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of 08/05/2021)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
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08/07/2014	Regular Meeting of the CalOptima Board of Directors
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For 20210805 BOD Review Only

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For 20210805 BOD Review Only

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Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative

1

For 20210805 BOD Review Only

GLOSSARY

Not Applicable

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised ~~March 04, 2021~~ August 05, 2021

To be Implemented ~~March 14, 2021~~ August 05, 2021

Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$68,000	$77,000
	Accountant Int	I	634	$61,000	$73,000	$85,000
	Accountant Sr	K	68	$70,000	$84,000	$98,000
	Accounting Clerk	D	334	$44,000	$51,000	$58,000
	Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000
	Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000
	Actuarial Analyst	I	558	$61,000	$73,000	$85,000
	Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000
	Actuary	O	357	$105,000	$127,000	$149,000
	Administrative Assistant	D	19	$44,000	$51,000	$58,000
	Analyst	H	562	$59,000	$68,000	$77,000
	Analyst Int	I	563	$61,000	$73,000	$85,000
	Analyst Sr	J	564	$65,000	$78,000	$91,000
	Applications Analyst	I	232	$61,000	$73,000	$85,000
	Applications Analyst Int	J	233	$65,000	$78,000	$91,000
	Applications Analyst Sr	L	298	$77,000	$93,000	$109,000
	Associate Director	P	682	$117,000	$141,000	$165,000
	Associate Director Customer Service	P	593	$117,000	$141,000	$165,000
	Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000
	Associate Director Information Services	Q	557	$130,000	$157,000	$184,000
	Auditor	I	565	$61,000	$73,000	$85,000
	Auditor Sr	J	566	$65,000	$78,000	$91,000
	Behavioral Health Manager	M	383	$85,000	$103,000	$121,000
	Biostatistics Manager	M	418	$85,000	$103,000	$121,000
	Board Services Specialist	E	435	$48,000	$55,000	$62,000
	Business Analyst	J	40	$65,000	$78,000	$91,000
	Business Analyst Sr	L	611	$77,000	$93,000	$109,000
	Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000
	Buyer	G	29	$55,000	$63,000	$71,000
	Buyer Int	H	49	$59,000	$68,000	$77,000
	Buyer Sr	I	67	$61,000	$73,000	$85,000
	Care Manager	K	657	$70,000	$84,000	$98,000
	Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000
	Certified Coder	H	399	$59,000	$68,000	$77,000
	Certified Coding Specialist	H	639	$59,000	$68,000	$77,000
	Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000
	Change Control Administrator	I	499	$61,000	$73,000	$85,000
	Change Control Administrator Int	J	500	$65,000	$78,000	$91,000
**	Chief Counsel	X	132	$289,000	$361,000	$433,000
**	Chief Executive Officer	Z	138	$400,000	$500,000	$600,000
**	Chief Financial Officer	X	134	$289,000	$361,000	$433,000
**	Chief Information Officer	W	131	$246,000	$307,000	$368,000
**	Chief of Staff	U	TBD	$209,000	$261,000	$313,000
**	Chief Medical Officer	X	137	$289,000	$361,000	$433,000
**	Chief Operating Officer	X	136	$289,000	$361,000	$433,000
	Claims - Lead	G	574	$55,000	$63,000	$71,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised ~~March 04, 2021~~ August 05, 2021

To be Implemented ~~March 14, 2021~~ August 05, 2021

Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Claims Examiner	C	9	$41,000	$47,000	$53,000
	Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000
	Claims Examiner Sr	E	20	$48,000	$55,000	$62,000
	Claims QA Analyst	E	28	$48,000	$55,000	$62,000
	Claims QA Analyst Sr.	F	540	$51,000	$59,000	$67,000
	Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000
	Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000
	Clerk of the Board	O	59	$105,000	$127,000	$149,000
	Clinical Auditor	L	567	$77,000	$93,000	$109,000
	Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000
	Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000
	Clinical Pharmacist	P	297	$117,000	$141,000	$165,000
	Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000
	Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000
	Communications Specialist	G	188	$55,000	$63,000	$71,000
	Community Partner	G	575	$55,000	$63,000	$71,000
	Community Partner Sr	H	612	$59,000	$68,000	$77,000
	Community Relations Specialist	G	288	$55,000	$63,000	$71,000
	Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000
	Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000
	Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000
	Contract Administrator	K	385	$70,000	$84,000	$98,000
	Contracts Manager	M	207	$85,000	$103,000	$121,000
	Contracts Manager Sr	N	683	$95,000	$114,000	$133,000
	Contracts Specialist	I	257	$61,000	$73,000	$85,000
	Contracts Specialist Int	J	469	$65,000	$78,000	$91,000
	Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000
*	Controller	T	464	$182,000	$227,000	$272,000
	Credentialing Coordinator	E	41	$48,000	$55,000	$62,000
	Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000
	Customer Service Coordinator	E	182	$48,000	$55,000	$62,000
	Customer Service Rep	C	5	$41,000	$47,000	$53,000
	Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000
	Data Analyst	J	337	$65,000	$78,000	$91,000
	Data Analyst Int	K	341	$70,000	$84,000	$98,000
	Data Analyst Sr	L	342	$77,000	$93,000	$109,000
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000
	Data Entry Tech	A	3	$36,000	$41,000	$46,000
	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000
	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000
	Database Administrator	L	90	$77,000	$93,000	$109,000
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000
**	Deputy Chief Counsel	W	160	$246,000	$307,000	$368,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised ~~March 04, 2021~~ August 05, 2021

To be Implemented ~~March 14, 2021~~ August 05, 2021

Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Deputy Chief Medical Officer	W	561	$246,000	$307,000	$368,000
	Deputy Clerk of the Board	K	684	$70,000	$84,000	$98,000
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000
*	Director Behavioral Health Services	S ~~Q~~	392	$154,000 ~~$130000~~	$193,000 ~~$157000~~	$232,000 ~~$184000~~
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000
*	Director Case Management	S	318	$154,000	$193,000	$232,000
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000
*	Director Communications	R	361	$144,000	$174,000	$204,000
*	Director Community Relations	R	TBD	$144,000	$174,000	$204,000
*	Director Contracting	R	184	$144,000	$174,000	$204,000
*	Director Customer Service	R	118	$144,000	$174,000	$204,000
*	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000
*	Director Facilities	Q	428	$130,000	$157,000	$184,000
*	Director Financial Analysis	T	374	$182,000	$227,000	$272,000
*	Director Financial Compliance	R	460	$144,000	$174,000	$204,000
*	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000
*	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000
*	Director Human Resources	S	322	$154,000	$193,000	$232,000
*	Director Information Services	T	547	$182,000	$227,000	$272,000
*	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000
*	Director Network Management	R	125	$144,000	$174,000	$204,000
*	Director PACE Program	S	449	$154,000	$193,000	$232,000
*	Director Population Health Management	R ~~Q~~	675	$144,000 ~~$130000~~	$174,000 ~~$157000~~	$204,000 ~~$184000~~
*	Director Process Excellence	R	447	$144,000	$174,000	$204,000
*	Director Program Implementation	R	489	$144,000	$174,000	$204,000
*	~~Director Provider Data Quality~~ Director Data Management Services	Q	655	$130,000	$157,000	$184,000
*	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000
*	Director Quality Analytics	R	591	$144,000	$174,000	$204,000
*	Director Quality Improvement	R	172	$144,000	$174,000	$204,000
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000
*	Director Vendor Management	Q	685	$130,000	$157,000	$184,000
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000
	Executive Assistant	G	339	$55,000	$63,000	$71,000
	Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000
**	Executive Director Behavioral Health Integration	U	614	$209,000	$261,000	$313,000
**	Executive Director Clinical Operations	U	501	$209,000	$261,000	$313,000
**	Executive Director Compliance	U	493	$209,000	$261,000	$313,000
**	Executive Director Human Resources	U	494	$209,000	$261,000	$313,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised ~~March 04, 2021~~ August 05, 2021

To be Implemented ~~March 14, 2021~~ August 05, 2021

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Executive Director Network Operations	U	632	$209,000	$261,000	$313,000
**	Executive Director Operations	U	276	$209,000	$261,000	$313,000
**	Executive Director Program Implementation	U	490	$209,000	$261,000	$313,000
**	Executive Director Public Affairs	U	290	$209,000	$261,000	$313,000
**	Executive Director Quality & Population Health Management	U	676	$209,000	$261,000	$313,000
	Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000
	Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000
	Facilities Coordinator	E	438	$48,000	$55,000	$62,000
	Financial Analyst	J	51	$65,000	$78,000	$91,000
	Financial Analyst Sr	L	84	$77,000	$93,000	$109,000
	Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000
	Graphic Designer	K	387	$70,000	$84,000	$98,000
	Graphic Designer Sr	L	TBD	$77,000	$93,000	$109,000
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000
	Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000
	Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000
	Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000
	Health Coach	K	556	$70,000	$84,000	$98,000
	Health Educator	H	47	$59,000	$68,000	$77,000
	Health Educator Sr	I	355	$61,000	$73,000	$85,000
	Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000
	Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000
	HEDIS Case Manager	M	443	$85,000	$103,000	$121,000
	Help Desk Technician	E	571	$48,000	$55,000	$62,000
	Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000
	HR Assistant	D	181	$44,000	$51,000	$58,000
	HR Business Partner	M	584	$85,000	$103,000	$121,000
	HR Coordinator	F	316	$51,000	$59,000	$67,000
	HR Representative	J	278	$65,000	$78,000	$91,000
	HR Representative Sr	L	350	$77,000	$93,000	$109,000
	HR Specialist	G	505	$55,000	$63,000	$71,000
	HR Specialist Sr	H	608	$59,000	$68,000	$77,000
	Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000
	Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000
	Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000
	Intern	A	237	$36,000	$41,000	$46,000
	Investigator Sr	I	553	$61,000	$73,000	$85,000
	IS Coordinator	E	365	$48,000	$55,000	$62,000
	IS Project Manager	N	424	$95,000	$114,000	$133,000
	IS Project Manager Sr	O	509	$105,000	$127,000	$149,000
	IS Project Specialist	K	549	$70,000	$84,000	$98,000
	IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000
	Kitchen Assistant	A	585	$36,000	$41,000	$46,000
	Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised ~~March 04, 2021~~ August 05, 2021
To be Implemented ~~March 14, 2021~~ August 05, 2021
Effective as of May 01, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max
Litigation Support Specialist	K	588	$70,000	$84,000	$98,000
LVN (PACE)	K	533	$70,000	$84,000	$98,000
LVN Specialist	K	686	$70,000	$84,000	$98,000
Mailroom Clerk	A	1	$36,000	$41,000	$46,000
Manager Accounting	O	98	$105,000	$127,000	$149,000
Manager Actuary	Q	453	$130,000	$157,000	$184,000
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000
Manager Business Integration	O	544	$105,000	$127,000	$149,000
Manager Case Management	P	270	$117,000	$141,000	$165,000
Manager Claims	O	92	$105,000	$127,000	$149,000
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000
Manager Coding Quality	N	382	$95,000	$114,000	$133,000
Manager Communications	N	398	$95,000	$114,000	$133,000
Manager Community Relations	N	384	$95,000	$114,000	$133,000
Manager Contracting	O	329	$105,000	$127,000	$149,000
Manager Creative Branding	M	430	$85,000	$103,000	$121,000
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000
Manager Customer Service	M	94	$85,000	$103,000	$121,000
Manager Electronic Business	N	422	$95,000	$114,000	$133,000
Manager Encounters	M	516	$85,000	$103,000	$121,000
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000
Manager Finance	O	148	$105,000	$127,000	$149,000
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000
Manager Government Affairs	N	437	$95,000	$114,000	$133,000
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000
Manager Human Resources	O	526	$105,000	$127,000	$149,000
Manager Information Services	P	560	$117,000	$141,000	$165,000
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000
Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000
Manager MSSP	O	393	$105,000	$127,000	$149,000
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000
Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000
Manager PACE Center	N	432	$95,000	$114,000	$133,000
Manager Population Health Management	N	674	$95,000	$114,000	$133,000
Manager Process Excellence	O	622	$105,000	$127,000	$149,000
Manager Program Implementation	N	488	$95,000	$114,000	$133,000
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000
Manager Provider Network	O	191	$105,000	$127,000	$149,000
Manager Provider Relations	M	171	$85,000	$103,000	$121,000
Manager Purchasing	O	275	$105,000	$127,000	$149,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised ~~March 04, 2021~~ August 05, 2021

To be Implemented ~~March 14, 2021~~ August 05, 2021

Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager QI Initiatives	M	433	$85,000	$103,000	$121,000
	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000
	Manager Utilization Management	P	250	$117,000	$141,000	$165,000
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000
	Medical Assistant	C	535	$41,000	$47,000	$53,000
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000
	Medical Case Manager	L	72	$77,000	$93,000	$109,000
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000
*	Medical Director	V	306	$221,400	$276,300	$331,200
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000
	Occupational Therapist	L	531	$77,000	$93,000	$109,000
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000
	Office Clerk	A	335	$36,000	$41,000	$46,000
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000
	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000
	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000
	Outreach Specialist	C	218	$41,000	$47,000	$53,000
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000
	Payroll Specialist	E	554	$48,000	$55,000	$62,000
	Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000
	Performance Analyst	I	538	$61,000	$73,000	$85,000
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000
	Personal Care Coordinator	C	525	$41,000	$47,000	$53,000
	Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000
	Pharmacy Resident	G	379	$55,000	$63,000	$71,000
	Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000
	Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000
	Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000
	Physical Therapist	L	530	$77,000	$93,000	$109,000
	Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000
	Policy Advisor Sr	M	580	$85,000	$103,000	$121,000
	Privacy Manager	N	536	$95,000	$114,000	$133,000
	Privacy Officer	O	648	$105,000	$127,000	$149,000
	Process Excellence Manager	N	529	$95,000	$114,000	$133,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised ~~March 04, 2021~~ August 05, 2021

To be Implemented ~~March 14, 2021~~ August 05, 2021

Effective as of May 01, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max
Program Assistant	C	24	$41,000	$47,000	$53,000
Program Coordinator	C	284	$41,000	$47,000	$53,000
Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000
Program Manager	L	421	$77,000	$93,000	$109,000
Program Manager Sr	M	594	$85,000	$103,000	$121,000
Program Specialist	E	36	$48,000	$55,000	$62,000
Program Specialist Int	G	61	$55,000	$63,000	$71,000
Program Specialist Sr	I	508	$61,000	$73,000	$85,000
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000
Programmer	K	43	$70,000	$84,000	$98,000
Programmer Int	M	74	$85,000	$103,000	$121,000
Programmer Sr	N	80	$95,000	$114,000	$133,000
Project Manager	L	81	$77,000	$93,000	$109,000
Project Manager - Lead	M	467	$85,000	$103,000	$121,000
Project Manager Sr	N	105	$95,000	$114,000	$133,000
Project Specialist	E	291	$48,000	$55,000	$62,000
Project Specialist Sr	I	503	$61,000	$73,000	$85,000
Projects Analyst	G	254	$55,000	$63,000	$71,000
~~Provider Enrollment Data Coordinator~~ Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000
~~Provider Enrollment Data Coordinator Sr~~ Provider Data Management Services Coordinator Sr	F	586	$51,000	$59,000	$67,000
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000
Provider Network Specialist	H	44	$59,000	$68,000	$77,000
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000
Provider Relations Rep	G	205	$55,000	$63,000	$71,000
Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000
Publications Coordinator	G	293	$55,000	$63,000	$71,000
QA Analyst	I	486	$61,000	$73,000	$85,000
QA Analyst Sr	L	380	$77,000	$93,000	$109,000
QI Nurse Specialist	M	82	$85,000	$103,000	$121,000
QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000
Receptionist	B	140	$38,000	$44,000	$50,000
Records Manager	Q	TBD	$130,000	$157,000	$184,000
Recreational Therapist	H	487	$59,000	$68,000	$77,000
Registered Dietitian	I	57	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000
Regulatory Affairs and Compliance - Lead	L	630	$77,000	$93,000	$109,000
RN (PACE)	M	480	$85,000	$103,000	$121,000
Security Analyst Int	M	534	$85,000	$103,000	$121,000
Security Analyst Sr	N	474	$95,000	$114,000	$133,000
Security Officer	B	311	$38,000	$44,000	$50,000
SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised ~~March 04, 2021~~ August 05, 2021

To be Implemented ~~March 14, 2021~~ August 05, 2021

Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Social Worker	J	463	$65,000	$78,000	$91,000
	Social Worker Sr	K	690	$70,000	$84,000	$98,000
*	Special Counsel	T	317	$182,000	$227,000	$272,000
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000
	Staff Attorney	P	195	$117,000	$141,000	$165,000
	Staff Attorney Sr	R	691	$144,000	$174,000	$204,000
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000
	Supervisor Claims	I	219	$61,000	$73,000	$85,000
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000
	Supervisor Encounters	I	253	$61,000	$73,000	$85,000
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000
	Supervisor Finance	M	419	$85,000	$103,000	$121,000
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000
	Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000
	Supervisor MSSP	M	348	$85,000	$103,000	$121,000
	Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000
	Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000
	Supervisor Payroll	M	517	$85,000	$103,000	$121,000
	Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000
	Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000
	Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000
	Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000
	Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000
	Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000
	Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000
	Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000
	Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000
	Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000
	Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000
	Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000
	Systems Operations Analyst	F	32	$51,000	$59,000	$67,000
	Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000
	Technical Analyst Int	J	64	$65,000	$78,000	$91,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised ~~March 04, 2021~~ August 05, 2021
To be Implemented ~~March 14, 2021~~ August 05, 2021
Effective as of May 01, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max
Technical Analyst Sr	L	75	$77,000	$93,000	$109,000
~~Technical Writer~~ Communications Specialist Sr	H	247	$59,000	$68,000	$77,000
~~Technical Writer Sr~~ Communications Specialist - Lead	J	470	$65,000	$78,000	$91,000
Therapy Aide	E	521	$48,000	$55,000	$62,000
Training Administrator	I	621	$61,000	$73,000	$85,000
Training Program Coordinator	H	471	$59,000	$68,000	$77,000
Translation Specialist	B	241	$38,000	$44,000	$50,000
Web Architect	N	366	$95,000	$114,000	$133,000

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Text in red indicates new changes to the salary schedule proposed for Board approval.

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised August 05, 2021
To be Implemented August 05, 2021
Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$68,000	$77,000
	Accountant Int	I	634	$61,000	$73,000	$85,000
	Accountant Sr	K	68	$70,000	$84,000	$98,000
	Accounting Clerk	D	334	$44,000	$51,000	$58,000
	Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000
	Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000
	Actuarial Analyst	I	558	$61,000	$73,000	$85,000
	Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000
	Actuary	O	357	$105,000	$127,000	$149,000
	Administrative Assistant	D	19	$44,000	$51,000	$58,000
	Analyst	H	562	$59,000	$68,000	$77,000
	Analyst Int	I	563	$61,000	$73,000	$85,000
	Analyst Sr	J	564	$65,000	$78,000	$91,000
	Applications Analyst	I	232	$61,000	$73,000	$85,000
	Applications Analyst Int	J	233	$65,000	$78,000	$91,000
	Applications Analyst Sr	L	298	$77,000	$93,000	$109,000
	Associate Director	P	682	$117,000	$141,000	$165,000
	Associate Director Customer Service	P	593	$117,000	$141,000	$165,000
	Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000
	Associate Director Information Services	Q	557	$130,000	$157,000	$184,000
	Auditor	I	565	$61,000	$73,000	$85,000
	Auditor Sr	J	566	$65,000	$78,000	$91,000
	Behavioral Health Manager	M	383	$85,000	$103,000	$121,000
	Biostatistics Manager	M	418	$85,000	$103,000	$121,000
	Board Services Specialist	E	435	$48,000	$55,000	$62,000
	Business Analyst	J	40	$65,000	$78,000	$91,000
	Business Analyst Sr	L	611	$77,000	$93,000	$109,000
	Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000
	Buyer	G	29	$55,000	$63,000	$71,000
	Buyer Int	H	49	$59,000	$68,000	$77,000
	Buyer Sr	I	67	$61,000	$73,000	$85,000
	Care Manager	K	657	$70,000	$84,000	$98,000
	Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000
	Certified Coder	H	399	$59,000	$68,000	$77,000
	Certified Coding Specialist	H	639	$59,000	$68,000	$77,000
	Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000
	Change Control Administrator	I	499	$61,000	$73,000	$85,000
	Change Control Administrator Int	J	500	$65,000	$78,000	$91,000
**	Chief Counsel	X	132	$289,000	$361,000	$433,000
**	Chief Executive Officer	Z	138	$400,000	$500,000	$600,000
**	Chief Financial Officer	X	134	$289,000	$361,000	$433,000
**	Chief Information Officer	W	131	$246,000	$307,000	$368,000
**	Chief of Staff	U	TBD	$209,000	$261,000	$313,000
**	Chief Medical Officer	X	137	$289,000	$361,000	$433,000
**	Chief Operating Officer	X	136	$289,000	$361,000	$433,000
	Claims - Lead	G	574	$55,000	$63,000	$71,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised August 05, 2021
To be Implemented August 05, 2021
Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Claims Examiner	C	9	$41,000	$47,000	$53,000
	Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000
	Claims Examiner Sr	E	20	$48,000	$55,000	$62,000
	Claims QA Analyst	E	28	$48,000	$55,000	$62,000
	Claims QA Analyst Sr	F	540	$51,000	$59,000	$67,000
	Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000
	Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000
	Clerk of the Board	O	59	$105,000	$127,000	$149,000
	Clinical Auditor	L	567	$77,000	$93,000	$109,000
	Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000
	Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000
	Clinical Pharmacist	P	297	$117,000	$141,000	$165,000
	Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000
	Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000
	Communications Specialist	G	188	$55,000	$63,000	$71,000
	Communications Specialist Sr	H	TBD	$59,000	$68,000	$77,000
	Communications Specialist - Lead	J	TBD	$65,000	$78,000	$91,000
	Community Partner	G	575	$55,000	$63,000	$71,000
	Community Partner Sr	H	612	$59,000	$68,000	$77,000
	Community Relations Specialist	G	288	$55,000	$63,000	$71,000
	Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000
	Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000
	Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000
	Contract Administrator	K	385	$70,000	$84,000	$98,000
	Contracts Manager	M	207	$85,000	$103,000	$121,000
	Contracts Manager Sr	N	683	$95,000	$114,000	$133,000
	Contracts Specialist	I	257	$61,000	$73,000	$85,000
	Contracts Specialist Int	J	469	$65,000	$78,000	$91,000
	Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000
*	Controller	T	464	$182,000	$227,000	$272,000
	Credentialing Coordinator	E	41	$48,000	$55,000	$62,000
	Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000
	Customer Service Coordinator	E	182	$48,000	$55,000	$62,000
	Customer Service Rep	C	5	$41,000	$47,000	$53,000
	Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000
	Data Analyst	J	337	$65,000	$78,000	$91,000
	Data Analyst Int	K	341	$70,000	$84,000	$98,000
	Data Analyst Sr	L	342	$77,000	$93,000	$109,000
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000
	Data Entry Tech	A	3	$36,000	$41,000	$46,000
	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000
	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000
	Database Administrator	L	90	$77,000	$93,000	$109,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised August 05, 2021
To be Implemented August 05, 2021
Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000
**	Deputy Chief Counsel	W	160	$246,000	$307,000	$368,000
**	Deputy Chief Medical Officer	W	561	$246,000	$307,000	$368,000
	Deputy Clerk of the Board	K	684	$70,000	$84,000	$98,000
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000
*	Director Behavioral Health Services	S	392	$154,000	$193,000	$232,000
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000
*	Director Case Management	S	318	$154,000	$193,000	$232,000
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000
*	Director Communications	R	361	$144,000	$174,000	$204,000
*	Director Community Relations	R	TBD	$144,000	$174,000	$204,000
*	Director Contracting	R	184	$144,000	$174,000	$204,000
*	Director Customer Service	R	118	$144,000	$174,000	$204,000
*	Director Data Management Services	Q	TBD	$130,000	$157,000	$184,000
*	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000
*	Director Facilities	Q	428	$130,000	$157,000	$184,000
*	Director Financial Analysis	T	374	$182,000	$227,000	$272,000
*	Director Financial Compliance	R	460	$144,000	$174,000	$204,000
*	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000
*	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000
*	Director Human Resources	S	322	$154,000	$193,000	$232,000
*	Director Information Services	T	547	$182,000	$227,000	$272,000
*	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000
*	Director Network Management	R	125	$144,000	$174,000	$204,000
*	Director PACE Program	S	449	$154,000	$193,000	$232,000
*	Director Population Health Management	R	675	$144,000	$174,000	$204,000
*	Director Process Excellence	R	447	$144,000	$174,000	$204,000
*	Director Program Implementation	R	489	$144,000	$174,000	$204,000
*	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000
*	Director Quality Analytics	R	591	$144,000	$174,000	$204,000
*	Director Quality Improvement	R	172	$144,000	$174,000	$204,000
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000
*	Director Vendor Management	Q	685	$130,000	$157,000	$184,000
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000
	Executive Assistant	G	339	$55,000	$63,000	$71,000
	Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000
**	Executive Director Behavioral Health Integration	U	614	$209,000	$261,000	$313,000
**	Executive Director Clinical Operations	U	501	$209,000	$261,000	$313,000
**	Executive Director Compliance	U	493	$209,000	$261,000	$313,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised August 05, 2021
To be Implemented August 05, 2021
Effective as of May 01, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max
** Executive Director Human Resources	U	494	$209,000	$261,000	$313,000
** Executive Director Network Operations	U	632	$209,000	$261,000	$313,000
** Executive Director Operations	U	276	$209,000	$261,000	$313,000
** Executive Director Program Implementation	U	490	$209,000	$261,000	$313,000
** Executive Director Public Affairs	U	290	$209,000	$261,000	$313,000
** Executive Director Quality & Population Health Management	U	676	$209,000	$261,000	$313,000
Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000
Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000
Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000
Facilities Coordinator	E	438	$48,000	$55,000	$62,000
Financial Analyst	J	51	$65,000	$78,000	$91,000
Financial Analyst Sr	L	84	$77,000	$93,000	$109,000
Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000
Graphic Designer	K	387	$70,000	$84,000	$98,000
Graphic Designer Sr	L	TBD	$77,000	$93,000	$109,000
Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000
Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000
Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000
Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000
Health Coach	K	556	$70,000	$84,000	$98,000
Health Educator	H	47	$59,000	$68,000	$77,000
Health Educator Sr		355	$61,000	$73,000	$85,000
Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000
Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000
HEDIS Case Manager	M	443	$85,000	$103,000	$121,000
Help Desk Technician	E	571	$48,000	$55,000	$62,000
Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000
HR Assistant	D	181	$44,000	$51,000	$58,000
HR Business Partner	M	584	$85,000	$103,000	$121,000
HR Coordinator	F	316	$51,000	$59,000	$67,000
HR Representative	J	278	$65,000	$78,000	$91,000
HR Representative Sr	L	350	$77,000	$93,000	$109,000
HR Specialist	G	505	$55,000	$63,000	$71,000
HR Specialist Sr	H	608	$59,000	$68,000	$77,000
Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000
Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000
Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000
Intern	A	237	$36,000	$41,000	$46,000
Investigator Sr	I	553	$61,000	$73,000	$85,000
IS Coordinator	E	365	$48,000	$55,000	$62,000
IS Project Manager	N	424	$95,000	$114,000	$133,000
IS Project Manager Sr	O	509	$105,000	$127,000	$149,000
IS Project Specialist	K	549	$70,000	$84,000	$98,000
IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000
Kitchen Assistant	A	585	$36,000	$41,000	$46,000
Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised August 05, 2021
To be Implemented August 05, 2021
Effective as of May 01, 2014

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Litigation Support Specialist	K	588	$70,000	$84,000	$98,000
LVN (PACE)	K	533	$70,000	$84,000	$98,000
LVN Specialist	K	686	$70,000	$84,000	$98,000
Mailroom Clerk	A	1	$36,000	$41,000	$46,000
Manager Accounting	O	98	$105,000	$127,000	$149,000
Manager Actuary	Q	453	$130,000	$157,000	$184,000
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000
Manager Business Integration	O	544	$105,000	$127,000	$149,000
Manager Case Management	P	270	$117,000	$141,000	$165,000
Manager Claims	O	92	$105,000	$127,000	$149,000
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000
Manager Coding Quality	N	382	$95,000	$114,000	$133,000
Manager Communications	N	398	$95,000	$114,000	$133,000
Manager Community Relations	N	384	$95,000	$114,000	$133,000
Manager Contracting	O	329	$105,000	$127,000	$149,000
Manager Creative Branding	M	430	$85,000	$103,000	$121,000
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000
Manager Customer Service	M	94	$85,000	$103,000	$121,000
Manager Electronic Business	N	422	$95,000	$114,000	$133,000
Manager Encounters	M	516	$85,000	$103,000	$121,000
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000
Manager Finance	O	148	$105,000	$127,000	$149,000
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000
Manager Government Affairs	N	437	$95,000	$114,000	$133,000
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000
Manager Human Resources	O	526	$105,000	$127,000	$149,000
Manager Information Services	P	560	$117,000	$141,000	$165,000
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000
Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000
Manager MSSP	O	393	$105,000	$127,000	$149,000
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000
Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000
Manager PACE Center	N	432	$95,000	$114,000	$133,000
Manager Population Health Management	N	674	$95,000	$114,000	$133,000
Manager Process Excellence	O	622	$105,000	$127,000	$149,000
Manager Program Implementation	N	488	$95,000	$114,000	$133,000
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000
Manager Provider Network	O	191	$105,000	$127,000	$149,000
Manager Provider Relations	M	171	$85,000	$103,000	$121,000
Manager Purchasing	O	275	$105,000	$127,000	$149,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised August 05, 2021
To be Implemented August 05, 2021
Effective as of May 01, 2014

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	Manager QI Initiatives	M	433	$85,000	$103,000	$121,000
	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000
	Manager Utilization Management	P	250	$117,000	$141,000	$165,000
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000
	Medical Assistant	C	535	$41,000	$47,000	$53,000
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000
	Medical Case Manager	L	72	$77,000	$93,000	$109,000
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000
*	Medical Director	V	306	$221,400	$276,300	$331,200
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000
	Occupational Therapist	L	531	$77,000	$93,000	$109,000
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000
	Office Clerk	A	335	$36,000	$41,000	$46,000
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000
	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000
	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000
	Outreach Specialist	C	218	$41,000	$47,000	$53,000
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000
	Payroll Specialist	E	554	$48,000	$55,000	$62,000
	Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000
	Performance Analyst	I	538	$61,000	$73,000	$85,000
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000
	Personal Care Coordinator	C	525	$41,000	$47,000	$53,000
	Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000
	Pharmacy Resident	G	379	$55,000	$63,000	$71,000
	Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000
	Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000
	Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000
	Physical Therapist	L	530	$77,000	$93,000	$109,000
	Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000
	Policy Advisor Sr	M	580	$85,000	$103,000	$121,000
	Privacy Manager	N	536	$95,000	$114,000	$133,000
	Privacy Officer	O	648	$105,000	$127,000	$149,000
	Process Excellence Manager	N	529	$95,000	$114,000	$133,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised August 05, 2021
To be Implemented August 05, 2021
Effective as of May 01, 2014

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Program Assistant	C	24	$41,000	$47,000	$53,000
Program Coordinator	C	284	$41,000	$47,000	$53,000
Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000
Program Manager	L	421	$77,000	$93,000	$109,000
Program Manager Sr	M	594	$85,000	$103,000	$121,000
Program Specialist	E	36	$48,000	$55,000	$62,000
Program Specialist Int	G	61	$55,000	$63,000	$71,000
Program Specialist Sr	I	508	$61,000	$73,000	$85,000
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000
Programmer	K	43	$70,000	$84,000	$98,000
Programmer Int	M	74	$85,000	$103,000	$121,000
Programmer Sr	N	80	$95,000	$114,000	$133,000
Project Manager	L	81	$77,000	$93,000	$109,000
Project Manager - Lead	M	467	$85,000	$103,000	$121,000
Project Manager Sr	N	105	$95,000	$114,000	$133,000
Project Specialist	E	291	$48,000	$55,000	$62,000
Project Specialist Sr	I	503	$61,000	$73,000	$85,000
Projects Analyst	G	254	$55,000	$63,000	$71,000
Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000
Provider Data Management Services Coordinator Sr	F	586	$51,000	$59,000	$67,000
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000
Provider Network Specialist	H	44	$59,000	$68,000	$77,000
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000
Provider Relations Rep	G	205	$55,000	$63,000	$71,000
Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000
Publications Coordinator	G	293	$55,000	$63,000	$71,000
QA Analyst	I	486	$61,000	$73,000	$85,000
QA Analyst Sr	L	380	$77,000	$93,000	$109,000
QI Nurse Specialist	M	82	$85,000	$103,000	$121,000
QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000
Receptionist	B	140	$38,000	$44,000	$50,000
Records Manager	Q	TBD	$130,000	$157,000	$184,000
Recreational Therapist	H	487	$59,000	$68,000	$77,000
Registered Dietitian	I	57	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000
Regulatory Affairs and Compliance - Lead	L	630	$77,000	$93,000	$109,000
RN (PACE)	M	480	$85,000	$103,000	$121,000
Security Analyst Int	M	534	$85,000	$103,000	$121,000
Security Analyst Sr	N	474	$95,000	$114,000	$133,000
Security Officer	B	311	$38,000	$44,000	$50,000
SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000
Social Worker	J	463	$65,000	$78,000	$91,000

For20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised August 05, 2021
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Effective as of May 01, 2014

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	Social Worker Sr	K	690	$70,000	$84,000	$98,000
*	Special Counsel	T	317	$182,000	$227,000	$272,000
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000
	Staff Attorney	P	195	$117,000	$141,000	$165,000
	Staff Attorney Sr	R	691	$144,000	$174,000	$204,000
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000
	Supervisor Claims	I	219	$61,000	$73,000	$85,000
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000
	Supervisor Encounters	I	253	$61,000	$73,000	$85,000
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000
	Supervisor Finance	M	419	$85,000	$103,000	$121,000
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000
	Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000
	Supervisor MSSP	M	348	$85,000	$103,000	$121,000
	Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000
	Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000
	Supervisor Payroll	M	517	$85,000	$103,000	$121,000
	Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000
	Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000
	Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000
	Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000
	Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000
	Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000
	Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000
	Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000
	Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000
	Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000
	Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000
	Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000
	Systems Operations Analyst	F	32	$51,000	$59,000	$67,000
	Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000
	Technical Analyst Int	J	64	$65,000	$78,000	$91,000
	Technical Analyst Sr	L	75	$77,000	$93,000	$109,000

For 20210805 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised August 05, 2021
To be Implemented August 05, 2021
Effective as of May 01, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max
Therapy Aide	E	521	$48,000	$55,000	$62,000
Training Administrator	I	621	$61,000	$73,000	$85,000
Training Program Coordinator	H	471	$59,000	$68,000	$77,000
Translation Specialist	B	241	$38,000	$44,000	$50,000
Web Architect	N	366	$95,000	$114,000	$133,000

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Revised 08/05/2021

For 20210805 BOD Review Only

Summary of Changes to Salary Schedule

For August 2021 Board Meeting

	Title	Old Pay Grade	Pay Grade	Job Code	Min	Mid	Max	Notes/Reason
**	Chief of Staff	N/A	U	TBD	$209,000	$261,000	$313,000	New position requires specific approval as an Executive Director level position in accordance with the Compensation Administration Guidelines
*	Director Behavioral Health Services	Q	S	392	154,000 ~~130000~~	193,000 ~~157000~~	232,000 ~~184000~~	Pay grade change based on review of current market data and internal evaluation of job responsibilities
*	Director Community Relations	N/A	R	TBD	$144,000	$174,000	$204,000	New position under the Executive Director of Public Affairs
*	Director Population Health Management	Q	R	675	144,000 ~~130000~~	174,000 ~~157000~~	204,000 ~~184000~~	Pay grade change based on review of current market data and internal evaluation of job responsibilities
*	~~Director Provider Data Quality~~ Director Data Management Services	Q	Q	~~655~~ TBD	$130,000	$157,000	$184,000	Title Change
	Graphic Designer Sr	N/A	L	TBD	$77,000	$93,000	$109,000	New position under the Director Communications
	~~Provider Enrollment Data Coordinator~~ Provider Data Management Services Coordinator	D	D	12	$44,000	$51,000	$58,000	Title Change
	~~Provider Enrollment Data Coordinator Sr~~ Provider Data Management Services Coordinator Sr	F	F	586	$51,000	$59,000	$67,000	Title Change
	~~Technical Writer~~ Communications Specialist Sr	H	H	~~247~~ TBD	$59,000	$68,000	$77,000	Title Change
	~~Technical Writer Sr~~ Communications Specialist Lead	J	J	~~470~~ TBD	$65,000	$78,000	$91,000	Title Change

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Revised ~~03/04/2021~~ 08/05/2021

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Ratification of New Finance Policy: MA.3003: Medicare Shared Risk Pool

Contact
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions
Ratify new CalOptima Policy MA.3003: Medicare Shared Risk Pool

Background
CalOptima's OneCare program began operations in January 2006 as a Medicare Advantage Special Needs Plan to serve low-income seniors and persons with disabilities. The OneCare Connect program was launched as part of the California Cal MediConnect Pilot program in July 2015 to serve dual eligible members in Orange County by integrating their Medicare and Medi-Cal benefits in order to streamline and simplify access to quality health care services.

As part of CalOptima's arrangement to serve our OneCare and OneCare Connect members, CalOptima and each shared risk health network established Shared Risk Pools in order to share the risk for the cost of caring for these members. CalOptima reconciles the Shared Risk Pool with each of the health networks on an annual basis.

Discussion
CalOptima establishes new and modifies existing policies and procedures to implement federal and state laws, regulations, contracts, and business practices. In addition, CalOptima staff performs an annual policy review to add or update internal policies and procedures to ensure compliance with applicable requirements.

Below is a list of substantive areas in the policy. There is no redline document available, as this is a new policy.

Policy Section	Proposed Change	Rationale	Impact
All	New policy that formalizes existing process for OneCare and OneCare Connect shared risk pools.	Creates internal policy to align with current operations and existing shared risk group (SRG) health network contract provisions related to shared risk pools.	No additional fiscal or operational impact
I. Purpose	This policy outlines the process for CalOptima's	N/A	N/A

Back to Agenda

Policy Section	Proposed Change	Rationale	Impact
	administration of a Medicare Shared Risk Pool with a Shared Risk Group.		
II. Policy	This section defines Medicare Shared Risk Pool measurement period, pool budget, qualified expenses, reporting and settlement periods.	N/A	N/A
III. Procedure	This section provides more details on how to perform quarterly and annual shared risk reporting, reconciliation and settlement.	N/A	N/A

Staff recommends ratification of a new CalOptima Policy MA.3003: Medicare Shared Risk Pool with an effective date of January 1, 2021. This policy formalizes an existing process for CalOptima's administration of the shared risk pools with shared risk group (SRG) health networks for CalOptima's OneCare and OneCare Connect programs and is consistent with the OneCare and OneCare Connect Shared Risk Health Network contracts. This policy applies to both the OneCare and OneCare Connect programs As the State of California plans to discontinue its Cal MediConnect (OneCare Connect) pilot program in conjunction with the CalAIM initiative by the end of December 2022, Staff plans to update this policy in the future so that it will only apply to the OneCare program.

Fiscal Impact

The recommended action to ratify CalOptima Policy MA.3003 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

The recommended action will enhance the efficiency of CalOptima's operations and governance and ensure compliance with applicable regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Finance and Audit Committee

Back to Agenda

Attachments

1. CalOptima Policy MA.3003: Medicare Shared Risk Pool

/s/ Richard Sanchez *07/28/2021*

Authorized Signature **Date**

Back to Agenda

Policy:	MA.3003
Title:	**Medicare Shared Risk Pool**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/*
Effective Date:	01/01/2021
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

For 20210805 BOD Review Only

I. PURPOSE

This policy outlines the process for CalOptima's administration of a Medicare Shared Risk Pool with a Shared Risk Group.

II. POLICY

A. CalOptima shall establish the Medicare Shared Risk Pool for the Shared Risk Group in accordance with the Contract for Health Care Services and the terms and conditions of this Policy.

B. CalOptima shall establish the Medicare Shared Risk Pool each calendar year (CY) during the term of the Shared Risk Group's Contract for Health Care Services.

C. Medicare Shared Risk Budget. The Medicare Shared Risk Budget shall be established based on the Medicare Hospital Budget allocated for Members assigned to the Shared Risk Group within the applicable period.

D. Medicare Shared Risk Expenses. The Medicare Shared Risk Expenses shall include:

1. Claims paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;

2. An estimate of Incurred But Not Reported (IBNR) claims for Shared Risk Services; and

3. Deduction for any recoveries related to Shared Risk Services, including but not limited to copayments, overpayment recoveries and coordination of benefit recoveries.

E. Quarterly Medicare Shared Risk Reporting. CalOptima shall report the status of the Medicare Shared Risk Pool to its corresponding Shared Risk Group within thirty (30) calendar days following the end of each quarter as follows:

1. Period Ending January 1 to March 31: Due April 30.

2. Period Ending January 1 to June 30: Due July 31.

3. Period Ending January 1 to September 30: Due October 31.

Back to Agenda Back to Item

4. Period Ending January 1 to December 31: Due January 31.

F. Annual Medicare Shared Risk Reconciliation and Settlement. By April 30, CalOptima shall distribute an annual report of the Medicare Shared Risk Program for the preceding CY to the Shared Risk Group. Upon an acceptance of the annual report from the Shared Risk Group, CalOptima shall settle the Medicare Shared Risk Pool for:

1. Surplus. If Medicare Shared Risk Expenses are less than Medicare Shared Risk Budget, CalOptima shall pay a Shared Risk Group an amount equal to fifty percent (50%) of that surplus, less any deficits carried forward from the previous annual settlement. CalOptima shall retain the balance of the Shared Risk Pool.

2. Deficit. If Medicare Shared Risk Expenses exceed Medicare Shared Risk Budget, CalOptima shall carry forward an amount equal to fifty percent (50%) of that deficit, up to an amount not to exceed $5.00 per Enrollee per month calculated on CY basis, into the next annual reconciliation, along with any additional deficits carried forward from the previous annual settlement.

G. In the event that CalOptima or a Shared Risk Group terminates the Contract for Health Care Services, CalOptima shall settle the Medicare Shared Risk Pool within one hundred twenty (120) calendar days following the date of contract termination, in accordance with Section III.C. of this Policy. If the Medicare Shared Risk Pool settlement calculation results in a deficit, in accordance with the Contract with the Shared Risk Group, CalOptima shall forgive the deficit.

H. Upon identification of a payment error, the Shared Risk Group must submit a written notification on a timely basis in order for CalOptima to seek necessary provider recoupment. CalOptima cannot request recoupment from a provider after more than three hundred sixty-five (365) calendar days from the date of CalOptima's original claims payment.

I. If the Shared Risk Group identifies an overpayment of an annual settlement payment, the Shared Risk Group shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima's Accounting Department in writing of the reason for the overpayment. CalOptima shall coordinate with the Shared Risk Group on the process to return the overpayment.

III. PROCEDURE

A. Quarterly Medicare Shared Risk Reporting

1. Within thirty (30) calendar days following the end of each quarter, as detailed in section II.F. of this Policy, CalOptima shall provide the Shared Risk Group with a written report of the status of the Shared Risk Pool.

2. The quarterly report shall estimate the projected Medicare Shared Risk Budget, Expenses, and Surplus or Deficit as described in sections II.C., D., and E. of this Policy, for the reporting period.

B. Annual Medicare Shared Risk Reconciliation and Settlement

1. No later than April 30 of each year, CalOptima shall provide the Shared Risk Group with an annual report. The annual report shall show the status of the Medicare Shared Risk Pool for the immediately preceding CY.

For 20210805 BOD Review Only

2. CalOptima shall compute the annual Medicare Shared Risk Pool Budget, Expenses, and Surplus or Deficit as described in sections II.C., D. and, E. of this Policy.

3. Each annual report shall include refreshed reports from the previous two (2) annual shared risk periods. CalOptima shall refresh the annual report at the time of the following Shared Risk Period's annual settlement to update IBNR and actual claims payment for previous shared risk periods. After two (2) years, the refreshed annual Shared Risk Program report should not contain IBNR and shall be considered final. (e.g., CY2020 Shared Risk Period will be final April 30, 2023).

4. If, upon review of the annual report, the Shared Risk Group objects to the calculations and determination, the Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and any supporting documentation to the CalOptima Accounting Department within thirty (30) calendar days from the date of receipt of the annual report.

   a. If CalOptima does not receive any written objection from the Shared Risk Group within thirty (30) calendar days of receipt of the annual report, CalOptima shall settle the Medicare Shared Risk Pool and apply any surplus or deficit within fifteen (15) calendar days after the expiration of the review period, but no later than June 15. Such settlement shall be considered final.

   b. If CalOptima receives written notice of objection from the Shared Risk Group within the objection period, CalOptima shall re-evaluate its calculations based on additional documentation provided by the Shared Risk Group and provide a final annual report to the Shared Risk Group within forty-five (45) calendar days after receipt of the written objection.

   c. CalOptima shall settle the Medicare Shared Risk Pool based on this final annual report and apply any surplus or deficit within fifteen (15) calendar days after the date of issuance of the final annual report.

5. If CalOptima determines that a Shared Risk Group has Medicare Shared Risk Pool deficits in two (2) successive fiscal years, or if there is a significant change in risk pool performance, CalOptima may meet with the Shared Risk Group in order to discuss and understand the reason for the pool deficits and develop an improvement plan.

C. Medicare Shared Risk Settlement upon Termination

1. Within one-hundred-twenty (120) calendar days after the effective date of termination of the Contract for Health Care Services with a Shared Risk Group, CalOptima shall provide the terminated Shared Risk Group with a Final Reconciliation and Settlement Report.

2. CalOptima shall compute the Final Medicare Shared Risk Pool Budget, Expenses, and Surplus or Deficit as described in Section II.C., D. and, E. in accordingly.

3. The Final Reconciliation and Settlement Report shall include refreshed reports from the previous two (2) annual shared risk periods. Or, CalOptima shall refresh any annual report which otherwise would not be considered final as of the effective date of termination of the Contract for Health Care Services with the Shared Risk Group.

4. If, upon review of the Final Reconciliation and Settlement Report, the terminated Shared Risk Group objects to the calculations and determination, the terminated Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and any supporting documentation

For 20210805 BOD Review Only

to the CalOptima Accounting Department within thirty (30) calendar days from the date of receipt of the Final Reconciliation and Settlement Report.

a. If CalOptima does not receive any written objection from the terminated Shared Risk Group within thirty (30) calendar days of receipt of the Final Reconciliation and Settlement Report, CalOptima shall settle the Medicare Shared Risk Pool within fifteen (15) calendar days after the expiration of the review period. Such settlement shall be considered final. If the settlement calculation from the Final Reconciliation and Settlement Report results in a deficit, in accordance with the Contract with the Shared Risk Group, CalOptima shall forgive the deficit.

b. If CalOptima receives written notice of objection from the terminated Shared Risk Group within the objection period, CalOptima shall re-evaluate its calculations based on additional documentation provided by the terminated Shared Risk Group and provide a revised Final Reconciliation and Settlement Report to the terminated Shared Risk Group within forty-five (45) calendar days after receipt of the written objection.

c. CalOptima shall settle the Medicare Shared Risk Pool based on this revised Final Reconciliation and Settlement Report within fifteen (15) calendar days after the date of issuance of the revised Final Reconciliation and Settlement Report. If the settlement calculation from the revised Final Reconciliation and Settlement Report results in a deficit, in accordance with the Contract with the Shared Risk Group, CalOptima shall forgive the deficit.

IV. ATTACHMENT(S)

A. Risk Pool Claims Objection Form

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. Medicare Physician Group Service Agreement
C. CalOptima Policy FF.2003: Coordination of Benefits

VI. REGULATORY AGENCY APPROVAL(S)

None To Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2021	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect

For 20210805 BOD Review Only

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) a physician group under a shared risk contract, or HMO, and DHCS Medi-Cal Managed Care Division Policy Letters.
Contracted CalOptima Hospital	A hospital that has entered into a CalOptima Hospital Services Contract to provide hospital services to CalOptima Direct Members.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare / OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima 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 and the County of Orange.
Incurred But Not Reported (IBNR)	IBNR means "incurred but not reported," and refers to 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.
Medicare Hospital Budget	The amount equal to the Non-Part D related capitation that CalOptima receives from Center for Medicare & Medicaid Services (CMS) for Members assigned to the Shared Risk Physician multiplied by Hospital Budget percentage set forth in the Shared Risk Group Contract for Health Care Services.
Medicare Shared Risk Pool	Covered Services which are the financial responsibility under the Hospital Budget as set forth in the Division of Financial Responsibility (DOFR) of the Contract for Health Care Services.
Member	A beneficiary enrolled in a CalOptima program.

For 20210805 BOD Review Only

Term	Definition
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, health maintenance organization, Health Network, physician group or other person or institution that furnishes Covered Services.
Shared Risk Budget	The total amount that CalOptima allocates to the Shared Risk Pool to pay for Shared Risk Services set forth in the DOFR of the contract.
Shared Risk Expenses	Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group; An estimate of Incurred But Not Reported (IBNR) expenses; and Administrative expenses at a rate established in the Contract for Health Care Services.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.
Shared Risk Pool	The risk sharing program, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima and the contracted Health Network.
Shared Risk Services	Covered Services which are the financial responsibility under the Hospital Budget as set forth in the Division of Financial Responsibility (DOFR) of the Contract for Health Care Services.

1

For 20210805 BOD Review Only

Hospital Shared Risk Pool
Shared Risk Group: _____
Risk Pool Period
Date of Service: _____
Date of Payment: _____

Line Of Business
- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect

Item #	Payment Question/Issue	CalOptima Claim No.	Member Name	Provider Name	Start Date of Service	End Date of Service	Amount Paid	Date of Payment	Requested Credit	CalOptima Review	2nd Level CalOptima GARS Appeal Review	CalOptima Potential Claim Overpayment
							$ -		$ -			$ -

For 20210805 BOD Review Only

Back to Agenda

Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Consider Approval of New CalOptima Policies IS.1600: Provider Access to In-House Provider Portal, and IS.1601: In-House Provider Portal Administration and Support (Internal)

Contacts
Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Mike Herman, Director Information Services, (714) 246-8820

Recommended Action
Approve new CalOptima Policies IS.1600: Provider Access to In-House Provider Portal and IS.1601: In-House Provider Portal Administration and Support (Internal)

Background
CalOptima currently has a provider portal hosted by a vendor, Medecision. This provider portal was implemented in 2011 and is currently branded as "CalOptima Link." The current vendor-hosted portal has limited functionality and annual licensing and maintenance fees of just over $1.5 million. In 2018, research was completed by Information Services staff to determine the availability of a commercially available solution that could be licensed or purchased to satisfy CalOptima's business requirements.

The research consisted of:
a) Surveying other Medi-Cal health plans to learn about their provider portal solutions;
b) Attendance at presentations conducted by portal vendors in use by other Medi-Cal plans at the monthly Chief Information Officer meetings with those plans; and
c) Consulting the CalOptima-contracted technology research vendor, Gartner, for information regarding trends in the industry, pros and cons of various vendor solutions, and gathering information about how other Medi-Cal and commercial health plans are implementing portal solutions across the United States.

As this research was conducted, it became clear that no commercially available solution would satisfy all the defined CalOptima business requirements with reasonable costs for licensing, maintenance, and custom development. On November 1, 2018, the Board of Directors authorized a reallocation of funding within the Fiscal Year (FY) 2018-2019 capital budget for development of a new In-House Provider Portal (IHPP) by internal staff and temporary staff to replace the current CalOptima Link hosted solution.

The new IHPP has been designed with easy-to-navigate functions and strong privacy and security controls and differs from the CalOptima Link hosted solution in a number of ways, including provider user registration, local office administrator, monitoring of user activity for appropriate use of the IHPP, and new access roles for users of the IHPP. Once the internal system is fully implemented (estimated for December 2021), the contract with the current provider portal vendor will be terminated. The new IHPP allows registered provider office users to securely look up CalOptima member eligibility, view the provider's claims payment status from CalOptima, submit medical and behavioral health service referrals, and view status of their referrals as well as future feature sets for providers.

Back to Agenda

The current CalOptima Policy EE.1140 CalOptima Link Non-Compliance for the vendor-hosted portal is not applicable to the new IHPP and, in preparation for the inhouse implementation, CalOptima staff has developed two new policies to support the new IHPP usage and support guidelines.

Discussion

The new policy IS.1600: Provider Access to In-House Provider Portal defines the standards and procedures pursuant to which provider office users shall be permitted to use CalOptima's new IHPP.

General policy outlines for use and adherence by provider office users include the following:

- The process for provider office user account registration to access Protected Health Information (PHI) to carry out payment and health care operations
- Registration and training requirements for provider office users
- Role-based access for provider office users limited to privileges necessary to perform their work assignments
- Confidentiality and protection of information under Health Insurance Portability and Accountability Act of 1996 (HIPAA) including controls to prevent unauthorized access to PHI, such as not sharing login credentials
- Restricting provider office users from accessing information that requires higher levels of access control and security protection, such as procedure and diagnosis codes related to treatment for sexually transmitted or venereal diseases, family planning services, and treatment for substance abuse and mental health issues
- Administrative and technical safeguards to be followed by provider office users to protect electronic PHI and control access to it
- CalOptima monitoring and review of provider office users' activity on the provider portal in accordance with Compliance
- Establishing a Provider Portal User Agreement and Terms and Conditions of Use, and annual review and update of terms, as necessary
- Ensuring that all provider office user(s) complete and attest to the IHPP user training annually
- Imposing sanctions, as appropriate, when a provider office and/or provider office user(s) are found in violation of the policy or the Provider Portal Access Agreement
- Process for reporting any suspected, potential, or actual security incident, breach, or violation of the policy
- Requiring each provider office to designate a local office administrator with responsibility for controlling access to the IHPP, serving as the point-of-contact to CalOptima, and granting or terminating role-based access to authorized provider office users
- Establishing procedures for terminating and reinstating provider office user accounts

New policy IS.1601: In-House Provider Portal Administration and Support (Internal) defines the standards and procedures pursuant to which CalOptima shall manage access to the IHPP and implement administrative and technical safeguards to ensure compliance with HIPAA.

Back to Agenda

Below are general policy outlines for internal CalOptima staff to follow and adhere to:

- Designating the appropriate role to staff who need to use the IHPP system to perform their specific job-related duties, such as Enterprise Administration
- Granting access to and administration of the provider office users and staff users
- Logging and monitoring of users' activity for appropriate use of the IHPP, including monthly audits of random subsets of provider officer uses to confirm that access is appropriate for their job functions within the provider office
- Adhering to physical security and system application controls
- Implementing administrative and technical safeguards to prevent unauthorized access to PHI and protect the software from malicious intent
- Verifying that all account registration requirements have been satisfied for each provider office's request for access to the IHPP
- Delegating authority to the Chief Operating Officer, or an individual who reports directly to the COO and has the delegated authority to sign on his or her behalf, to sign the Provider Portal Access Agreement on behalf of CalOptima
- Establishing procedures for reporting any suspected, potential, or actual security incident, breach, or violation of the policy
- Establishing a CalOptima Provider Portal Advisory Group, made up of staff from Privacy, IS Security, Medical Affairs, Operations, and Information Services-Application Development to oversee the governance of which data will be accessible to users
- Establishing procedures for addressing planned or unplanned outages of the IHPP

Fiscal Impact

The recommended action to approve the new CalOptima Policies IS:1600 and IS:1601 are operational in nature and has no additional fiscal impact.

Rationale for Recommendation

CalOptima staff recommends approval of new policies IS.1600: Provider Access to In-House Provider Portal, and IS.1601: In-House Provider Portal Administration and Support (Internal) to ensure alignment with the new operational practices and current regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Policy IS.1600 Provider Access to In-House Provider Portal
    - CalOptima Provider Portal User Agreement Terms and Conditions of Use
    - Provider Portal User Training
    - CalOptima Provider Portal Access Agreement
2. CalOptima Policy IS.1601 In-House Provider Portal Administration and Support (Internal)
3. Previous Board Action dated November 1, 2018: Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2018–19 Capital Budget for the CalOptima Provider Portal Project

Back to Agenda

4. Entities Covered by this Recommended Board Action
5. CalOptima Policy EE.1140 CalOptima Link Non-Compliance

/s/ Richard Sanchez *07/28/2021*
Authorized Signature **Date**

Back to Agenda

Policy:	IS.1600
Title:	**Provider Access to In-House Provider Portal**
Department:	Information Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20210805 BOD Review Only

I. PURPOSE

This policy defines the standards and procedures pursuant to which Provider Office Users shall be permitted to use CalOptima's In-House Provider Portal ("Provider Portal").

II. POLICY

A. The Provider Portal is an information system developed by CalOptima which grants authorized Provider Office Users access to Protected Health Information ("PHI") to carry out Payment and Health Care Operations for CalOptima's eligible Members.

B. The Provider Portal is available to Provider Office Users with a registered user account.

C. Role-based user assignment shall be implemented to comply with the Principle of Least Privilege within the Provider Portal, and Users shall be granted only the Minimum Necessary Access to the data that is required for the User to perform the User's specific job-related duties, in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

D. Most of the information contained within the Provider Portal is confidential and protected by HIPAA. Provider Office Users are authorized to use such information for the sole purpose of carrying out Payment and Health Care Operations. Users are prohibited from downloading, printing, copying, taking a screen shot of, or forwarding Provider Portal information or documents for purposes other than Payment and Health Care Operations.

E. Controls to Prevent Unauthorized Access to PHI

1. A Provider Office shall take reasonable and appropriate measures to control unauthorized access to PHI in oral and electronic forms.

2. To the extent a Provider Office or its Users print and/or copy Provider Portal information or documents for purposes of Payment or Health Care Operations, a Provider Office shall take reasonable and appropriate measures to control unauthorized access to PHI in paper form.

F. All records referring to or containing Restricted Information shall be suppressed from view within the Provider Portal.

Back to Agenda

Back To Item

G. CalOptima implements Administrative and Technical Safeguards in compliance with HIPAA, and in accordance with CalOptima Policies, including, but not limited to, CalOptima Policies IS.1601: In-House Provider Portal Administration and Support (Internal) and HH.3002Δ: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls.

H. CalOptima monitors and reviews all access to and use of the Provider Portal, in accordance with CalOptima Policy IS.1303Δ: Audit, Review, Testing, and Change Management.

I. CalOptima shall establish a CalOptima Provider Portal User Agreement and Terms and Conditions of Use (Attachment A), review it annually and update its terms as necessary.

J. CalOptima shall ensure that all Provider Office User(s) complete and attest to the Provider Portal User Training on an annual basis.

K. CalOptima may impose Sanctions on a Provider Office and/or Provider Office User(s) found in violation of this policy, the CalOptima Provider Portal User Agreement and Terms and Conditions of Use, or the Provider Portal Access Agreement.

1. The extent of the Sanction shall be commensurate with the severity of the deficiency identified as it relates to the risk posed to the CalOptima Member(s) and shall be designed to correct the underlying issue to prevent future recurrence. Sanctions include, but are not limited to Corrective Action Plans, re-education and/or termination of access for Provider Office Users.

L. Any person with knowledge of a violation, or potential violation, of this Policy shall report such information to the Privacy Officer directly, or through the CalOptima Compliance and Ethics Hotline at 1-877-837-4417 or email: privacy@caloptima.org in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI.

III. PROCEDURE

A. Provider Office User Account Registration

1. To request access to CalOptima's Provider Portal, the following must occur:

a. The Provider Office will complete and sign the Provider Portal Access Agreement (Attachment C) for Provider Office Entity and return it to CalOptima prior to access being permitted by CalOptima.

b. Each Provider Office shall designate a Local Office Administrator who is responsible for approving Provider Office User account requests and for granting permissions to access the Provider Portal as needed to carry out their specific job-related duties.

c. Provider Office Users must:

i. Supply the following information using the Provider Portal registration form:

a) First name;

b) Last name;

c) Street address;

For 20210805 BOD Review Only

Back to Agenda

Back To Item

d) City;

e) Zip code;

f) Phone number; and

g) Email address.

h) Job position and/or title

ii. Specify the Provider Office to which they are affiliated.

iii. Verify that they have access to the email address using a one-time passcode that is sent to the email address during account registration.

iv. Agree to the requirements set forth on the CalOptima Provider Portal User Agreement and Terms and Conditions of Use.

v. Complete and attest to the Provider Portal User Training.

B. Provider Office User Account Setup and Validation

1. Upon completion of account registration, the Provider Portal system will route the access request to the Local Office Administrator for review and approval.

2. In the event there is no designated Local Office Administrator for the specified Provider Office, the system will route the access request to the Enterprise Administrator queue.

3. Access requests must be approved or denied by the Local Office Administrator or an Enterprise Administrator.

a. For access requests that are approved by the Local Office Administrator, the system will store the approval date along with the name of the Local Office Administrator that approved the request.

b. For Provider Offices with no existing Local Office Administrators, the access request will be routed to the Enterprise Administrators within CalOptima. The Enterprise Administrator will reach out to the Provider Office Manager to assist with the Provider Office User request. In addition, the Enterprise Administrator will coordinate with the Provider Office Manager to establish a Local Office Administrator responsible for validating and approving access requests.

4. Upon approval of the access request, the registrant will receive an email that their account has been approved.

5. Upon denial of the access request, the registrant will receive an email that their request has been denied.

6. The Local Office Administrator shall review a User's job description to determine the appropriate level of access needed and grant the approved Provider Office User within their Provider Office with access to one or more of the following user roles, as applicable and necessary for the User to perform the User's specific job-related duties:

a. Eligibility Viewer: Grants Users access to view Member eligibility.

For 20210805 BOD Review Only

b. Claims Viewer: Grants Users access to view claims that belong to the Provider Office.

c. View Referrals: Grants Users access to view referrals that belong to the Provider Office.

d. Submit Referrals: Grants Users the ability to submit referrals to CalOptima.

7. The Local Office Administrator shall limit access to a Member's PHI to only those Provider Officer Users who need to Use the data to carry out their specific job-related duties related to Payment or Health Care Operations.

8. The Local Office Administrator may grant access to Provider Office Users on a specific "need-to-know" basis and shall restrict access to the minimum amount of PHI needed to complete the work activity.

9. The Local Office Administrator shall attest that the access designated to the Provider Office User is necessary to perform their job duties and complies with the Principle of Least Privilege and Minimum Necessary standard.

C. User Identification

1. Provider Office Users are identified by their email address.

2. Once the account has been created, the email address may not be changed.

3. The email address must be unique.

4. The email address must adhere to the following format requirements:

a. Must contain an at symbol (i.e., @); and

b. Must include a valid domain and extension (e.g., "User@registereddomain.com").

D. Passwords

1. Once a Provider Office User account is approved, the Provider Office User is required to establish an account password.

2. The account password may be changed by the Provider Office User at any time.

3. The password must meet the conditions specified below:

a. The password must contain at least 7 characters

b. The password must contain at least three of the following character types:

i. One lower case letter

ii. One upper case letter

iii. One number

iv. A special character (!,@,#,$,%,*, etc.)

For 20210805 BOD Review Only

Back to Agenda

Back To Item

4. The account password must not be the same as the email address.

5. The account password must be reset every sixty (60) calendar days.

E. Login

1. Provider Office Users must enter a valid email address and password in order to access the Provider Portal.

2. The User's login session will be closed after 15 minutes of inactivity.

3. Permission to access the Provider Portal is locked after five (5) failed login attempts. Specifically, where the input value for password does not match the specified login identifier.

4. To regain access to a locked Provider Portal account, Provider Office Users must:

   a. Contact an Enterprise Administrator; or

   b. Reset their password

F. Two-Factor Authentication

1. As an added layer of security, Provider Office Users shall complete two-factor Authentication:

   a. When logging in to the Provider Portal for the first time;

   b. When logging in to the Provider Portal using an unknown device;

   c. When the Provider Office User attempts to view or update their User accounts, using the following self-service tools:

      i. Forgot password;

      ii. Reset password; or

      iii. Update User profile

2. Provider Office Users shall complete two-factor Authentication as follows:

   a. By entering a security passcode delivered to the registered User's email address or mobile phone; or

   b. By answering security questions established during account registration.

3. Security passcodes delivered via email address or mobile phone are six (6) numeric characters in length and expire within fifteen (15) minutes.

G. User Administration

1. Provider Office Users may update their User information, except email address, through the Provider Portal's, "Update User Profile" interface.

H. Local Office Administrator Verification of Provider Office Users

For 20210805 BOD Review Only

Back to Agenda

Back To Item

1. Every forty-five (45) calendar days, commencing upon the date the Provider Office obtains access to the Provider Portal, each Local Office Administrator will be prompted to verify the Users for their corresponding Provider Office, including, each and every User's employment status, role, and security setting.

2. Any Local Office Administrator who has not completed the User verification within fifteen (15) calendar days of receiving the above-mentioned prompt will be restricted from navigating throughout the application until the verification is complete.

3. CalOptima shall systematically suspend access to the Provider Portal for every account associated with the Provider Office for failure to complete User verification within sixteen (16) calendar days of receiving the above-mentioned prompt. Each User will be notified upon login attempt that their account has been suspended.

4. Local Office Administrators may contact CalOptima's Provider Relations Department to complete the User verification process and request reinstitution of access to the Provider Portal.

5. Once the User verification process is complete, CalOptima's Provider Relations Department will contact e-Business to reinstate Provider Portal access to the Provider Office and its verified Users.

I. Restricted Information

1. CalOptima shall suppress all records referring to or containing Restricted Information from view within the Provider Portal, and Users shall not have access to such information through the Provider Portal. This includes:

    a. Birth Control
    b. Pregnancy
    c. Abortion
    d. STIs, Contagious and Reportable Diseases
    e. HIV/AIDS Treatment and Testing
    f. Sexual Assault Care
    g. Alcohol/Drug Counseling
    h. Outpatient Mental Health Treatment

2. CalOptima's Information Services Department shall maintain a list of diagnosis codes, procedure codes, and medications which will be restricted from view within the Provider Portal for all Users.

3. On a monthly basis, CalOptima will review the list of diagnosis codes, procedure codes, and medications to capture any changes, including additions or deletions, to such codes and medications.

J. Annual User Training

1. On an annual basis each Provider Office User will be prompted to complete and attest to the Provider Portal User Training.

2. Provider Office User(s) who have not completed and attested to the Provider Portal User Training by the required date specified by CalOptima will be restricted from accessing the Provider Portal until the training and attestation is complete.

For 20210805 BOD Review Only

Back to Agenda

Back To Item

3. Once the Provider Portal User Training and attestation are complete, the User will regain access to the Provider Portal.

K. Reporting, Responding to, and Investigating Breaches, Security Incidents, Violations, or Noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use

1. Local Office Administrators, Provider Offices, and Users are responsible for reporting any suspected, potential, or actual Security Incidents, Breaches, Violations, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use to CalOptima's Privacy Officer via email (Privacy@CalOptima.org) or through the CalOptima Compliance and Ethics Hotline at 1-877-837-4417, immediately, but no later than twenty-four (24) hours after discovery. Any suspected, potential, or actual Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use shall be treated as discovered by the Local Office Administrator, Provider Office, or User as of the first day on which it is known, or by exercising reasonable diligence would have been known, to any person who is a part of the Workforce (excepting the person committing the Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use).

2. Upon discovery of a Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use, the Provider Office and its Local Office Administrator shall:

   a. Take prompt action to mitigate, to the extent practicable, any risks or damages involved with the Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use. Notwithstanding the foregoing, all corrective actions are subject to the approval of CalOptima and CalOptima's regulator(s).

   b. Take any action pertaining to such Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use required by applicable Federal and State laws and regulations.

   c. Take any corrective actions required by CalOptima and CalOptima's regulator(s).

   d. Immediately investigate such Security Incident, Breach, Violation, or noncompliance with CalOptima Provider Portal User Agreement and Terms and Conditions of Use, and within forty-eight (48) hours of the discovery, notify CalOptima of the matters described below.

      i. The date of the Security Incident, Breach, Violation, or noncompliance with CalOptima Provider Portal User Agreement and Terms and Conditions of Use and the date it was discovered;

      ii. A description of the probable causes of the Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use;

      iii. A description of the unauthorized persons known or reasonably believed to have improperly Used or Disclosed PHI or confidential data;

      iv. The nature of the PHI or confidential data elements involved and the extent of the PHI or confidential data involved in the Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and

For 20210805 BOD Review Only

Conditions of Use and whether the PHI or confidential data that is the subject of the Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use included Unsecured Protected Health Information;

v. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized;

vi. The identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Provider Office and Local Office Administrator to have been accessed, acquired, used or disclosed during the Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use;

vii. Any other available information that the Provider Office is required to include in notification to the individual under 45 C.F.R. § 164.404(c);

e. Provider Office shall make itself and any of its subcontractors, employees or agents available to CalOptima at no cost to CalOptima to testify as witnesses or otherwise in the event of litigation or administrative proceedings being commenced against CalOptima, its directors, officers or employees based upon claimed violation of HIPAA, the HITECH Act and/or implementing regulations and/or State privacy laws, which involve actions or inactions by the Provider Office or its Workforce related to the Provider Portal, except where Provider Office or its subcontractor, employee or agent is named as an adverse party.

3. In the event CalOptima staff is made aware of an actual, suspected, or potential Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use, CalOptima staff shall comply with the procedures and requirements in CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI, including, but not limited to, immediately notifying the CalOptima Privacy Officer or Designee by telephone, fax, or email Privacy@caloptima.org.

4. If CalOptima's Privacy Office and/or Information Services Security is made aware of an actual, potential, or suspected Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use, they will contact the Enterprise Administrator to suspend the User(s) account(s) pending further investigation.

5. Enterprise Administrators must suspend a User's account immediately upon receiving a report of an actual, potential, or suspected Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use.

6. CalOptima's Privacy Office and/or Information Services Security department will contact the CalOptima's Provider Relations Department to assist with the investigation, including Provider outreach and education, if necessary.

a. Provider Offices, Local Office Administrators and Users must cooperate and assist CalOptima's Privacy Officer and/or Security Officer with the investigation of actual, suspected, or potential Security Incidents, Breaches, Violation, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use occurring in their office or committed by their current or former employees.

For 20210805 BOD Review Only

Back to Agenda

Back To Item

b. During an investigation, the Local Office Administrator, Provider Office, and Users must respond to and fully comply with all requests for information or documents within the time specified by the CalOptima Privacy Officer and/or Security Officer in order to ensure CalOptima meets regulatory requirements for reporting Breaches, Security Incidents, Violations, or noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use.

7. Upon completion of the investigation, CalOptima's Privacy Office and/or Information Services Security, in conjunction with Provider Relations and e-Business, will make a recommendation on corrective actions. Examples of corrective actions may include, but are not limited to, Provider Office re-education, Provider User training, Corrective Action Plan(s), and termination of User account(s).

8. CalOptima's Privacy Office and/or Information Services Security department will contact an Enterprise Administrator to reinstate accounts at the conclusion of such investigations, as applicable.

9. CalOptima may revoke access to all Provider Office Users associated with a Provider Office and its Workforce if the non-compliance action deems necessary.

L. User Activity Logs

1. CalOptima shall log User account activity, including Authentication successes and failures, in accordance with CalOptima Policy IS.1303Δ: Audit, Review, Testing, and Change Management.

2. Each page visited by a Provider Office User will be recorded in a secure audit log as new row record containing the date and time, and the email address of the User that viewed the record.

3. Changes to the Provider Office User record will be reflected in a secure audit log as a new row record containing the date and time of change, and the email address of the User that made the change.

4. Access to Provider Office User activity logs shall be limited to authorized managers and Enterprise Administrators.

5. User activity logs shall be retained according to CalOptima Policy HH.2022Δ: Record Retention and Access.

M. Terminated User Accounts

1. A Provider Office User whose account has not been used for over sixty (60) calendar days shall not be able to log into the Provider Portal.

2. A Provider Office User whose account has been disabled by either a Local Office Administrator or an Enterprise Administrator shall not be able to login to the Provider Portal.

3. The Local Office Administrator is responsible for immediately terminating or limiting, as applicable, User access for staff who are no longer employed or whose job responsibilities no longer require access to the Provider Portal or to certain modules within it. The system requires entry of the User's employment termination date from the Provider Office, or the change in job responsibilities date, and the date that User's access to the Provider Portal is revoked or limited. If the date entered is greater than one (1) business day of the User's employment termination date, or change in job responsibilities date, the system shall generate a report for CalOptima's e-

For 20210805 BOD Review Only

Business Department detailing any areas of the Provider Portal that may have been accessed by the User, if any. The e-Business Department will review this audit report to determine whether a potential breach must be reported to CalOptima's Privacy Office.

4. Upon termination of a Provider Office in FACETS, all Providers and the Workforce connected to the Provider Office shall not be able to login to the Provider Portal.

N. Reinstatement of User accounts

1. Upon reinstatement of a Provider Office in FACETS, Provider Office Users connected to the Provider Office may regain access to the Provider Portal after completing account registration.

2. Provider Office Users whose access to the Provider Portal were previously revoked after being dormant for over sixty (60) calendar days may be reinstated after password reset.

IV. ATTACHMENT(S)

A. CalOptima Provider Portal User Agreement and Terms and Conditions of Use
B. Provider Portal User Training
C. CalOptima Provider Portal Access Agreement

V. REFERENCE(S)

A. CalOptima Policy HH.2022Δ: Record Retention and Access
B. CalOptima Policy HH.3002Δ: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls.
C. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
D. CalOptima Policy IS.1303Δ: Audit, Review, Testing, and Change Management
E. CalOptima Policy IS.1601: In-House Provider Portal Administration and Support (Internal)
F. Title 45 Code of Federal Regulations (CFR), Part 164 - Security and Privacy, §§164.102 -164.534
G. Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
TBD	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	IS.1600	Provider Access to In-House Provider Portal	Administrative

For 20210805 BOD Review Only

Back to Agenda

Back To Item

IX. GLOSSARY

Term	Definition
Access	Has the meaning given such term in Section 164.304 of Title 45, Code of Federal Regulations, i.e., the ability or the means necessary to read, write, modify, or communicate data or information or otherwise use any CalOptima system resource.
Administrative Safeguard	Has the meaning given such term in Section 164.304 of Title 45, Code of Federal Regulations. The administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's or business associate's workforce in relation to the protection of that information.
Authentication	Has the meaning given such term in Section 164.304 of Title 45, Code of Federal Regulations (i.e., the corroboration that a person is the one claimed).
Breach	The acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of 45 CFR Part 164 which compromises the security or privacy of the Protected Health Information. Breach excludes: (i) Any unintentional acquisition, access, or Use of Protected Health Information by a Provider Office or User, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of 45 CFR Part 164. (ii) Any inadvertent Disclosure by a User to another User authorized to access Protected Health Information at the same Provider Office, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of 45 CFR Part 164. (iii) A Disclosure of Protected Health Information where a Provider Office or User has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.
Corrective Action Plan (CAP)	A plan delineating specific and identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

For 20210805 BOD Review Only

Back to Agenda

Back To Item

Term	Definition
Covered Services	Means the following: • 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 effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS ("Contract") and are Medically Necessary (as defined in the Contract), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. • Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. • Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Disclosure or Disclose	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations, including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Enterprise Administrator	An access role within Provider Portal designated to CalOptima staff residing in the Information Services, e-Business, or Provider Relations department responsible for: 1. Managing internal and external Provider Portal accounts; 2. Act as a point of contact to Local Office Administrators; and 3. Provide and terminate access to authorized staff for any Provider Office.
FACETS	Licensed software product that supports administrative, claims processing and adjudication, Membership data, and other information needs of managed care organizations.

For 20210805 BOD Review Only

Back to Agenda

Back To Item

Term	Definition
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with HIPAA.
HIPAA	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, which 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.
In-House	Developed and supported by internal CalOptima staff.
Local Office Administrator	A User at a Provider Office designated to: 1. Control CalOptima Link access; 2. Is the point of contact to CalOptima; and 3. Has the authority to provide and terminate access to authorized staff at the Provider's Office.
Member	A beneficiary enrolled in a CalOptima program.
Minimum Necessary	The standard which requires a covered entity to make reasonable efforts to limit the scope of the PHI it uses, discloses or makes a request for PHI to the minimum amount of PHI needed to accomplish the intended purpose. Minimum Necessary applies to internal uses of PHI, disclosures of PHI to external parties in response to a request and when Requesting PHI from another covered entity unless an exception under HIPAA applies (e.g. Minimum Necessary standard does not apply to treatment).
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including activities carried out by CalOptima such as: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Principle of Least Privilege	The concept that all Users at all times should have as few privileges as possible, and access applications with as few privileges as possible to perform their work assignments.

For 20210805 BOD Review Only

Back to Agenda

Back To Item

Term	Definition
Protected Health Information	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider(s)	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 Office	For the purpose of this policy, a representation of one or more Providers participating in an office or as a group setting.
Provider Office Manager	For the purpose of this policy, an authorized representative of the Provider Office that manages the provider office and can confirm User employment for the Provider Office.
Provider Portal	CalOptima's information system which enables a Provider and/or a Provider Office and its Workforce to access Member health-related information to assist with Payment and Health Care Operations, not including CalOptima Link.
Provider Portal User Training	Required training module that must be completed by all Provider Portal Users prior to using the Provider Portal and no less than annually thereafter.
Restricted Information	Information that requires the highest level of access control and security protection, including, but not limited to, procedure and diagnosis codes related to treatment for HIV/AIDs, sexually transmitted or venereal diseases, family planning services, treatment for substance abuse and mental health issues or certain information related to minors or victims of abuse.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier, Downstream, and Related Entity's (FDR's) or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima programs.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
Technical Safeguard	Has the meaning given such term in Section 164.304 of Title 45, Code of Federal Regulations. The technology, and the policy and procedures for its use, that protect electronic protected health information and control access to it.

For 20210805 BOD Review Only

Back to Agenda

Back To Item

Term	Definition
Unsecured Protected Health Information	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of PHI within an entity that maintains such information.
User	A person or entity with authorized access to the Provider Portal.
Violation	Violation means, as the context may require, failure to comply with an administrative simplification provision, as defined in 42 CFR Section 160.103.
Workforce	For the purposes of this policy, employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of such covered entity or business associate, whether or not they are paid by the covered entity or business associate.

1

For 20210805 BOD Review Only

Back to Agenda

Back To Item

CalOptima Provider Portal
User Agreement
and
Terms and Conditions of Use

I. Purpose

CalOptima provides access to its Provider Portal application via www.caloptima.org. The Provider Portal is a web application that is accessible through a desktop computer or mobile device. This application allows Providers, Provider Offices, and their Workforce, as applicable, to:

A. Verify Member eligibility
B. View health-related information
C. View CalOptima claims status information
D. View CalOptima referral status information for authorization of covered services
E. Submit referrals to CalOptima for authorization of covered services
F. View Member profile and demographic information
G. View check payments and remittance advices issued by CalOptima

II. Agreement

A. The terms and conditions herein ("Terms & Conditions") are a legal agreement between you and CalOptima governing your use of the Provider Portal. The Terms & Conditions, together with CalOptima's Website Privacy Policy ("Website Privacy Policy"), found at _____, and CalOptima Policy IS.1600, Provider Access to In-House Provider Portal ("Provider Portal Policy"), found at _____, constitute the entire agreement (collectively, "Agreement") between you and CalOptima with respect to your use of the Provider Portal. The capitalized terms used herein without definition shall have the meanings assigned to them in the Provider Portal Policy.

B. BY ACCESSING, USING AND/OR VIEWING THE PROVIDER PORTAL, YOU ATTEST THAT YOU HAVE REVIEWED AND UNDERSTAND THIS AGREEMENT AND AGREE TO BE BOUND BY THE TERMS OF THIS AGREEMENT, INCLUDING THE WEBSITE PRIVACY POLICY AND PROVIDER PORTAL POLICY. IF YOU DO NOT AGREE TO THE WEBSITE PRIVACY POLICY, PROVIDER PORTAL POLICY, AND THESE TERMS & CONDITIONS, DO NOT USE THE PROVIDER PORTAL. YOUR USE OF THE PROVIDER PORTAL MEANS YOU AGREE TO THE WEBSITE PRIVACY POLICY, PROVIDER PORTAL POLICY, AND THESE TERMS & CONDITIONS.

C. We may revise the information on the Provider Portal or otherwise change or update the application and its content, including this Agreement. If CalOptima makes changes to this Agreement, reasonable efforts will be used to post such changes on the Provider Portal before they become effective and to specify the date they will become effective. In the absence of any specific date being provided, the changes are effective immediately upon posting. A current version of this Agreement showing the last revision date is always available at this location. We encourage you to periodically read this Agreement to see if there have been any changes that may affect you. CalOptima may also make improvements and/or changes in products and/or services described on the Provider Portal or add new features at any time without notice. Your continued use of the site will indicate your continued agreement to this Agreement as it may be revised.

For 20210805 BOD Review Only

Back to Agenda

Back To Item

D. Your failure to comply with the Terms and Conditions shall constitute a material breach of the Agreement.

E. CalOptima expressly reserves the right, in its sole discretion, to terminate a User's or Provider Office's access to the Provider Portal due to any act that would constitute a violation of these Terms & Conditions. Each Provider Office shall also ensure that each User within its Workforce adheres to the Terms & Conditions of this Agreement and agrees that a breach thereof by any of its Users shall constitute a breach of this Agreement by the Provider Office.

F. CalOptima's Compliance Officer, on the advice of legal counsel, may terminate the Agreement at any time upon written notice to the User and/or Provider Office based upon a determination, in his or her reasonable discretion, that the User's and/or Provider Office's use of the Provider Portal presents a compliance risk.

III. Registration

You are not obligated to register with CalOptima in order to access www.caloptima.org. However, the Provider Portal is available only to Providers, Provider Offices and their Workforce with a registered User account. Prior to registration, your Provider Office must complete and sign CalOptima's Provider Portal Access Agreement. If you are a registered User, you agree to accurately maintain and update any information about yourself that you have provided to CalOptima.

IV. User Account and Password

A. The Provider Portal has several tools that allow you to record and store information. You are responsible for taking all reasonable steps to ensure that no unauthorized person shall have access to your Provider Portal online password or account. It is your sole responsibility to:

i. control the disclosure and use of your activation codes, password reset codes and password;
ii. authorize, monitor, and control access to and use of your online account and password;
iii. immediately change your password if you feel it has become compromised; and
iv. immediately inform CalOptima of any need to deactivate an account entirely.

B. To change your password, sign on and choose the drop-down arrow icon next to your name at the top right corner of the page. Then, select User Profile. To deactivate your account, you may contact CalOptima's Provider Relations Department using the contact information available at the bottom of each Provider Portal page.

V. User Access and Permitted Activities

A. Provided that you are a registered User of the Provider Portal, you are hereby granted a personal, non-exclusive, non-transferable, revocable license to access the Provider Portal and the information contained within the Provider Portal, subject to any limitations and restrictions set forth or authorized in CalOptima policies, including CalOptima Policy IS.1600, Provider Access to In-House Provider Portal. You agree that any hardware, software, or other

For 20210805 BOD Review Only

Back to Agenda

Back To Item

components necessary for access to and use of the Provider Portal must be acquired and maintained by User and Provider Office at their sole cost and expense. Said hardware, software, and other components must meet the minimum specifications for access to and use of the Provider Portal, and User and Provider Office are solely responsible for such hardware, software, and other components, including the security of same.

B. User's and Provider Office's use of the Internet is solely at their own risk and is subject to all applicable laws and regulations. CalOptima is not responsible for the security of information transmitted via the Internet, the accuracy of the information contained on the Provider Portal, or for the consequences of User's or Provider Office's reliance on such information.

C. The Provider Portal offers interactive features, including software tools and databases that allow you to search and retrieve information. Providers may use this site to access information on Member eligibility, claims processing status, referral status and payment status through the internet, subject to any limitations set forth or authorized in CalOptima policies. Additionally, Providers and Provider Representatives may submit referrals for CalOptima Members.

D. You agree, represent, and warrant that any information submitted by you is:

i. truthful, accurate, and not misleading;
ii. offered in good faith; and
iii. submitted because you have the right to transmit such information.

E. The Website Privacy Policy explains how CalOptima collects, stores, uses, protects, and discloses information collected on www.caloptima.org, and the Provider Portal. The Website Privacy Policy can be found here Website Privacy Policy, as well as through a link at the bottom of each page on the Provider Portal. To the extent there is an inconsistency between these Terms & Conditions and the Website Privacy Policy, these Terms & Conditions shall govern.

F. You agree to immediately, but no later than twenty-four (24) hours after discovery, notify CalOptima of any unauthorized use of your account, username, or password, Breach, Security Incident, Violation, or noncompliance with this Agreement that you become aware of involving or relating to the Provider Portal. You agree, at no cost to CalOptima, to fully cooperate with CalOptima in its investigation into such unauthorized uses, Breaches, Security Incidents, Violations, or noncompliance and to mitigate any harm caused by such incident.

G. CalOptima has the right, in its sole discretion, to limit the number of Users that have access to the Provider Portal.

VI. Links to Third-Party Websites

A. The Provider Portal may provide links to other websites that are not owned or controlled by CalOptima ("Third Party Websites"). A message will be displayed to let you know when you are leaving the Provider Portal and linking to a Third-Party Website.

B. CalOptima is not responsible for the content, security or the privacy practices of Third-Party Websites. Please review the privacy statement and any terms of use of each Third-Party Website you visit. Links to Third-Party Websites do not constitute or imply endorsement by CalOptima of

For 20210805 BOD Review Only

Back to Agenda

Back To Item

those sites, the information they contain or any products or services they describe. CalOptima does not receive payment or other remuneration in exchange for linking to or using any Third-Party Website.

VII. Communications by Email or Mobile Phone

A. By accepting these Terms & Conditions, you agree to receive essential communications from CalOptima about the Provider Portal via email. CalOptima's communications to your email will not include Protected Health Information. These communications may include (but are not limited to):

i. Notification confirming the successful User account registration
ii. Notifications confirming successful updates to your User account
iii. Notices related to application & service updates

B. If you forget your password, or access the Provider Portal from an unknown device, you will be able to choose to have a one-time passcode sent to the email address or by text to your mobile phone number that you provided when you registered for a Provider Portal account.

VIII. Prohibited Activities

A. In consideration of being allowed to use the Provider Portal, you agree to all the following:

i. You may not gain or attempt to gain unauthorized access to the Provider Portal, to other Users' accounts, to other Users' names or personally identifiable information, or to other computers or websites connected or linked to the Provider Portal.
ii. You may not send or otherwise transmit to or through the Provider Portal unsolicited messages, so-called "spamming" or "phishing" messages, or messages marketing or advertising goods and services.
iii. You may not use the Provider Portal to post, transmit or otherwise distribute unlawful material. Examples of unlawful material include, but are not limited to, threats of physical harm, defamatory statements, pornographic material, and copyrighted, trademarked, and other proprietary material used without proper authorization.
iv. You may not post, transmit or otherwise make available any virus, worm, spyware or any other computer code, file or program that may or is intended to damage or hijack the operation of any hardware, software or telecommunications equipment.
v. You may not "flood" or disrupt the Provider Portal through any means or process such as launching or using any automated system, including but not limited to, "robots," "spiders," or "offline readers."
vi. You may not misrepresent your identity in any way.
vii. You may not restrict or inhibit any person from using the Provider Portal, disclose personal information about other individuals on the Provider Portal or obtained from the Provider Portal or collect information about Users of the Provider Portal.
viii. You may not reverse engineer, disassemble or decompile any section or technology on the Provider Portal, or attempt to do any of the foregoing.
ix. You are responsible for all use of CalOptima's services and the Provider Portal, with or without your consent, by yourself and others, which occurs by, through, or in connection with access to the Provider Portal via your computer.

For 20210805 BOD Review Only

Back to Agenda

Back To Item

IX. Disclaimer of Warranties

To the extent permitted by applicable law, CalOptima's Provider Portal is provided on an "as is" basis without guarantee, warranty, or representation of any kind, either expressed or implied, including but not limited to any implied warranty of merchantability, fitness for a particular purpose, or non-infringement. CalOptima does not guarantee or warrant that the Provider Portal will be error free, continuously available, or operate uninterrupted.

X. Release, Indemnification, and Limitation of Liability

A. To the extent permitted by applicable law, CalOptima shall not be liable to you or any third party for any indirect, consequential, special, incidental or punitive damages (including lost revenues or profits), or any other monetary or other damages, fees, fines, penalties, or liabilities arising out of this Agreement, the Provider Portal, or your access to, or use of, or inability to use the Provider Portal, or the content or materials therein, whether in a contract action or based on negligence, or other tort action, under statute, in equity, or in law, or otherwise, even if CalOptima has been advised of the possibility of such damages.

B. You shall also indemnify and hold harmless CalOptima and its officers, directors, employees, affiliates, interns, volunteers, and agents from any and all claims, liabilities, demands, costs, and damages of every kind and nature, in law, equity, or otherwise arising out of, or in any way related to, your access to, or use of, or inability to use, the Provider Portal, or the content or materials therein, whether or not arising from any acts or omissions by CalOptima or its officers, directors, employees, affiliates, interns, volunteers, and agents.

C. The provisions in this Section shall survive any termination of this Agreement.

XI. Notice Regarding No Liability of County of Orange

This Provider Portal is produced and maintained by CalOptima, which is not a department, agency or otherwise a part of the County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, you acknowledge and agree that any obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and that the County of Orange has no obligation or liability as related to this Provider Portal.

XII. Intellectual Property Rights

All copyrightable content and other materials contained within or on, or used in connection with, the Provider Portal, including, but not limited to, text, graphics, logos, button icons, pictures, images, audio recordings and files, video recordings and files, software, data, routines, documentation, literary works, and compilations (collectively, "the Content") comprise protectable copyrighted works owned by, or licensed by third parties to, CalOptima and are protected by the United States' copyright laws and international copyright laws. All patent rights, copyrights, trademark rights, trade dress rights, trade secret rights and other intellectual property and other rights applicable to CalOptima's products, services, systems, software, processes, and methods are owned by CalOptima, and CalOptima retains ownership of all such rights. In addition, CalOptima may have licensed from third party's certain intellectual property and/or other rights that may be related to CalOptima's products, services, systems, software, processes, and methods. Downloading,

For 20210805 BOD Review Only

Back to Agenda

Back To Item

republication, retransmission, reproduction, or other use of licensed or copyrighted material is prohibited. The Provider Portal uses Google Noto and Font Awesome open source fonts licensed under the SIL Open Font License, Version 1.1.

XIII. Governing Law and Venue

This Agreement will be governed by and construed in accordance with the laws of the State of California, without reference to its choice of law rules. By accessing, viewing, or using the Provider Portal, or using the materials contained therein, you consent to the exclusive jurisdiction of the federal and state courts presiding in Orange County, California. Any claim or dispute between you and CalOptima that arise in whole or in part from this Agreement will be decided exclusively by the foregoing courts. If any part of this Agreement is held to be invalid or unenforceable for any reason by a court of competent jurisdiction, then the remaining parts will remain in full force and effect.

XIV. Severability

If any provision of the Agreement is or becomes illegal, invalid or unenforceable, such provision shall be deemed stricken from the Agreement and its illegality, invalidity or unenforceability shall not affect the remainder of the provisions of the Agreement, which shall remain in full force and effect. The parties hereto shall endeavor in good faith negotiations to replace any illegal, invalid or unenforceable provision with a valid, legal and enforceable provision, the economic effect of which comes as close as possible to the economic effect of the illegal, invalid or unenforceable provision.

XV. Waiver

No delay or omission by a party to exercise any right occurring upon any noncompliance or default by another party with respect to any of the terms of this Agreement shall impair any such right or power or be construed to be a waiver thereof. A waiver by one of the parties of any of the covenants, conditions or agreements to be performed by one of the other parties shall not be construed to be a waiver of any succeeding breach thereof or of any covenant, condition or agreement herein contained.

XVI. Assignability

CalOptima may assign its rights and delegate its duties, either in whole or in part, under this Agreement at any time and its sole and absolute discretion, without your consent. The Agreement is not assignable by you, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion.

XVII. Relationship

This Agreement does not establish any relationship of partnership, joint venture, employment, franchise or agency between you and CalOptima.

XVIII. No Third-Party Beneficiaries

For 20210805 BOD Review Only

Back to Agenda

Back To Item

Nothing express or implied in the terms and conditions of this Agreement is intended to confer, nor shall anything herein confer, upon any person or entity other than CalOptima or User, and their approved respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

XIX. Supported Browsers

A. CalOptima's supported list of browsers is as follows:

i. Firefox 80 and above
ii. Safari 12 and above
iii. Google Chrome 86 and above

XX. Contact Us

If you have any questions or concerns regarding the Terms and Conditions, please contact CalOptima at:

Privacy Officer

CalOptima
505 City Parkway West Orange, CA 92868
1-888-587-8088

Or call:

CalOptima Provider Relations Department
1-714-246-8600

XXI. Revisions and Updates

The Terms & Conditions may be revised periodically in CalOptima's sole discretion. CalOptima also reserves the right to modify the Agreement at any time should such modification be required by applicable law or regulation. In the absence of any specific date being provided, the revised Terms & Conditions is effective immediately upon posting. Please periodically read the Terms & Conditions to see if there are any changes that may affect you.

XXII. Effective Date: <insert date>

XXIII. References

A. CalOptima Policy IS.1600: Provider Access to In-House Provider Portal
B. CalOptima Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI

For 20210805 BOD Review Only

Back to Agenda

Back To Item

A Public Agency

CalOptima

Better. Together.

Provider Portal User Training

Created: August, 2020

For 20210805 BOD Review Only

Back to Agenda

Back To Item

CalOptima Provider Portal - Overview

- You have been granted access to the CalOptima Provider Portal. This system contains Protected Health Information (PHI) which must be secured and protected in accordance with all federal and state laws, regulations and CalOptima policies.
- The CalOptima Provider Portal gives Providers and their staff a tool that will enhance the care provided to their patients by:
  - Accelerating services by allowing online submission of referrals
  - Enabling Providers to see their submitted claims status
  - Enabling Providers to see their submitted referrals status
  - Allows Users to verify CalOptima Member Eligibility Status.
- If you have any questions about the Provider Portal please contact: CalOptima's Provider Relations Department at (714) 246-8600.

For 20210805 BOD Review Only

Back to Agenda

Back To Item

CalOptima
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Definitions

- **Minimum Necessary** - The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information. It is based on sound current practice that protected health information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function.
- **Role Based Access Controls (RBAC)** - Role-based access control is a method of restricting network access based on the roles of individual users within an office. RBCA lets employees have access rights only to the information they need to do their jobs and prevents them from accessing information that doesn't pertain to them.

For 20210805 BOD Review Only

Back to Agenda

Back To Item

CalOptima
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Definitions

- **Protected Health Information (PHI)** - Information which can be tied to a specific individual's health information, and can include;
  - the individual's past, present or future physical or mental health or condition,
  - the provision of health care to the individual, or
  - the past, present, or future payment for the provision of health care to the individual which identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.
- **Electronic Protected Health Information** (ePHI) – PHI that is saved or accessed in an electronic format.
- **Breach** - The acquisition, access, use, or disclosure of protected health information in a manner not permitted which compromises the security or privacy of the protected health information.

For 20210805 BOD Review Only

Use of the Provider Portal

- Users must adhere to the Terms of Use to protect and safeguard PHI. You can safeguard PHI by doing the following:
- Applying the minimum necessary standard and only accessing or using PHI for a justified business purpose (example: Treatment or Payment) and the information must be related to your job duties.
- Using Role Based Access - If you have been granted access to the Provider Portal that exceeds what you need to complete your job duties, inform your Local Office Administrator or contact CalOptima's Provider Relations Department at (714) 246-8600.
- Keeping your passwords and logins secure; never share your passwords or log in information with another individual.
- Locking your workstations when you walk away from your computer.
  - *This is important so that others do not document in the system under your user-id or gain access to information they may not be authorized to view.*

For 20210805 BOD Review Only

Misuse of the Provider Portal

- CalOptima monitors usage of the Provider Portal. Each page visited or action taken in the Provider Portal is tracked and recorded for audit purposes.
- Misuse of this system may result in your access being revoked or terminated, referral to regulators or law enforcement for further investigation. You may also be subjected to civil monetary penalties and fines.
- Violations can include:
  - Accessing PHI you are not authorized to view or that is not related to your job. (I.e. snooping)
  - Submitting information when you are not authorized to do so.
  - Sharing your username or password.
  - Forwarding, downloading or copying information in violation of the Terms of Use
- Any actual or suspected misuse of the Provider Portal must be reported immediately to CalOptima's Compliance and Ethics Hotline at 1-877-837-4417 or email: privacy@caloptima.org. You may report anonymously.

For 20210805 BOD Review Only

Local Office Administrator Training

- You have been identified as a Local Office Administrator (LOA) for your practice location.
- In this training, you will learn about some of the roles and responsibilities associated with this role.
  - Set up appropriate access for Users in the office.
  - Verify User access every 60 days
  - Update a User's access when their responsibilities change.
  - Terminate accounts for staff who are no longer employed or no longer need access to the CalOptima Provider Portal.
  - Assist with responding to non-compliance investigations.

For 20210805 BOD Review Only

Granting Access

- As a LOA, you are responsible for approving, maintaining and terminating staff accounts and levels of access in CalOptima's Provider Portal in accordance with HIPAA regulations.
- Granting access must follow the HIPAA Security Rule principles of Role Based Access Controls (RBAC) and Minimum Necessary.
- Staff should only be granted access to modules that are relevant and necessary for their daily work.
- If you have any questions about granting access or whether staff access is appropriate, please contact CalOptima's Provider Relations Department at (714) 246-8600.

For 20210805 BOD Review Only

Managing Access

- Once access to the system is granted, staff access levels must be reviewed periodically to ensure that the PHI they can view is still appropriate and related to their job.
- Every 60 days, you will be prompted by the system to review and validate that all User's levels of access in the Provider Portal are appropriate.
  - If you identify a staff member with access that is no longer appropriate (i.e. no longer necessary for their role), their permissions must be updated immediately.
- If you do not complete this task by the deadline, access to your entire office will be suspended until your provider account is reinstated.
- If you identify or suspect any misuse of the Provider Portal, call CalOptima's Compliance and Ethics Hotline at 1-877-837-4417 or email Privacy@CalOptima.org . You may report anonymously

For 20210805 BOD Review Only

Terminating Access

- When an employee is terminated or voluntarily resigns from your organization, the Local Office Administrator (LOA) is responsible for terminating that user's account immediately.
- Allowing an individual to have access to systems associated with your practice once they are no longer part of your workforce could result in privacy breach if any patient PHI is accessed by the individual.
- It is extremely important that system access to the CalOptima Provider Portal be terminated immediately after an employee leaves an organization.

For 20210805 BOD Review Only

Incident Response

- As the Local Office Administrator, you may be required to assist CalOptima's Privacy Officer and/or Security Officer with breach or non-compliance investigations regarding current or past employees.
- During investigations, it is important to respond timely to requests for information. CalOptima must meet stringent reporting timeframes set forth by the Department of Healthcare Services. (DHCS)
- CalOptima may impose Sanctions on a Provider Office and/or Provider Office Users found in violation of this policy, the Provider Portal Terms of Use, or the Affiliate Agreement.
  - The extent of the Sanction shall be commensurate with the severity of the deficiency identified as it relates to the risk posed to the CalOptima Member(s) and are designed to correct the underlying issue and prevent future recurrence. Sanctions include, but are not limited to Corrective Action Plans, re-education and/or termination of access for Provider Office Users.
  - Access to the system may be temporarily suspended for Users while CalOptima completes an investigation regarding mis-use or breaches.

For 20210805 BOD Review Only

Additional information and resources

- CMS HIPAA Basic for Providers: Privacy, Security and Breach
- HHS – HIPAA for Professionals
- CalOptima Provider Manual

- CalOptima's Provider Relations Department - (714) 246-8600
- CalOptima's Compliance and Ethics Hotline - 1-877-837-4417
- CalOptima's Privacy Officer - Privacy@CalOptima.org

For 20210805 BOD Review Only

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

For 20210805 BOD Review Only

CalOptima Provider Portal Access Agreement

This CalOptima Provider Portal Access Agreement is made and entered into, and shall be effective, as of the date last signed below by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima", and «Company Name», a «Business Entity», hereinafter referred to as "Provider Office."

RECITALS

A. Whereas, CalOptima provides access to its Provider Portal application at www.caloptima.org through a desktop computer or mobile device;

B. Whereas, the Provider Portal allows providers, provider offices, and their workforce, as applicable, to:

- Verify member eligibility
- View health related information
- View CalOptima claims status information
- View CalOptima referral status information for authorization of covered services
- Submit referrals to CalOptima for authorization of covered services
- View member profile and demographic information
- View check payments and remittance advices issued by CalOptima;

C. Whereas, Provider Office desires access to the Provider Portal for itself and its users/workforce; and

D. Whereas, Provider Office must sign this Agreement before it and its users/workforce can access the Provider Portal;

E. Whereas, CalOptima and Provider Office desire to enter into this Agreement on the terms and conditions set forth herein below.

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:

I. COMPLIANCE WITH CALOPTIMA POLICY IS.1600

In addition to the requirements and obligations set forth herein, Provider Office shall comply with all applicable terms and conditions of CalOptima Policy IS.1600, Provider Access to In-House Provider Portal (Policy), and use its best efforts to ensure its users and workforce comply with the Policy and CalOptima Provider Portal User Agreement and Terms and Conditions of Use (Terms and Conditions of Use).

II. LOCAL OFFICE ADMINISTRATORS

A. Provider Office must promptly designate an LOA to give the Provider Office the ability to manage its users on the Provider Portal. Once the Provider Office designates its LOA, and this Agreement is received and processed by CalOptima, CalOptima will email the LOA with training instructions on the LOA's role and how Provider Office users will enroll and obtain access to the Provider Portal using an automated online process.

B. The LOA will have the ability to:

i. View list of users with access to the Provider Portal

For 20210805 BOD Review Only

Back to Agenda

Back To Item

ii. Edit user access roles
iii. Routinely monitor users and their access roles to the Provider Office
iv. Approve new users associated with the Provider Office
v. Deactivate users

C. The LOA may periodically receive communications from CalOptima and will also be responsible for following the role-based access controls in the Provider Portal and described in the Terms and Conditions of Use and the Policy.

Provider Office Name:_____

Local Office Administrator Name: _____

Local Office Administrator Contact Information:

Street Address:_____

City, State, Zip:_____

Phone: ( ) -

Fax: ( ) -
Email Address:_____

D. Once an LOA is no longer employed by the Provider Office, the Provider Office or authorized Provider Office representative will be required to notify the CalOptima Provider Relations Department at 714-246-8600 immediately to have a new LOA designated by the Provider Office or authorized Provider Office representative.

III. USER REGISTRATION AND ACCESS

Once the LOA completes the required training and obtains access to the Provider Portal to perform the LOA functions and responsibilities described in the Policy, each Provider Office user will be allowed to register for use of the Provider Portal, provided that each user complies with the registration requirements set forth in the Policy.

IV. INDEMNIFICATION

A. To the extent permitted by applicable law, CalOptima shall not be liable to Provider Office for any indirect, consequential, special, incidental or punitive damages (including lost revenues or profits), or any other monetary or other damages, fees, fines, penalties, or liabilities arising out of this Agreement, the Provider Portal, or Provider Office's access to, or use of, or inability to use the Provider Portal, or the content or materials therein, whether in a contract action or based on negligence, or other tort action, under statute, in equity, or in law, or otherwise, even if CalOptima has been advised of the possibility of such damages.

B. Provider Office shall also indemnify and hold harmless CalOptima and its officers, directors, employees, affiliates, interns, volunteers, and agents from any and all claims, liabilities, demands, costs, and damages of every kind and nature, in law, equity, or otherwise arising out of, or in any way related to, Provider Office's or its users' access to, or use of, or inability to use, the Provider Portal, or the content or materials therein, whether or not arising from any acts or omissions by CalOptima or its officers, directors, employees, affiliates, interns, volunteers, and agents.

For 20210805 BOD Review Only

Back to Agenda

Back To Item

C. The provisions in this Section shall survive any termination of this Agreement.

V. AMENDMENT AND TERMINATION OF AGREEMENT

A. CalOptima has the right to modify this Agreement in its sole discretion and will notify the Provider Office of the modifications by email. Modifications to this Agreement shall be deemed effective and accepted unless the Provider Office notifies CalOptima within thirty (30) calendar days following receipt of said notice with written rejection of the modifications, at which point the Provider Office's and its users' access to the Provider Portal will be terminated.

B. CalOptima may terminate this Agreement and the Provider Office's and its users' access to the Provider Portal at any time without cause and without notice.

VI. NOTICE REGARDING NO LIABILITY OF COUNTY OF ORANGE

The Provider Portal is produced and maintained by CalOptima, which is not a department, agency or otherwise a part of the County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, you acknowledge and agree that any obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and that the County of Orange has no obligation or liability as related to the Provider Portal.

VII. GOVERNING LAW AND VENUE

This Agreement will be governed by and construed in accordance with the laws of the State of California, without reference to its choice of law rules. By accessing, viewing, or using the Provider Portal, or using the materials contained therein, Provider Office consents to the exclusive jurisdiction of the federal and state courts presiding in Orange County, California. Any claim or dispute between Provider Office and CalOptima that arise in whole or in part from this Agreement will be decided exclusively by the foregoing courts. If any part of this Agreement is held to be invalid or unenforceable for any reason by a court of competent jurisdiction, then the remaining parts will remain in full force and effect.

VIII. SEVERABILITY

If any provision of the Agreement is or becomes illegal, invalid or unenforceable, such provision shall be deemed stricken from the Agreement and its illegality, invalidity or unenforceability shall not affect the remainder of the provisions of the Agreement, which shall remain in full force and effect. The parties hereto shall endeavor in good faith negotiations to replace any illegal, invalid or unenforceable provision with a valid, legal and enforceable provision, the economic effect of which comes as close as possible to the economic effect of the illegal, invalid or unenforceable provision.

IX. WAIVER

No delay or omission by a party to exercise any right occurring upon any noncompliance or default by another party with respect to any of the terms of this Agreement shall impair any such right or power or be construed to be a waiver thereof. A waiver by one of the parties of any of the covenants, conditions or agreements to be performed by one of the other parties shall not be construed to be a waiver of any succeeding breach thereof or of any covenant, condition or agreement herein contained.

For 20210805 BOD Review Only

Back to Agenda

Back To Item

X. ASSIGNABILITY

CalOptima may assign its rights and delegate its duties, either in whole or in part, under this Agreement at any time and its sole and absolute discretion, without Provider Office's consent. The Agreement is not assignable by Provider Office, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion.

XI. RELATIONSHIP

This Agreement does not establish any relationship of partnership, joint venture, employment, franchise or agency between Provider Office and CalOptima.

XII. NO THIRD-PARTY BENEFICIARIES

Nothing express or implied in the terms and conditions of this Agreement is intended to confer, nor shall anything herein confer, upon any person or entity other than CalOptima or Provider Office, and their approved respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

XIII. EXECUTION

The persons executing this Agreement on behalf of the parties warrant that they are duly authorized to execute this Agreement and that by executing this Agreement the parties are formally bound.

[SIGNATURES ON FOLLOWING PAGE]

For 20210805 BOD Review Only

Back to Agenda

Back To Item

IN WITNESS WHEREOF, these parties have, by their duly authorized representatives, executed this Agreement on the day and year last shown below.

Provider Office	**CalOptima**
Print Name	Print Name
Signature	Signature
Title	Title
Date	Date

For 20210805 BOD Review Only

Back to Agenda

Back To Item

Policy:	IS.1601
Title:	**In-House Provider Portal Administration and Support (Internal)**
Department:	Information Services
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20210805 BOD Review Only

I. PURPOSE

This Policy defines the standards and procedures pursuant to which CalOptima shall manage access to CalOptima's In-House Provider Portal ("Provider Portal") and implement administrative and technical safeguards to ensure compliance with HIPAA.

II. POLICY

A. The Provider Portal is an information system developed by CalOptima which grants authorized Provider Office Users access to Protected Health Information ("PHI") to carry out Payment and Health Care Operations for CalOptima's eligible Members.

B. CalOptima shall designate certain Staff to perform the duties of an Enterprise Administrator.

C. CalOptima shall limit access to the Provider Portal to those Staff who need to use it to carry out their specific job-related duties.

D. CalOptima shall log and monitor Provider Office User and CalOptima User account activity.

E. CalOptima shall implement physical safeguards to protect PHI and the facilities that house such PHI in accordance with the applicable procedures and requirements in CalOptima Policy GA.4000: Physical Security and Access Controls.

F. CalOptima shall implement Administrative and Technical Safeguards to prevent unauthorized access to PHI and limit all access to Restricted Information.

G. CalOptima shall periodically review physical, Administrative, and Technical Safeguards to ensure such safeguards are consistent with current physical, administrative, and technology standards.

III. PROCEDURE

A. Provider Office and User Account Setup and Validation

Back to Agenda

Back To Item

1. Enterprise Administrators shall review each Provider Office's request for access to the Provider Portal and verify that all the account registration requirements in CalOptima Policy IS.1600: Provider Access to In-House Provider Portal, have been satisfied. If satisfied, the Enterprise Administrator shall:

    a. Submit the Provider Portal Access Agreement completed and signed by the Provider Office to be executed by the person(s) expressly authorized to sign the document on behalf of CalOptima.

        i. The signatory to the Provider Portal Access Agreement shall be the Chief Operating Officer (COO), or an individual who reports directly to the COO and has the delegated authority to sign on his or her behalf. The COO shall remain ultimately responsible for the execution of the Provider Portal Access Agreement and to certify the accuracy of information submitted by the Provider Office to CalOptima.

        ii. The delegated authority to sign the Provider Portal Access Agreement on behalf of CalOptima is limited to situations where no changes have been made to the Provider Portal Access Agreement other than the addition of information regarding the Provider Office and Local Office Administrator that is needed to complete the document.

        iii. Provider Offices shall not revise, nor shall CalOptima staff accept revisions or negotiate any changes to, the terms and conditions in the Provider Portal Access Agreement.

    b. Receive the executed Provider Portal Access Agreement by CalOptima's authorized signatory and grant the designated Local Office Administrator access to the Provider Portal.

2. If there is no designated Local Office Administrator to approve a Provider Office User's account access request, an Enterprise Administrator shall be responsible for approving or denying the access request.

    a. When approving an access request, the Enterprise Administrator shall review a User's job description to determine the appropriate level of access needed and grant the approved Provider Office User with access to one or more of the following user roles, as applicable and necessary for the User to perform his or her specific job-related duties:

        i. Eligibility Viewer: Grants Users access to view Member eligibility.

        ii. Claims Viewer: Grants Users access to view claims submitted by the Provider Office.

        iii. View Referrals: Grants Users access to view referrals submitted by the Provider Office.

        iv. Submit Referrals: Grants Users the ability to submit referrals to CalOptima.

    b. The Enterprise Administrator shall limit access to a Member's PHI to only those Provider Officer Users who need to Use the data to carry out their specific job-related duties related to Payment or Health Care Operations.

    c. The Enterprise Administrator may grant access to Provider Office Users on a specific "need-to-know" basis and shall restrict access to the minimum amount of PHI needed to complete the work activity.

    d. Enterprise Administrators shall be responsible for communicating with Provider Offices and Local Office Administrators regarding account registration and setup, and if a Provider

For 20210805 BOD Review Only

Office does not have a Local Office Administrator, coordinating with the Provider Office for a Local Office Administrator to be designated in a timely manner.

B. Staff Access to Provider Portal

1. Enterprise Administrators shall create accounts for certain Staff and grant access to one or more of the following modules, as applicable and necessary for the Staff member to perform his or her specific job-related duties:

   a. Eligibility Viewer: Grants Staff access to view Member eligibility.

   b. Claims Viewer: Grants Staff access to view all claims.

   c. View Referrals: Grants Staff access to view all referrals.

   d. Admin Module: Grants Staff access to manage Provider Office, Provider Office User, and Staff accounts

2. Staff shall access the Provider Portal through a link granting single sign-on authentication to the Provider Portal through CalOptima's internal private network.

3. Staff will not be able to login to the Provider Portal when their CalOptima internal private access is revoked.

4. Most of the information contained within the Provider Portal is confidential and protected by HIPAA. Staff are authorized to use such information for the sole purpose of carrying out Payment and Health Care Operations. Staff are prohibited from downloading, printing, copying, taking a screen shot of, or forwarding Provider Portal information or documents for purposes other than Payment and Health Care Operations.

5. When a Staff User's role or job-related duty changes, managers or directors must submit a request ticket to IS Help Desk. Upon receipt, Enterprise Administrators shall modify the account access as designated by the manager or director to comply with HIPAA and maintain the Principle of Least Privilege.

6. Enterprise Administrators shall disable Staff access to the Provider Portal, effective on the last day of work or employment at CalOptima, regardless of whether Staff leaves the organization voluntarily or involuntarily. If a Staff member leaves CalOptima but is re-employed at a later date by CalOptima, a new account should be requested and created according to the procedures described in Section III.B of this Policy.

7. Information Services shall document and review Staff access privileges to the Provider Portal on an annual basis pursuant to CalOptima Policy IS.1303: Audit, Review, Testing, and Change Management, unless an earlier or more frequent review becomes warranted by specific circumstances.

C. User Activity Logs

1. Audit logs of Users' actions within the Provider Portal and monitoring reports shall be reviewed daily by authorized Enterprise Administrators. The audit logs and monitoring reports will include:

   a. Users' successful and failed registration attempts.

For 20210805 BOD Review Only

b. Users' successful and failed login attempts.

c. Users' acceptance of and agreement to the CalOptima Provider Portal User Agreement and Terms and Conditions of Use.

d. Users' completion of and attestation to the Provider Portal User Training.

e. Changes to the User access role made by the Local Office Administrator or the Enterprise Administrator, including the date and time of, and reason for, the change.

f. Each page visited by a User containing the date and time of each visit, including when a User:

i. Views a Member record.

ii. Views a claim.

iii. Views a referral.

iv. Submits a referral.

v. Edits their user information.

g. Repeated login activity by a User for less than 20 minutes during a 24-hour period.

h. Dashboard alert when a User has multiple login sessions from different computer or mobile devices.

2. User audit logs and monitoring reports shall be retained according to CalOptima Policy HH.2022Δ: Record Retention and Access.

D. Technical Safeguards

1. The CalOptima Provider Portal Advisory Group, made up of Staff from Privacy, IS Security, Medical Affairs, Operations, and Information Services Application Development, will oversee the governance of which data can be accessible to the Users of the Provider Portal based on User access control roles and will ensure all Restricted Information is suppressed from view within the Provider Portal.

a. CalOptima's Information Services Department shall maintain a list of diagnosis codes, procedure codes, and medications which will be restricted from view within the Provider Portal for all Users, including, but not limited to diagnosis codes, procedure codes, and medications pertaining to family planning, HIV test results, and behavioral health services.

b. On a monthly basis, the CalOptima Provider Portal Advisory Group shall review the list of diagnosis codes, procedure codes, and medications to capture any changes, including additions or deletions, to procedure and/or drug classification codes.

2. All data within the Provider Portal will only be accessible through a secure Application Programming Interface (API) service.

3. The API will use a RESTful Service that neither maintains state information nor stores retrieved data upon such services being requested.

For 20210805 BOD Review Only

4. All access from the member and provider API will only be accessible through the Provider Portal application.

5. The User will be authenticated into the application through a Web Access Management (WAM) system.

6. The API will only allow requests for data from an authenticated User Token provided by the WAM system.

7. Prior to any data being presented to a User, the User Token will be validated against the access role to which the User belongs to ensure the User has the permission to access the data; for example, if the User keys in a claim number that does not belong to their Provider Office, then the system will return an error to the User.

8. The Provider Portal software code will go through regular secure code review and penetration tests to ensure the application is being protected against unwanted malicious cyber-attacks.

    a. Upon completion of a software development iteration, the code will undergo a static analysis scan for secure code vulnerability by an industry leading product.

    b. The results of the static analysis scan will be reviewed by the developer staff, and they will remediate any vulnerabilities, starting with the most critical.

    c. The static analysis scan will complete a full assessment of the code with an audit trail for compliance purposes.

    d. Prior to the first deployment, and on a quarterly basis, or when there is a major technology change, the Provider Portal application will go through a dynamic analysis scan which will simulate a cyber-attack against the software code.

        i. The results of the dynamic analysis scan will be reviewed by the developer staff, and they will remediate any vulnerabilities, starting with the most critical.

        ii. When there are changes to the Provider Portal application, including, but not limited to, major technology changes, the CalOptima Provider Portal Advisory Group shall promptly determine whether such changes necessitate revisions to this Policy, CalOptima Policy IS.1600: Provider Access to In-House Provider Portal, CalOptima Provider Portal User Agreement and Terms and Conditions of Use, Provider Portal User Training, and/or CalOptima Provider Portal Access Agreement and make the necessary revisions.

9. The Provider Portal application's service level is classified as a high available system.

    a. The Provider Portal application is set up to be available to the authorized Provider Office Users up to seven days a week and twenty-four hours a day except for planned maintenance or unplanned outage. To the extent possible, CalOptima shall provide advanced notice on the Provider Portal home page of any planned outages for purposes of maintenance. While CalOptima promotes the use of the Provider Portal, if the system is unavailable, CalOptima has alternative resources to maintain support of information provided through the Provider Portal.

    b. The Provider Portal application resides on a redundant platform, with load balancing, to maintain performance and ensure reliability of the application.

For 2021 0805 BOD Review Only

10. The application data will be backed up in accordance with CalOptima Policy IS.1302: Contingency and Data Backup Plan.

11. In the event of a planned or unplanned outage of the Provider Portal, the Provider Portal home page shall display the following information and instructions:

    a. Notification to Provider Office Users that the Provider Portal is not accessible due to a planned or unplanned outage, whichever is applicable;

    b. Information regarding when the outage will end, or instructions to Provider Office Users to check back periodically to determine whether access to the Provider Portal has been restored; and

    c. Instructions to Provider Office Users to contact the CalOptima Customer Service Department to check for Member eligibility, to contact CalOptima Utilization Management Department for authorization requests, and to contact CalOptima Claims Department for claims status. The contact information and fax information will be displayed on the home page.

E. Verification of Provider User Access to Provider Portal

1. On a monthly basis, CalOptima's e-Business Department shall conduct an audit of a random subset of Provider Office Users to confirm that their access to the Provider Portal is appropriate for their job function within the Provider Office.

    a. In the event CalOptima's e-Business Department finds unauthorized access as a result of its audit, they will disable the applicable User account and notify the Privacy Office to conduct an investigation in accordance with CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI.

2. Every forty-five (45) calendar days, commencing upon the date the Provider Office obtains access to the Provider Portal, each Local Office Administrator will be prompted to verify the Users for their corresponding Provider Office, including each User's employment status, role, and security setting.

3. Any Local Office Administrator who has not completed the User verification within fifteen (15) calendar days of receiving the above-mentioned prompt will be restricted by the Provider Portal system from navigating throughout the application until the verification is complete.

4. The Provider Portal system shall automatically suspend access for every account associated with the Provider Office for failure to complete User verification within sixteen (16) calendar days of receiving the above-mentioned prompt. Each User will be notified upon login attempt that their account has been suspended.

5. To reinstate access to the Provider Portal for all accounts associated with the Provider Office, the Local Office Administrator for the Provider Office shall complete the User verification process, upon which the Provider Portal system will reinstate access to the Provider Portal.

F. Reporting, Responding to, and Investigating Breaches, Security Incidents, Violations, or Noncompliance with the CalOptima Provider Portal User Agreement and Terms and Conditions of Use

1. In the event CalOptima Staff discovers or is made aware of an actual, potential, or suspected Security Incident, Breach, Violation, or noncompliance with the CalOptima Provider Portal

For 20210805 BOD Preview Only

User Agreement and Terms and Conditions of Use, Staff shall take prompt action in compliance with the procedures and requirements in CalOptima Policy IS.1600: Provider Access to In-House Provider Portal, and CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI, including, but not limited to, immediately notifying the CalOptima Privacy Officer or designee by telephone, fax, or email at Privacy@caloptima.org.

G. Provider Portal User Training

1. The Office of Compliance Privacy Department shall review the Provider Portal User Training in accordance with CalOptima's annual policy review schedule and make any necessary revisions to the training.

2. Information Services shall promptly make all necessary revisions to this Policy, CalOptima Policy IS.1600: Provider Access to In-House Provider Portal, CalOptima Provider Portal User Agreement and Terms and Conditions of Use, Provider Portal User Training, and/or CalOptima Provider Portal Access Agreement if any changes to laws, rules, or regulations necessitate revisions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Policy GA.4000: Physical Security and Access Controls
B. CalOptima Policy HH.2022Δ: Record Retention and Access
C. CalOptima Policy HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
D. CalOptima Policy IS.1302: Contingency and Data Backup Plan
E. CalOptima Policy IS.1303: Audit, Review, Testing, and Change Management
F. CalOptima Policy IS.1600: Provider Access to In-House Provider Portal

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
TBD	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	IS.1601	In-House Provider Portal Administration and Support (Internal)	Administrative

For 20210805 BOD Review Only

IX. GLOSSARY

Term	Definition
Access	Has the meaning given such term in Section 164.304 of Title 45, Code of Federal Regulations i.e., the ability or the means necessary to read, write, modify, or communicate data or information or otherwise use any CalOptima system resource.
Administrative Safeguard	Has the meaning given such term in Section 164.304 of Title 45, Code of Federal Regulations. The administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's or business associate's workforce in relation to the protection of that information.
Application Programming Interface (API)	An application programming interface is a computing interface which defines interactions between multiple software intermediaries. It defines the kinds of calls or requests that can be made, how to make them, the data formats that should be used, the conventions.
Breach	The acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of 45 CFR Part 164 which compromises the security or privacy of the Protected Health Information. Breach excludes: (i) Any unintentional acquisition, access, or Use of Protected Health Information by a Provider Office or User, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of 45 CFR Part 164. (ii) Any inadvertent Disclosure by a User to another User authorized to access Protected Health Information at the same Provider Office, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of 45 CFR Part 164. (iii) A Disclosure of Protected Health Information where a Provider Office or User has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.
Corrective Action Plan (CAP)	A plan delineating specific and identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.

For 20210805 BOD Review Only

Term	Definition
Covered Services	Means the following: 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 effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS ("Contract") and are Medically Necessary (as defined in the Contract), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Enterprise Administrator	An access role within Provider Portal designated to CalOptima staff residing in the Information Services, e-Business, or Provider Relations department responsible for: 1. Managing internal and external Provider Portal accounts; 2. Act as a point of contact to Local Office Administrators; and 3. Provide and terminate access to authorized staff for any Provider Office.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with HIPAA.

For 20210805 BOD Review Only

Term	Definition
HIPAA	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, which 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.
In-House	Developed and supported by internal CalOptima staff.
Local Office Administrator	A User at a Provider Office designated to: 1. Control CalOptima Link access; 2. Is the point of contact to CalOptima; and 3. Has the authority to provide and terminate access to authorized staff at the Provider's Office.
Member	A beneficiary enrolled in a CalOptima program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including activities carried out by CalOptima such as: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Principle of Least Privilege	The concept that all Users at all times should run with as few privileges as possible, and also launch applications with as few privileges as possible to perform their work assignments.
Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Provider Office	For the purpose of this policy, a representation of one or more Providers participating in an office or as a group setting.
Provider Portal	CalOptima's information system which enables a Provider and/or a Provider Office and its Workforce to access Member health-related information to assist with Payment and Health Care Operations, not including CalOptima Link.

For 20210805 BOD Review Only

Term	Definition
RESTful Service	A Web service that that conforms to the representational state transfer (REST) software architectural style, a software architectural style that defines a set of constraints to be used for creating Web services. Web services that conform to the REST architectural style provide interoperability between computer systems on the internet.
Restricted Information	Information that requires the highest level of access control and security protection, including, but not limited to, procedure and diagnosis codes related to treatment for HIV/AIDs, sexually transmitted or venereal diseases, family planning services, treatment for substance abuse and mental health issues or certain information related to minors or victims of abuse.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
Staff	Employees of CalOptima who are required to follow policies, procedures, and participate in annual compliance and security trainings.
Technical Safeguards	Has the meaning given such term in Section 164.304 of Title 45, Code of Federal Regulations. The technology, and the policy and procedures for its use, which protect electronic protected health information, and control access to it.
Token	A unique identification encrypted algorithm that creates a single session agreement between the client browser application and the web server application.
User	A person or entity with authorized access to the Provider Portal.
Violation	Violation means, as the context may require, failure to comply with an administrative simplification provision, as defined in 42 CFR Section 160.103.
Web Access Management (WAM)	Web access management is a form of identity management that controls access to web resources, providing authentication management, policy-based authorizations, audit and reporting services and single sign-on convenience. Authentication management is the process of determining a user's identity.
Workforce	For the purposes of this policy, employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of such covered entity or business associate, whether or not they are paid by the covered entity or business associate.

For 20210805 BOD Review Only

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2018-19 Capital Budget for the CalOptima Provider Portal Project

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400

Recommended Action

Authorize reallocation of budgeted but unused funds of $675,000 from Capital Hardware and Software to Capital Professional Fees to fund the CalOptima Provider Portal project through June 30, 2019.

Background

In March 2011, CalOptima contracted with a vendor that provides the current provider portal solution, branded as "CalOptima Link." The current portal has limited functionality and annual licensing and maintenance fees of just over $1.5 million per year. Of the existing functions, such as eligibility verification, submission of authorization requests, provider claim status, and provider roster, the most frequently used by the provider community is eligibility verification.

A project to implement a new and more feature-rich portal has been on the project roadmap since 2013, however, other more business critical projects have taken priority until now. In 2017, Staff formed a workgroup of Care Management and Operations Staff to define business requirements for an improved portal solution.

The project was officially proposed for the CalOptima Fiscal Year (FY) 2018-19 Capital Budget and was ultimately approved at the Board meeting of June 7, 2018. The project was defined to deliver a new provider portal solution - either a vendor-provided solution or an in-house custom developed solution.

Research was completed by Information Services Staff to determine the availability of commercially available solutions that could be purchased to satisfy CalOptima's business requirements. The research consisted of (a) surveying the other Medi-Cal Health Plans to learn about their provider portal solutions; (b) attendance at presentations conducted by some portal vendors in use by the other Medi-Cal plans at the monthly Chief Information Officer meetings with those Plans; and (c) consulting the CalOptima-contracted technology research vendor, Gartner, for information regarding trends in the industry, pros and cons of many vendor solutions, and specific intelligence about how other Med-Cal and Commercial Health Plans are implementing portal solutions across the United States.

It became clear that no commercially available solution would satisfy all the defined CalOptima business requirements with reasonable costs for licensing, maintenance, and custom development/enhancements. An internally developed solution will incur lower recurring costs and will operate on primarily existing hardware and use primarily existing software development tools.

Back to Agenda

Back To Item

Additionally, internal software development work for the CalOptima Member Portal and the CalOptima.org public website is already completed (yet ongoing) and economies of scale for common features can be realized. Therefore, the decision was made to implement an in-house custom developed solution.

As a result, staff is recommending that the Board authorize that funding from the approved FY 2018-19 hardware and software capital budget be shifted to professional fees.

Discussion
The CalOptima FY 2018-19 Capital Budget was approved by the CalOptima Board of Directors on June 7, 2018. The budget for the provider portal solution included hardware expenses of $50,000, software expenses of $700,000, and professional fees expenses of $300,000, totaling $1,050,000.

To complete this software development work internally, the expenses require shifting. Management proposes to make a reallocation of budgeted funds of $675,000, to reflect that less hardware and software will be needed. Specifically, Management recommends:

- Reallocation of $25,000 from Capital Hardware to Capital Professional Fees; and
- Reallocation of $650,000 from Capital Software to Capital Professional Fees.

The reallocation to Capital Professional Fees will provide funding for additional temporary labor to develop the software for the provider portal solution internally. While additional resources will be necessary for some of the design, development, testing and quality assurance of the new software, it is not anticipated that these resources will be required long term, rather only for a portion of Calendar Year 2019. At this time, staff has estimated three to four temporary resources at approximately $90.00 to $150.00 per hour, depending on skillset. The total expenses for the project will remain unchanged at $1,050,000, with no additional funds requested.

Fiscal Impact
The fiscal impact for this recommended action is budget neutral.

Concurrence
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader — *10/24/2018*
Authorized Signature — **Date**

Back to Agenda

Back To Item

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Medecision	500 N. Akard Street Suite 1400	Dallas	TX	75201

Back to Agenda

Back To Item

Policy #:	EE.1140
Title:	**CalOptima Link Non-Compliance**
Department:	eBusiness
Section:	Not Applicable
CEO Approval:	*/s/ Michael Schrader*
Effective Date:	11/01/2013
Revised Date:	05/01/2019

I. PURPOSE

This policy establishes the process by which CalOptima shall address a **User's** failure to comply with CalOptima Link and CalOptima Link's On-Line Access Authorization Form.

II. POLICY

A. CalOptima Link is CalOptima's online web portal that is available to **Provider** offices by visiting www.caloptima.org.

B. CalOptima On-Line Access Authorization Form contains the terms and conditions for use of CalOptima Link for **Provider** offices and authorized staff. CalOptima Link shall enable **Provider** offices and authorized staff to the following, including but not limited to:

1. Verify **Member** eligibility;
2. Submit a **Member's** referral;
3. View claims and referral status; and
4. View a **Member's** health data.

C. **Providers** shall recommend certain staff from their office to request a CalOptima Link **User** account.

D. To request a CalOptima Link **User** account, a **Provider** and/or authorized staff must:

1. Register to CalOptima Link by visiting www.caloptima.org;
2. Request a **User** account and **Password**; and
3. Agree to the requirements set forth on the CalOptima On-Line Access Authorization Form.

E. If a CalOptima Link **User** requires resetting their **Password**, they may do so by answering a security question on the web portal login page or by calling CalOptima Link's support line.

F. CalOptima prohibits the sharing of CalOptima Link **User** accounts and **Passwords**, and considers such activities a breach of CalOptima Link's On-Line Access Authorization Form's terms and conditions.

G. CalOptima eBusiness Department shall monitor usage of CalOptima Link through the following activities:

1. On a quarterly basis, send reminder emails to **Site Administrators** to verify staff **User Access** and terminate **User Access** for staff who are no longer employed or whose job responsibility no longer requires **Access** to CalOptima Link;

Back to Agenda

Back To Item

2. On a monthly basis, call twenty (20) random **Users** from different **Provider** offices to confirm CalOptima Link **User Access** of those who recently submitted a referral, or reviewed **Member** eligibility, and confirm the **User**:

    a. Is the person on the submitted authorization; and

    b. Knows the office **Site Administrator(s)**.

H. CalOptima eBusiness Department shall regularly monitor the **Provider User** list located on the CalOptima Link site, to ensure accuracy and prevent misuse.

I. CalOptima shall investigate **Provider** offices regarding any reported or potential security or privacy incident, as defined in Section III.A. of this Policy, involving CalOptima Link.

1. If misuse or a security and/or privacy incident is confirmed by the CalOptima eBusiness Department, all case information shall be immediately reported to CalOptima Office of Compliance for further action, as appropriate.

J. CalOptima Office of Compliance and eBusiness Departments shall enforce corrective action(s) involving CalOptima Link non-compliance, such as notifying the Privacy and Security Officer, as applicable, when a security or privacy incident occurs that may give rise to potential liability under federal or state privacy laws, such as the **Health Insurance Portability and Accountability Act (HIPAA)**. If the Privacy and/or Security Officer deems appropriate, they may conduct an investigation into the incident, and if necessary, request a **Corrective Action Plan (CAP)**.

III. PROCEDURE

A. Identification of first CalOptima Link non-compliance violation

1. Upon identification and confirmation of misuse of CalOptima Link, the eBusiness Department shall deactivate the **User** account that is in non-compliance on the day that the incident is discovered and shall notify the **User** and **Site Administrator(s)** of the deactivation via email.

2. Misuse of CalOptima Link include, but are not limited, to the following:

    a. Inappropriate sharing of CalOptima Link **User** accounts and **Passwords**;

    b. Failure to notify CalOptima of changes in **Site Administrator(s)** at a **Provider** office;

    c. Unauthorized usage of information such as **Protected Health Information (PHI)**; and

    d. **Health Insurance Portability and Accountability Act (HIPAA)** violations.

3. On a weekly basis, the eBusiness Department shall monitor the **Provider User** list to ensure that the deactivated **User** is not able to activate or create a new account with a different Username. The **User** must complete their training to regain **Access** to reactive their CalOptima Link **User** account.

4. The Office of Compliance shall send, via U.S. mail or email, a letter with instructions regarding how to reactivate the CalOptima Link **User** account.

5. CalOptima shall reactivate the CalOptima Link **User** account, upon the **User** completing the following:

a. The **User** and **Site Administrator(s)** must attend and complete an in-house training at the **Provider's** office or complete an over-the-phone CalOptima Link security training course;

b. The **User** and **Site Administrator(s)** must sign and submit the Attestation of Training Completion Form to CalOptima's eBusiness Department, and CalOptima's eBusiness Department shall submit the Attestation of Training Completion Form to CalOptima's Office of Compliance; and

c. The **User's Provider** office must submit a **CAP** to the Office of Compliance, in accordance with CalOptima Policy HH.2005Δ: Corrective Action Plan, outlining the appropriate steps the **Provider** office shall take to educate staff and prevent future issues.

i. The Office of Compliance shall notify eBusiness Department once the **CAP** has been received.

6. The Office of Compliance shall notify the eBusiness Department and the **Provider** office of the **CAP** decision.

7. Upon **User** completion of the training, the eBusiness Department shall reactivate the CalOptima Link **User** account and inform the **Provider** office.

8. CalOptima may terminate CalOptima Link **Access** for the **User** or the entire **Provider** office if the **Provider** office fails to complete the training or submit a **CAP**. CalOptima Link **Access** shall be reinstated as deemed appropriate by CalOptima.

B. Identification of second CalOptima Link non-compliance violation

1. Upon identification and confirmation of misuse of CalOptima Link, the eBusiness Department shall deactivate the **User** account that is in non-compliance on the day that the incident is discovered and shall notify the **User** and **Site Administrator(s)** of the deactivation via email.

2. Upon a second non-compliance violation, the **User** shall receive an account suspension for a minimum of thirty (30) calendar days.

3. On a weekly basis, the eBusiness Department shall monitor the **Provider User** list to ensure that the deactivated **User** is not able to activate or create a new account with a different **User**name. The **User** must complete their training to regain **Access** to reactive their CalOptima Link **User** account.

4. The CalOptima Office of Compliance shall send, via U.S. mail or email, a letter with instructions regarding how to reactivate the CalOptima Link **User** account.

5. CalOptima shall reactivate the CalOptima Link **User** account, upon the **User** completing the following:

a. The **User** and **Site Administrator(s)** must attend and complete an in-house training at the **Provider's** office or complete an over-the-phone CalOptima Link security training course;

b. The **User** and **Site Administrator(s)** must sign and submit the Attestation of Training Completion Form to the eBusiness Department, and CalOptima's eBusiness Department shall submit the Attestation of Training Completion Form to the Office of Compliance; and

c. The **User's Provider** office must submit a **CAP** within thirty (30) days to the Office of Compliance outlining the appropriate steps the **Provider** office shall take to educate staff and prevent future issues.

i. The Office of Compliance shall notify the eBusiness Department once the **CAP** has been received.

6. The Office of Compliance shall notify the eBusiness Department and the **Provider** office of the **CAP** decision.

7. Upon **User** completion of the training, the eBusiness Department shall reactivate the CalOptima Link **User** account and inform the **Provider** office.

8. CalOptima may terminate CalOptima Link **Access** for the **User** or the entire **Provider** office if the **Provider** office fails to complete the training or submit a **CAP**. CalOptima Link **Access** shall be reinstated as deemed appropriate by CalOptima.

C. Upon a third non-compliance violation and/or the **Provider** office fails to respond to the non-compliance incident within thirty (30) calendar days, CalOptima may terminate **Access** for the **User** or the entire office. CalOptima Link **Access** shall be reinstated as deemed appropriate by CalOptima.

IV. ATTACHMENT(S)

A. CalOptima Link On-Line Access Authorization Form
B. CalOptima Link Security Training Course
C. Attestation of Training Completion

V. REFERENCES

A. CalOptima Link User Agreement
B. CalOptima Policy HH.2005Δ: Corrective Action Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2013	EE.1140	CalOptima Link Non-Compliance	Medi-Cal
Revised	06/01/2016	EE.1140	CalOptima Link Non-Compliance	Medi-Cal
Revised	04/01/2017	EE.1140	CalOptima Link Non-Compliance	Medi-Cal
Revised	06/01/2018	EE.1140	CalOptima Link Non-Compliance	Medi-Cal
Revised	05/01/2019	EE.1140	CalOptima Link Non-Compliance	Medi-Cal

Back to Agenda

Back To Item

IX. GLOSSARY

Term	Definition
Access	The ability or the means necessary to read, write, modify, or communicate data or information or otherwise use any CalOptima system resource.
Corrective Action Plan (CAP)	A plan delineating specific and identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the State, or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy, and security of health information, and as subsequently amended.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Password	Confidential authentication information composed of a string of characters or any secret string of characters that serves to authenticate a person's identity, and is used to grant or deny access.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. This information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of the Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Site Administrator	A User at the Provider's office designated to: 1. Control CalOptima Link access; 2. Is the point of contact to CalOptima; and 3. Has the authority to provide and terminate access to authorized staff at the Provider's office.
User	For the purposes of this policy, anyone who has a CalOptima Link user account and password, and whose job responsibility requires him or her to use CalOptima Link.

Back to Agenda

Back To Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Ratification of Contract with Hunn Group, LLC and Authorization of Related Unbudgeted Expenditures

Contact

Richard Sanchez, Chief Executive Officer, (657) 900-1481

Recommended Action

1. Ratify contract with Hunn Group, LLC for organizational leadership consulting services; and
2. Authorize unbudgeted expenditures from existing reserves not to exceed $225,000 to fund this engagement.

Background/Discussion

CalOptima is currently focused on several high-priority and time sensitive issues, including, but not limited to, California Advancing and Innovating Medi-Cal (CalAIM) implementation and a Centers for Medicaid & Medicare Services (CMS) Program Audit of OneCare and OneCare Connect. While these issues are occurring, there have been several staffing changes at the executive level. Therefore, the need for organizational leadership consulting services was identified as a path to successfully dealing with the issues described, support effective on-boarding of new leadership and enhancement of operational efficiencies.

Given the timeliness of the need, an appropriate consultant was identified as having the necessary unique skill set to begin work immediately. Established in 2014, Hunn Group, LLC is a health care advisory firm poised to assist CalOptima with successful execution of its various initiatives in the coming months. CalOptima staff executed a contract with Hunn Group, LLC in July 2021, which will terminate on June 30, 2022. Hunn Group, LLC will initially focus on evaluating CalOptima's organizational structure and providing management support as CalOptima moves forward to implement major initiatives such as CalAIM and those mentioned above in the coming months. As the Board is aware, in July 2021, CalOptima was engaged with CMS on a Program Audit. Should findings result from that audit, Hunn Group, LLC will assist with any CMS-mandated remediation.

Regarding CalAIM, CalOptima is transitioning from approach development to operationalizing the approach. As CalOptima awaits feedback from the Department of Health Care Services on its proposed approach, Hunn Group, LLC will augment staff resources to ensure CalOptima is fully prepared for implementation beginning on January 1, 2022.

Fiscal Impact

The recommended actions to ratify a contract with Hunn Group, LLC for organizational leadership consulting services and authorize related expenditures are unbudgeted. An appropriation of up to $225,000 from existing reserves will fund the recommended actions.

Back to Agenda

Rationale for Recommendation

The recommended actions will provide additional support to ensure CalOptima's anticipated successful results in implementing CalAIM, successfully concluding the CMS audit and moving forward with a successful strategy in onboarding new leadership and implementing operational efficiencies.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Contract No. 22-10029 Between CalOptima and Hunn Group, LLC

/s/ Richard Sanchez — *07/28/2021*

Authorized Signature — **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Hunn Group, LLC	29632 Teracina	Laguna Niguel	CA	92677

Back to Agenda Back to Item

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CONTRACT NO. 22-10029
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
HUNN GROUP, LLC
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of the date last signed below, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Hunn Group, a Limited Liability Company (LLC), hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide Organizational Leadership Consulting, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

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

D. CONTRACTOR desires to perform these services for CalOptima; and

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

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto; and (ii) CONTRACTOR's proposal dated 6/29/2021. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. CONTRACTOR shall also perform in accordance with its Proposal dated 6/29/2021.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in

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this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

Name	Function/Title
Michael F. Hunn	President

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 RESERVED

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 RESERVED

a) RESERVED

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

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Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

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

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

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3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

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

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other

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amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

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

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harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further

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understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.5 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 CONTRACTOR and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, 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. CONTRACTOR and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its Subcontractors' obligation 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.

12.2 CONTRACTOR and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

12.3 CONTRACTOR and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

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12.4 CONTRACTOR and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 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.

12.5 CONTRACTOR and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

12.7 CONTRACTOR and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

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13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified, and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

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14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR agrees to abide by the terms of the CalOptima Travel Policy, attached hereto as Exhibit C, and incorporated herein by this reference.

15. Term. This Contract shall commence on the date last signed below, and shall continue in full force and effect through 06/30/2022, unless earlier terminated as provided in this Contract.

16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

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

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

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

16.2.3 In the event of Termination for Unavailability of Funds, as provided in this Section, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify CONTRACTOR in writing and CalOptima shall have the right to reinstate this Contract

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for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise), and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services, and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

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

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also

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apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance

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Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority,

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information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

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

23. Business Associate Protected Health Information Disclosure Agreement. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

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24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Medicare Advantage Program. Medicare Advantage Program requirements are not applicable under this Contract.

26. Time is of the Essence. Time is of the essence in performance of this Contract.

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

28. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

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

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

31. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
Hunn Group, LLC	CalOptima
29632 Teracina	505 City Parkway West
Laguna Niguel, CA 92677	Orange, CA 92868
Attention: Michael F. Hunn	Attention: Ryan Prest

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

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

33. Unavoidable Delays.

33.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

33.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

33.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

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

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

36. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

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

38. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall

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be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

39. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

40. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

41. Debarment and Suspension Certification.

41.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

41.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

41.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

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

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41.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 41.2.2 herein;

41.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

41.2.5 Have not and shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

41.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

41.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

41.4 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

41.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

42. Lobbying Restrictions and Disclosure Certification.

42.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

42.2 Certification and Disclosure Requirements.

42.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 42.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

42.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") 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 42.3 of this provision if paid for with appropriated funds.

42.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 42.2.2herein. An event that materially affects the accuracy of the information reported includes:

42.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

42.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

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42.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

42.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 42.2.1of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

42.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 42.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

42.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions, the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

43. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 et seq.), as amended.

44. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

45. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

46. Third Party Beneficiaries. There are no intended third party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

47. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

48. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

49. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 22-10029 on the day and year last shown below.

Hunn Group LLC	CalOptima
By:	By: DocuSigned by: Richard Sanchez 234AD421BDEC4D9...
Print Name: Michael F. Hunn	Print Name: Richard Sanchez
Title: President	Title: CEO, CalOptima
Date: 07.12.21	Date: 07/13/2021

By: NA	By:
Print Name:	Print Name:
Title:	Title:
Date:	Date:

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

Exhibit A

SCOPE OF WORK

OBJECTIVE

Consultant to complete an analysis of CalOptima's organizational structure and provide recommendations to streamline efficiencies.

SCOPE OF WORK

1. SERVICES
   a) Review CalOptima's organizational structure including the review of hiring processes.
   b) Through the above assessment, develop a plan for leadership development and establish leadership deliverables.
   c) Identify near-term and long-term leadership and operations planning support for CalOptima CEO
   d) Provide as-needed assistance to support special projects e.g. 2021 CMS Audit and subsequent Corrective Action Plans (CAPs)
   e) Initiate CEO and Leadership Weekly Management Operations Reviews that include Work Plan Development with clear action times.

2. DELIVERABLES
   a) Organizational Structure Report (Final Report Due September 30)
      i. Recommendations regarding organizational leadership structure
      ii. Implementation Approach
      iii. Recommendations regarding streamlining hiring processes.
   b) Leadership Team Analysis (Due September 30)
      i. Evaluate all current key leadership roles and any potential future roles
      ii. Establish key deliverables for each leadership role
   c) Management Operations Reviews (on-going)
      i. Develop Agenda's and facilitate weekly reviews with the CEO and leadership team, focusing on Work Plan Development with clear action plans.

3. ESTIMATED HOURS/WEEK:
   Estimated Hours: approximately 24-30 hours/week depending on requested services
   E.g. 2a) 6-8 hrs/week; 2b) 6-8 hrs/week; 2c) 6-8 hrs/week)

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Exhibit B

PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

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

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 22-10029; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed Two Hundred Twenty-Five Thousand Dollars ($225,000.00) including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, costs arising from or due to termination of this Contract, and any applicable travel expenses. Contract agrees to monitor this amount and shall not incur fees in excess of the maximum obligation without a signed Amendment between both Parties.

E. CONTRACTOR's hourly billable rate shall be Two Hundred Seventy-Five Dollars ($275.00) per hour. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

F. CONTRACTOR shall also invoice CalOptima on a monthly basis for travel-related expenses. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. CalOptima shall not pay CONTRACTOR for time spent traveling.

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Exhibit B-1

Not applicable for this Contract

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Exhibit C

CalOptima Travel Policy

CalOptima
A Public Agency
Better. Together.

Policy #:	GA.5004		
Title:	**Travel Policy**		
Department:	Finance		
Section:	Purchasing		
CEO Approval:		Michael Schrader	MS
Effective Date:	8/1/12	Revised: 9/6/12, 3/1/13	
Board Approval:	9/6/12		

I. PURPOSE

To establish a process for reasonable and equitable reimbursement of approved travel and other related expenses incurred by CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants while traveling on authorized CalOptima Business.

II. POLICY

A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.

B. CalOptima shall provide an expense reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel expenses and miscellaneous expenses incurred by authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal regulations.

C. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible.

1. Travel Expenses shall include the following items:

   a. Transportation: including commercial carriers, rental vehicles, and mileage for use of personal vehicle;

   b. Lodging;

   c. Meals;

   d. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

   e. Insurance for rental vehicles;

   f. Parking fees and tolls fees (i.e., toll roads and necessary parking);

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g. Miscellaneous expenses including:

i. Authorized local and long-distance telephone calls;

ii. Baggage fees;

iii. Internet or Wi-Fi charges;

iv. Facsimiles;

v. Expenses in connection with the preparation of authorized company reports or correspondence;

vi. Taxi or public transit fares, required to conduct business; and

vii. Other unforeseen or unusual expenses that are properly justified and substantiated.

D. Board Member/Standing Committee Member Travel

1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.

a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

i. CalOptima business-related activities;

ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

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Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

1. Attendance at any given conference and/or seminar shall be:

   a. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

   b. Approved by Human Resources.

2. Payment of Fees

   a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

   b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

1. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

2. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

   a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

      i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

ii. The authorized Individual elects to pay for the meals of individuals with whom authorized CalOptima Business was conducted; or

iii. Extraordinary circumstances may cause it to be impractical or unfeasible for the authorized Individual to stay within the established meal rates, and the authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

iv. Expense reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her designee.

b. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses, as stipulated in this policy. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member meal reimbursement rate.

3. CalOptima shall reimburse for Business Meals at actual reasonable and necessary expenses for refreshments or meals, excluding alcoholic beverages, provided in conjunction with on-site or off-site meetings (e.g., in-house developed formal training sessions, conferences, seminars, workshops, staff meetings, and board and commission meetings) which extend over normal breaks or meal periods. An Expense Report for Business Meals must include receipt, names of those in attendance, and the business topic.

H. Lodging Expenses

1. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-Local Travel.

2. Adequate lodging expenses will be allowed. Price is an issue in selecting "adequate lodging". Prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged; booking through online travel Websites, as opposed to directly with the lodging facility, might provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

3. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) Website; www.gsa.gov.

4. CalOptima may reimburse additional lodging expenses for Non-Local Travel if:

a. It results in offsetting lower airfare; and

b. The cost of returning to home or office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

5. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

a. It is not practical or feasible for the authorized Individual to return home due to extremely poor weather conditions; or

b. Less than eight (8) hours will elapse from the time business is concluded on one (1) day and the time business is scheduled to reconvene on the following calendar day; or

c. It is not practical or feasible for the authorized Individual to return home due to an extended commute.

6. Once approved, the Individual or his or her designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Purchasing Department.

7. The Individual shall be responsible for necessary cancellation of travel and lodging reservations, in accordance with the respective rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any cancellations.

I. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for Travel Expenses.

2. The Executive Management team shall approve cash advances for anticipated authorized travel.

3. CalOptima may authorize cash advances on a limited basis if the traveling Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized Travel Expenses, as defined in this policy.

4. When authorized, cash advances shall be based on an estimate of reasonable Travel Expenses, including travel, meals, lodging and miscellaneous expenses.

5. Individuals receiving cash advances shall complete an Expense Report within five (5) business days of the Individual's return to home or place of work, whichever occurs first. The Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate any cash amounts due back to CalOptima, in the event the cash advance was greater than actual authorized expenses, or cash amounts due the Individual, in the event actual authorized expenses exceed the amount of the cash advance.

J. Transportation

1. The mode of transportation shall be based on the distance of the final destination from the Individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of transportation.

2. Cost of arrangements for personal travel in conjunction with a business travel itinerary will be at the authorized Individual's expense. The Individual shall document the incremental travel costs assessed to CalOptima, in accordance with this policy.

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

3. The Individual shall make transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of transportation. A Saturday night stay may be required to obtain the lowest possible rate, and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

   a. Flight arrangements made through CalOptima's travel services provider shall be reviewed by CalOptima's Purchasing Department, and submitted directly to Accounts Payable for payment.

   b. Flight arrangements not made through the CalOptima travel services provider shall be submitted by the Individual on an Expense Report.

   c. Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance by the CEO. An Individual shall pay any increase in transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time, but shall be charged to the appropriate type of leave.

   d. Additional expenses shall not be the responsibility of the Individual if, through no fault or control of the Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time, and shall not be charged to any type of leave.

   e. Whenever available, all Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved.

   f. Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

   g. Any deviation from lowest available rate for commercial carriers shall be at the Individual's expense.

4. The Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carrier rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established carrier rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any such cancellations.

5. Use of Privately-Owned Vehicles

   a. An authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The Individual must be licensed, and shall carry liability insurance as required by the State of California, at the Individual's sole expense.

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

b. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate. Total mileage reimbursed should consider the Individual's daily commute.

c. CalOptima shall not reimburse costs for fuel, automobile repairs, or other automobile expense items.

d. If more than one authorized Individual is traveling for CalOptima Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

e. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

f. CalOptima shall compensate property damages to an Individual's automobile incurred without fault or cause on the part of the Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the Individual's insurance policy, whichever is the lesser amount, for each accident.

6. Rental Automobiles

a. An Individual may rent automobile when such rental is considered to be more advantageous to CalOptima than other means of transportation.

b. Advance reservations shall be made whenever possible. Reservations for employees, Board and Committee members shall be made in the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

c. The vehicle rental agreement for the authorized Individual shall reference the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

d. Rental automobile approved classes are as follows:

i. Economy Class: An Individual shall select an economy class vehicle whenever four (4) or fewer individuals, including the driver, will be passengers in the rental automobile at any one time.

ii. Mid-size Class: An Individual may select a mid-size class vehicle in the event more than four (4) individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure.

iii. Luxury Class: Under no circumstances shall an Individual select a luxury class vehicle.

7. Other Modes of Transportation

a. Taxi Fares: CalOptima shall reimburse taxi fares when public transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

III. PROCEDURE

A. Travel and Training Authorization Form

1. Shall be accessed and completed on-line by all Individuals or their designee using CalOptima's Intranet system (or similar system in place at the time request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Shall be routed for approval systemically based on the Individual's level, cost center, and whether they are a CalOptima employee according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

3. Shall also be routed systemically to the Human Resources Department in order to track the Individual's training.

4. Shall also be routed systemically to the Finance Department for confirmation that requested expenses are budgeted, and that enough budget remains to cover requested expenses.

5. Requestors shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

6. The Purchasing Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel commitments.

B. Travel and Training Arrangements

1. Authorizations that include event registration fees shall be pre-paid and processed by CalOptima's Purchasing Department, where possible. CalOptima's Purchasing Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Individual for the event.

2. The requestor, or his or her designee, shall make air travel arrangements through CalOptima's travel services provider, where possible. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima's travel services provider are subject to approval by CalOptima's Purchasing Department.

3. All other arrangements shall be made with the Individual's personal credit card, either through CalOptima's travel services provider, another approved method, or directly with the establishment(s), subject to CalOptima's Purchasing Department approval.

C. Expense Reimbursement using Expense Report

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

1. Individuals or designees shall prepare and submit request claims for reimbursement of Travel Expenses on a CalOptima Expense Report. The report shall be completed by the Individual or designee, including all details, and shall be routed with a copy of the previously-approved Travel and Training Authorization Form for appropriate Expense Report approval signatures, if applicable, as follows:

Individual	**Approver**
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee*
CEO	Board Chairperson or designee*
Board Member/Standing Committee Member	Board Chairperson, CEO or designee*

*Designee authorization is not valid when self approval would result.

2. Receipts

   a. For any expenses in excess of twenty-five dollars ($25.00), the Individual shall include an original credit card receipt, if available, or other computer-generated or hand-written receipt, in the event a credit card receipt is unavailable. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure.

   b. Small receipts, such as credit card, gas and airline receipts, shall be attached to an 8 ½ by 11 inch sheet of paper. Hotel receipts and other larger receipts may be submitted as is.

   c. In the absence of credit card receipts, or other proof of actual expenditure, CalOptima shall reimburse lodging expenses only if marked "paid" by the management of the lodging facility.

   d. In most instances, airfare for CalOptima employees and Board members shall be prepaid by CalOptima. CalOptima contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit passenger receipts for reimbursement consideration.

   e. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima shall not allow the amount.

3. Completed and approved Expense Reports and supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel.

4. No reimbursement shall be made for Expense Reports submitted beyond six (6) months after completion of travel.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

2. Code expenses to appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The Purchasing Department shall:

1. Provide travel reports to the CEO, Executive Management, and Department Directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event, and may be required to distinguish between budgeted and non-budgeted travel.

2. Review details of statements/invoices received from the CalOptima travel services provider for accuracy and reasonableness;

3. Attach appropriate copies of completed Travel and Training Authorization Forms related to travel service provider invoice line items, and submit to Accounts Payable for payment.

4. Review details of statements/invoices received from credit card account used by Purchasing to arrange attendance at conferences, training, and other events, and to make authorized purchases.

5. Attach appropriate copies of completed Travel and Training Authorization Forms related to credit card invoice travel and training line items, and submit to Accounts Payable for payment.

IV. ATTACHMENTS

A. Electronic Travel and Training Authorization Form
B. CalOptima Expense Report
C. Cash Advance Form

V. REFERENCES

A. Internal Revenue Service Publication 463
B. California Government Code Section 53232.2
C. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994

VI. APPROVALS OR BOARD ACTION

9/6/12: CalOptima Regular Board Meeting

VII. REVISION HISTORY

A. 9/6/12: GA.5004: Travel Policy
B. 8/1/12: GA.5004: Travel Policy

VIII. KEYWORDS

Approved Lodging
CalOptima Business
Executive Management

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

Expense Report
Individual
Local Travel
Lodging
Meals
Miscellaneous Expenses
Non-Local Travel
Non-Reimbursable Expenses
Parking, Fees and Tolls
Registration Fees
Reimbursable Expenses
Transportation
Travel
Travel and Training Authorization Form
Travel Expenses

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

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

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

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

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: _____ Date: 07.12.21

Print Name: Michael Hunn

Title: President

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

Exhibit E
Part 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

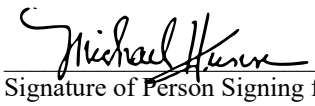
The undersigned certifies, to the best of his or her knowledge and belief, that :

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

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

HUNN GROUP LLC	Michael Hunn, President - HUNN GROUP LLC
Name of Contractor	Printed Name of Person Signing for Contractor
22-10029	
Contract/Grant Number	Signature of Person Signing for Contractor
07.12.21	President
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

Exhibit E

Part 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 NA ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	☐a. bid/offer/application NA ☐b. initial award ☐c. post-award	☐a. initial filing NA ☐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 Entity (*If individual, last name, first name, MI*):	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): *(attach Continuation Sheet(s) SF-LLLA, if necessary)*
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____
12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value_____	
14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: *(Attach Continuation Sheet(s) SF-LLL-A, If necessary)*	
15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No	
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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Exhibit E

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

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Exhibit F

Not applicable for this Contract

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

Exhibit G

Not applicable for this Contract

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

Exhibit H

Not applicable for this Contract

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: HUNN GROUP LLC

Business Entity Type: Sole Proprietor - LLC - State of California
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: 29632 Teracina

City: Laguna Niguel State: CA Zip: 96277

Business Phone: 714-272-9639 Email: : mhunn@hunngroup.com

President: Michael Hunn Contact Person: Michael Hunn

Person(s) Signing Contract & Title: : Michael Hunn - President

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
Michael F. Hunn	*President / Sole Owner / 100% (No Debt or Loans)*

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

Authorized Signature 07.12.21
Date

Michael Hunn, President - HUNN GROUP LLC
Name and Title

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Exhibit J

Not applicable for this Contract

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

Exhibit K

Not applicable for this Contract

DocuSign Envelope ID: 70E54CD5-9470-4CA6-A321-38B1B4487DC5

Exhibit L

Not applicable for this Contract

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing a Diabetes Mellitus (DM) Pilot Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetes

Contacts

Emily Fonda, Chief Medical Officer (714) 246-8887
Marie Jeannis, Executive Director, Quality & Population Health Management (714) 246-8591

Recommended Actions

1. Authorize implementation of a two-year pilot Multidisciplinary Approach to Improving Care for CalOptima Community Network (CCN) Medi-Cal members with Poorly Controlled Diabetes ;
2. Authorize up to $8.2 million in unbudgeted expenditures from reserves for the DM program; and
3. Subject to Department of Health Care Services (DHCS) approval, authorize the CEO, with the assistance of Legal Counsel, to contract with a vendor selected through the Request for Proposal (RFP) process to provide fresh produce delivery services as part of the DM program.

Background

Diabetes is a disease caused by too much sugar in the blood that requires a primary care provider's (PCP's) comprehensive care. When diabetes is not managed, it can damage vital organs and lead to various complications. Based on the Centers for Disease Control and Prevention's 2017 data[1], diabetes is the most expensive chronic condition in the United States, and the total annual cost spent on diabetes was $327 billion.

The high cost of diabetes is not just our nation's story; CalOptima is also seeing the high cost of diabetes for our CCN Medi-Cal members. Based on claims data from July 2019 through June 2020, CalOptima observed that approximately $247 million was spent on diabetic care (refer to Attachment 1). In addition to the enormous total cost, the average annual cost per diabetic member was $20,334, which is approximately four times higher than non-diabetic members' average annual cost.

Food insecurity is "a lack of consistent access to enough food for an active, healthy life and it's an issue that touches people of all ages with all types of diabetes[2]." According to the American Diabetes Association, diabetics with food insecurity have a higher risk of developing complications. Diabetes is a complex and challenging disease for members, as well as for their families and society at large. To reduce the risk of complications of diabetes, members need to learn about this complex disease and incorporate a variety of self-management behaviors into their daily lives. In order to better assist this population and facilitate PCP care, CalOptima staff proposes to offer a multidisciplinary approach to assist managing CCN Medi-Cal members with poorly controlled diabetes and their complex treatment regimens. The anticipated start date for the DM program is by the fourth quarter of 2021. The goals of this new DM program are: 1) lower HbA1c level to avoid complications; 2) reduce emergency department (ED) visits; 3) reduce hospitalization rates; 4) reduce costs for diabetic medications; 5) improve member and provider satisfaction; and 6) optimize diabetes medication management during the transition to Medi-Cal Rx. This new DM program is proposed in CalOptima's 2021 Quality Improvement (QI) Program. Through the QI

[1] https://www.cdc.gov/chronicdisease/programs-impact/pop/diabetes.htm
[2] https://www.diabetes.org/healthy-living/recipes-nutrition/food-insecurity-diabetes

Back to Agenda

Program, CalOptima aims to continuously improve the structure, processes, and outcomes of its health care delivery system to serve our members.

Discussion

Pharmacist Involvement and Intervention

Literature shows that pharmacists involved in diabetes care and management play a pivotal role in helping members achieve healthier lifestyle goals. This active participation in diabetes care and management requires that the CalOptima pharmacist's role extends to include individual member outreach and provider consultations. CalOptima staff believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dieticians/case managers. With this new DM program, CalOptima proposes to hire two Clinical Pharmacists to provide various interventions to optimize medical management. The estimated salary and benefit expenses for the two-year pilot period is $854,968.

Health Coach/Registered Dietician Intervention

CalOptima's Population Health Management department's Health Coaches have been providing chronic condition management and coaching for members. With the new multidisciplinary approach, CalOptima proposes to hire two Health Coaches to provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dieticians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. The estimated salary and benefit expenses for the two-year pilot period is $509,342.

Member Health Rewards Program

Subject to DHCS approval, staff proposes supporting member engagement and compliance by providing members with member health rewards (non- monetary incentives). The non-monetary incentives will be provided as gift cards subjected to DHCS approval.

Based on claims data, staff identified poorly controlled diabetic CCN Medi-Cal members as follows:

- Total diabetic members: 12,200
    - Known poorly controlled (HbA1c > 9%): 985 (almost 9% of total diabetics)
    - Intermediate control (HbA1c >= 8-9%): 714 (almost 6% of total diabetics)
    - Adequate control (HbA1c < 8%): 4,231
    - No HbA1c test (in past 12 months): 6,270
        - Potentially poorly controlled: 564 (9% of untested)
        - Potentially intermediate control: 367 (6% untested)

To encourage all CCN Medi-Cal members with diabetes to regularly monitor their blood sugar levels, staff recommends providing $25 non-monetary health rewards (e.g., gift cards) for those who complete their HbA1c test on an annual basis (eligible once a calendar year).

For those members with poorly controlled HbA1c levels, staff recommends providing $50 health rewards for reducing HbA1c levels by full 1 percentage point, for example, from HbA1c 10 to 9.

Back to Agenda

(eligible twice a year, totaling up to $100). For the 6,270 members who have not had HbA1c test, there is a possibility that 9% (564) of this population may be identified as poorly controlled based on the trends. There is also a possibility that 6% (367) of this population may be identified as intermediate control based on the trends.

Lastly, staff proposes offering $25 health rewards for those members with adequately maintained HbA1c levels for one year (HbA1c less than 8%).

Staff assumes a predicted participation rate of 80%. The total estimated cost for implementing these Health Rewards Programs for a two-year period is $1,103,040.

Description	**Amount**
$25 Non-monetary health rewards for HbA1c test completion	$244,000
$50 Health reward to improve HbA1c control by 1%	$210,400
$25 Health reward to maintain adequate control	$84,620
Annual Total	$539,020
Provider/member educational expenses	$25,000
Two-year pilot total	**$1,103,040**

Provider Incentives

For providers, staff plans to promote the existing Board-approved Pay for Value (P4V) CCN Program. The program was approved by the Board of Directors on February 6, 2020 and is currently approved through calendar year 2021 and encourages CCN providers to provide timely preventive health care services, deliver excellent outcomes, and achieve and maintain high levels of member satisfaction. In addition to the P4V program, in order to have successful provider buy-ins, staff proposes providing additional incentives for a year participation in the DM program. The additional incentives would not require provider contract amendments.

Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

To be eligible for these additional rewards:

- Year 1: $150
    - PCP to schedule appointment and see member
    - Order HbA1c lab test
    - PCP to have a consultation with CalOptima pharmacist to review the medication review tool list along with pharmacy recommendations and consider making changes
        - CalOptima Pharmacy documentation of PCP participation
- Year 2: $200
    - If a PCP manages to lower an eligible member's HbA1c < 8%, the PCP would be eligible to receive an additional $200 (one time per member).

Staff assumes a predicted participation rate of 80%. The total estimated cost for implementing provider incentives for a two-year period is $736,400.

Back to Agenda

Description	Amount
Year 1 Provider Incentives	$315,600
Year 2 Provider Incentives	$420,800
Two-year pilot total	**$736,400**

Fresh Produce Delivery Program
Along with physician activity, nutrition and attention to food insecurity are important parts of a healthy lifestyle when managing diabetes. Following a healthy meal plan can help members keep their blood sugar in their target range. Subject to DHCS approval, staff proposes including a fresh produce delivery service in this new multidisciplinary DM program to support an appropriate meal plan, based on a recommended American Diabetes Association diet, for our CCN Medi-Cal poorly controlled diabetic members.

In order to qualify for food delivery, members must meet the following requirements:

- Have an appointment with their PCP and have HbA1c lab test
- Lab results indicates that HbA1C >= 8
- Have consultation with CalOptima Pharmacist
- Have consultation with CalOptima Registered Dietician

Qualified members with intermediate to poorly controlled diabetes will receive fresh produce delivered to their homes twice per month following engagement in the program.

Staff assumes a predicted participation rate of 80%. The total estimated annual cost for implementing the fresh produce delivery program is $ $2,474,304 or $4,948,608 for the two-year period.

Staff released the RFP in early July 2021 and requested DHCS' approval. Staff will return to the Board to seek approval to contract with the recommended Fresh Produce Delivery Program vendor identified through the RFP process.

Evaluation Goals
During the two-year pilot intervention, staff proposes to review members' progress on a semiannual basis and study the following annually:

Hospitalization rates	Member satisfaction (survey)
% reduction in members with HbA1c > 9	Provider satisfaction (survey)
Rate of medication adherence	Review pharmaceutical cost savings
Participation rate	ED visits/rates

To measure member and provider satisfaction, staff proposes conducting a before-and-after survey. The estimated mailing cost for conducting a before-and-after survey is $7,500.

Back to Agenda

Fiscal Impact
The recommended action is unbudgeted. A proposed allocation of up to $8.2 million from existing reserves will fund this action.

Rationale for Recommendations
The recommended actions will support CalOptima's efforts to assist members with poorly controlled diabetes achieve healthier lifestyles and avoid complications.

Concurrence
Gary Crockett, Chief Counsel
Quality Assurance Committee

Attachments
1. Cost Comparison Diabetic vs. Non-Diabetic Members
2. PowerPoint Presentation
3. Draft Scope of Work

/s/ Richard Sanchez *07/28/2021*
Authorized Signature **Date**

Back to Agenda

Cost Comparison - Diabetic vs. Non-Diabetic Members

From: 2019-07 Through: 2020-06 For CCN - MC

	Distinct Members		Total Amount Paid		Avg Cost Per Member		% of Population Utilizing Services	
	Diabetic	**Non-Diabetic**	**Diabetic**	**Non-Diabetic**	**Diabetic**	**Non-Diabetic**	**Diabetic**	**Non-Diabetic**
Grand Total	12,200	69,426	$247,898,668	$370,585,854	$20,320	$5,338	100.0%	100.0%
LTC	340	298	$28,569,377	$25,269,785	$84,028	$84,798	2.8%	0.4%
Inpatient	2,087	6,082	$73,209,011	$97,481,773	$35,079	$16,028	17.1%	8.8%
Hospice	144	273	$1,875,977	$2,465,905	$13,028	$9,033	1.2%	0.4%
Outpatient	7,036	28,775	$41,171,497	$51,745,653	$5,852	$1,798	57.7%	41.4%
Pharmacy	11,821	55,186	$56,199,373	$88,097,684	$4,754	$1,596	96.9%	79.5%
Professional	11,609	64,740	$46,873,433	$105,525,053	$4,038	$1,630	95.2%	93.3%

Back to Agenda

Back To Item

Diabetic with HbA1c > 9

*Latest from last 12 months

Total	12,200
HbA1c > 9	985
HbA1c <= 9	4,945
No HbA1c Result	6,270

Back to Agenda

Back To Item

A Public Agency

CalOptima

Better. Together.

Multidisciplinary Approach to Improve Care in Poorly Controlled Diabetics

Board of Directors Meeting
August 5, 2021

Emily Fonda, MD, MMM
Chief Medical Officer

Back to Agenda

Back To Item

Diabetes

- Seventh leading cause of death in California
- Total annual national cost of diabetes in 2017 was $327 billion
- Total annual cost for diabetes is more than $247 million for Medi-Cal and CalOptima Community Network (CCN)
  - Pharmacy costs more than $56 million

Sources:

- Centers for Disease Control and Prevention, National Center for Health Statistics & National Center for Chronic Disease Prevention and Health Promotion
- National Center for Biotechnology Information, U.S. National Library of Medicine

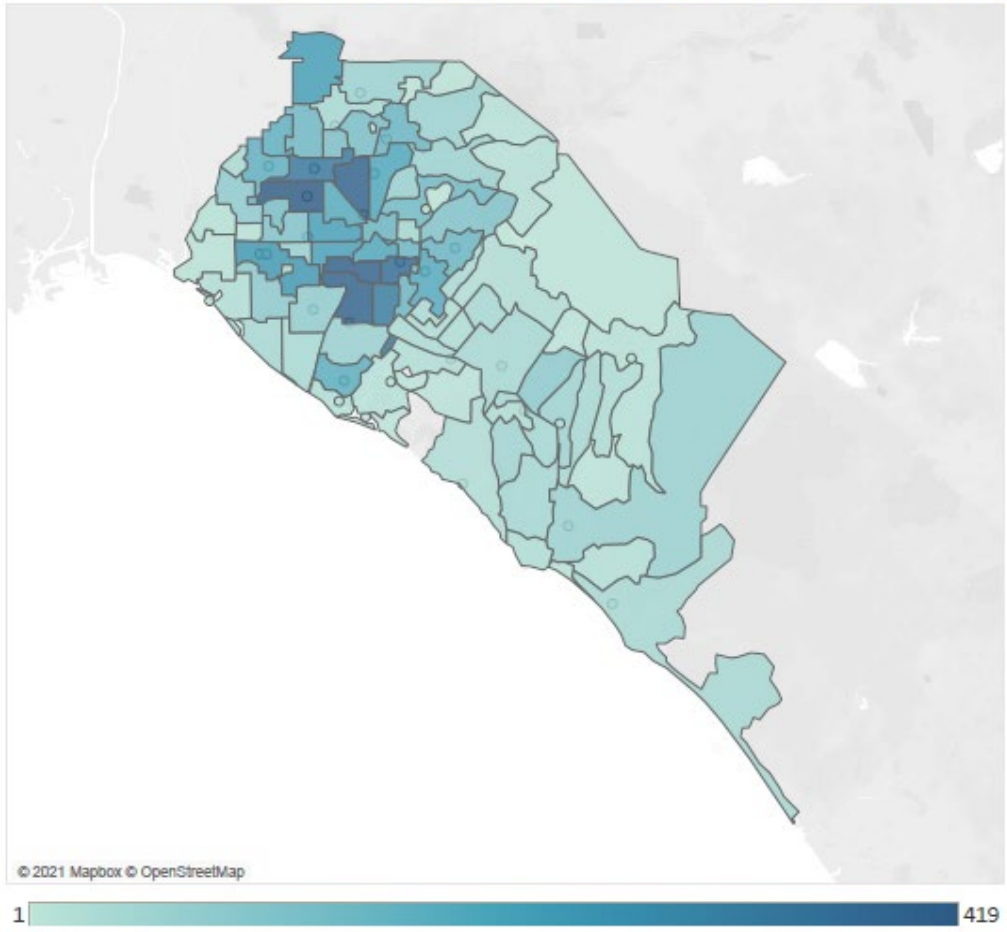
Back to Agenda Back To Item

CalOptima
A Public Agency

Members with Diabetes by Location

From: 2019-07 Through: 2020-06 For CCN - MC

*Includes diabetic members with poor HbA1c control, intermediate HbA1c control, and no recent HbA1c results available (approx. 8,000)



Top 10 ZIP Codes by Member Count

92804	421
92703	407
92805	406
92704	404
92701	373
92801	335
92707	326
92683	248
92840	225
92843	219

Top 10 Cities by Member Count

Santa Ana	1,854
Anaheim	1,603
Garden Grove	643
Orange	533
Fullerton	444
Buena Park	358
Costa Mesa	256
Westminster	253
Irvine	235
Huntingtn Bch	162

Back to Agenda

Back To Item

CalOptima
A Public Agency

Two-Year Pilot Proposal

- Multidisciplinary approach to care for CCN members with poorly controlled diabetes
- Goal: lower HbA1c to < 8% to reduce complications
- Key Components:
  - Collaborate with CalOptima pharmacists, health coaches and registered dietitians
  - Provider incentives
  - Member health rewards and fresh produce delivery
- Estimated cost: $8.2 million

Source: American Diabetes Association, Diabetes Care

Back to Agenda Back To Item

CalOptima
A Public Agency

Pharmacist, Health Coach and Registered Dietician

- Extend CalOptima pharmacist's role to include individual member outreach with consultation
- Consult with Primary Care Physician (PCP)
- Develop specific assessments to support the program and care planning
- Provide targeted education materials
- Conduct motivational interviewing
- Collaborate with the multidisciplinary team
- Refer members to other community resources

Provider Incentives

- Motivate providers to deliver improved outcomes
  - Separate from Pay for Value Program (P4V)
    - P4V includes comprehensive diabetes care
- PCP incentive eligibility criteria
  - Schedule appointment to see member with poorly controlled diabetes
  - Order HbA1c lab test
  - Consult with CalOptima pharmacist
- Recommended incentives
  - Year 1: $150 per member in the program and completing eligibility criteria
  - Year 2: $200 per member if a PCP manages to lower the member's HbA1c level < 8%

Member Health Rewards*

- Recommend health rewards for all members with diabetes
  - 12,200 members identified with diabetes
    - $25 reward for completing their annual HbA1c test
  - 2,630 members with intermediate to poorly controlled HbA1c level >= 8%
    - $50 reward for reducing HbA1c level by 1%
    - Eligible twice a year for up to $100 for reducing by 2%
  - 4,231 members with HbA1c level < 8% maintained for one year (intermediate to adequate control)
    - $25 reward for maintaining their HbA1c level <8% for one year

*Subject to DHCS approval

Back to Agenda
Back To Item

CalOptima
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Fresh Produce Delivery Program*

- Support access to nutritious food to improve outcomes
- Eligibility criteria
  - Complete appointment with PCP and have HbA1c lab test
  - Receive lab results indicating HbA1c level >= 8%
  - Consult with CalOptima pharmacist
  - Consult with CalOptima registered dietitian
- Eligible members will receive a fresh produce box delivered to their homes twice per month
- RFP issued on 7/1 and DHCS approval requested

*Subject to DHCS approval

Source: American Diabetes Association

Back to Agenda

Back To Item

CalOptima
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Next Steps

- Return to the Board in November to secure approval of Food Delivery Vendor
- Implement program by the fourth quarter of 2021
- Track outcome measures

• Member Satisfaction (Before/After Survey)	• Provider Satisfaction (Before/After Survey)
• ED visits/rates	• Hospitalization rates
• Rate of medication adherence	• Prescription cost savings
• Percent reduction in members with HbA1c level >=8%	• Program participation rate

- Return to the Board with an annual update

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Scope of Work

A. OBJECTIVE

CalOptima is seeking to partner with a contractor who can offer a fresh produce delivery program so CalOptima Community Network (CCN) Medi-Cal members can cook healthy and nutritious meals to manage their diabetic conditions.

Along with physician activity, nutrition and attention to food insecurity are important parts of a healthy lifestyle when managing diabetes. Following a healthy meal plan can help members keep their blood sugar in their target range. Therefore, CalOptima is planning to include a fresh produce delivery into our new multidisciplinary diabetes mellitus (DM) program to support an appropriate meal plan, based on a recommended American Diabetes Association diet, for our intermediate to poorly controlled diabetic members.

Fresh produce means fruits and vegetables that have not been processed in any manner.

Estimated eligible members: 3,000 diabetics

Eligible members will receive fresh produce delivered to their homes (in Orange County, California) twice per month following engagement in the program.

The successful Offeror must offer a variety of fresh produce options so members can select or customize fruits/vegetables based on their preference.

This is a two-year pilot program, and the tentative anticipated go live date is by quarter four of 2021.

B. CONTRACTOR'S RESPONSIBILITIES

The successful Offeror shall:

1. Prepare and deliver fresh produce boxes in sufficient quantity and quality within the time frame agreed to with CalOptima and/or members.

2. Maintain appropriate and current state and/or local certification demonstrating adequate fresh produce preparation facilities and transportation resources.

3. Cooperate in any member satisfaction survey which CalOptima's DM program may choose to undertake.

4. As part of their proposal, the Offeror shall submit the following:

    a. Certificate of Insurance as cited in the Sample Contract.
    b. Comprehensive general liability
    c. Automobile liability insurance
    d. Workers' compensation certificate

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e. Copy of Health Inspection Report and Copy of Seal provided by Orange County Health Department
f. Emergency preparedness plan

Delivery/Hours of Operation

- The successful Offeror must be able to deliver a fresh produce box to eligible members twice per month.
- The successful Offeror must be able to allow members to choose their delivery days.
- The successful Offeror must demonstrate proof of fresh produce delivery and provide data to CalOptima that includes a member's (or household member's) signature.
- The successful Offeror must provide a customer service line dedicated to our members.
- The successful Offeror must provide a point of contact for CalOptima who shall be available during CalOptima's normal business hours, excluding federal and state designated holidays, to receive inquiries by telephone or email.

Sanitation/Safety

- The successful Offeror will warrant that all food shall be fresh, clean, wholesome upon delivery, and prepared in properly equipped facilities under modern sanitary conditions in accordance with the best industry practice.
- All items shall be free from decay, discoloration, foreign matter, and shall pass through metal detection before packaging. Boxes shall be clean, sound, compact, sturdy, and sealed.
- The successful Offeror must have a process to address member satisfaction issues related to food delivery delays, decay or quality of produce.
- All products shall bear visible freshness code dates and shall meet industry standards for remaining shelf-life upon delivery to the members.

Nutrition Information

- The successful Offeror is required to provide complete product information sheets for all fresh produce items included in the proposal, indicating pack size, weight per unit, and nutritional analysis within 30 days of contract award.
- Product information sheets may be submitted in either hard copy or in electronic format.

CalOptima's Sign-Up Process

The successful Offeror must have the ability to ensure the safe handling of sensitive data including member's Protected Health Information (PHI). Proposals must include a description of the Offeror's ability to ensure the appropriate handling of this information, the security tools in place, and security policies and procedures.

The successful Offeror shall understand CalOptima's tentative member sign-up process and support CalOptima meeting this process goal.

After having consultations with a Primary Care Provider (PCP), CalOptima Pharmacist and CalOptima Registered Dietician (RD), CalOptima will identify and inform an eligible member that they can participate in a fresh produce delivery program. After receiving a list of eligible members, the successful Offeror shall work with CalOptima to determine specific delivery/member engagement turnaround times.

Payments (Monthly Invoices)

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The successful Offeror shall provide a monthly detailed invoice for fresh produce delivered to member's home. Invoice to include the following information (examples):

- Member name (may also include member Client Identification Number [CIN])
- Date of delivery
- Time of delivery
- Replacement of items (if any)
- Contract/Purchase Order Number

Performance Measures:

Performance and progress monitoring will be performed quarterly and conducted by the CalOptima DM Program leadership. Performance measures or outcome measures shall be met for the successful Offeror to be considered in compliance.

The successful Offeror shall:

- Maintain environmental health inspections in good standing.
- Changes in fresh produce (if any) submitted no less than one week prior to next delivery.
- Ensure monthly approval of fresh produce by the successful Offeror's dietitian or nutritionist and CalOptima RD prior to finalizing fresh produce options.
- Deliver fresh produce at the scheduled time (+/- 60 minutes of the stated time.)

C. CALOPTIMA RESPONSIBILITIES

- CalOptima will submit required member information to the successful Offeror to process fresh produce deliveries to eligible members.
- CalOptima shall maintain and provide a current point of contact for any inquiries by the successful Offeror.
- Some members may use CalOptima's Interpreter Services when interacting with the successful Offeror. CalOptima provides Interpreter Services as needed to accommodate members' requests. CalOptima's Interpreter Services are available for members at no cost. For calls other than English and cannot be answered by a bilingual staff, a Successful Offeror must support and work with CalOptima's Interpreter Services for various languages and dialects.
- CalOptima shall provide monitoring and oversight of the successful Offeror services.
- CalOptima will make payment to the successful Offeror within thirty (30) business days from receipt of an invoice of services provided by the successful Offeror under this contract.

DRAFT

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing a Contract with and Funding of a Consultant to Perform Readiness Assessment Activities Related to the California Advancing and Innovating Medi-Cal (CalAIM) Initiative.

Contacts

Ladan Khamseh, Chief Operating Officer, (714) 246-8866
Pallavi Patel, Director, (657) 235-6941

Recommended Action

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a contract with Public Consulting Group Inc. (PCG), effective 8/1/2021 through 7/31/22, to conduct a readiness assessment of Enhanced Care Management (ECM) providers and In Lieu of Services (ILOS) to support the implementation of CalAIM; *Rev. 8/5/2021*
2. Allocate up to $200,000 in CalAIM Payment Year (PY) 1 Program Incentive Dollars to fund the PCG contract, subject to DHCS's approval of CalOptima's ECM/In Lieu of Services (ILOS) Gap Assessment and Gap-Filling Plan; and
3. Authorize payments for this engagement prior to CalOptima's receipt of CalAIM Program Incentive Dollars from DHCS.

Background

On January 8, 2021, the Department of Health Care Services (DHCS) released a revised CalAIM proposal that takes a whole-person care approach (incorporating both clinical and nonclinical services) with the goal of improving health outcomes for Medi-Cal members. To be implemented by Managed Care Plans (MCPs) including CalOptima, CalAIM initiatives span across five years, beginning January 1, 2022. Two key initiatives have a January 1, 2022 go-live date: ECM and ILOS. CalOptima plans to design, implement, and administer ECM and ILOS for eligible members. An important component of these initiatives will be the transition of members currently participating in the CalOptima-led Health Homes Program (HHP) and/or the Orange County-led Whole Person Care (WPC) pilot. CalOptima's proposed approach to implementing ECM builds upon HHP infrastructure by transitioning HHP Community-Based Care Management Entities (CB-CMEs), CalOptima's delegated health networks, and the CalOptima Direct, to serve as ECM providers under CalAIM. This approach was submitted to DHCS for review as part of the CalAIM Model of Care Part 1 submission on July 1, 2021. DHCS expects MCPs to meet readiness requirements prior to providing ECM services to the mandatory Populations of Focus (POFs). To meet these expectations, CalOptima plans to perform readiness assessments of ECM providers to ensure that they are ready to render all required ECM services to members eligible for ECM.

Discussion

CalOptima will implement ECM for members currently enrolled in and receiving services via the HHP or are in the process of being enrolled in the HHP. Specifically for the members enrolled in the WPC pilot, CalOptima will implement ECM for those members who are identified by the WPC Lead Entity as

Back to Agenda

belonging to an ECM POF via a member transition list. CalOptima shall also ensure that each Member automatically authorized is assessed within six months to determine the most appropriate levels of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs. Finally, CalOptima will implement ECM for members who meet the Phase 1 POFs eligibility requirements, as defined by DHCS, beginning January 1, 2022.

DHCS has identified the CalAIM POFs and their respective phases and go-live dates:

Phase 1 (January 1, 2022):
- Members and families experiencing homelessness (adults and children/youth)
- High utilizers of covered services(adults)
- Serious Mental Illness (SMI)/substance use disorder (SUD) (adults)

Phase 2 (January 2023):
- Members incarcerated and transitioning to the community (adults and children/youth)[1]
- Members eligible for Long-Term Care and at risk for institutionalization
- Nursing facility residents transitioning to the community

Phase 3 (July 2023):
- High utilizers of covered services (children/youth)
- Serious Emotional Disturbance (SED) or identified to be at Clinical High Risk (CHR) for Psychosis or Experiencing a First Episode of Psychosis
- Enrolled in California Children's Services (CCS) Whole-Child Model (WCM) with additional needs beyond CCS
- Involved, or with a History of Involvement in, in Child Welfare (including Foster Care up to Age 26)

For these POFs, DHCS requires ECM providers to offer the following core ECM services, which are similar to HHP:
- Outreach and engagement
- Comprehensive assessment and care management plan
- Enhanced coordination of care
- Health promotion
- Comprehensive transitional care
- Member and family supports
- Coordination of and referral to community and social support services

To ensure ECM providers deliver the above services in a whole-person centered approach, CalOptima expects them to meet readiness requirements beginning January 1, 2022. Each ECM Provider participating in CalOptima's CalAIM program will need to be assessed for readiness by ensuring each

[1] Members incarcerated and transitioning to the community (adults and children/youth) were not part of OC HCA's WPC Pilot; therefore, these services will be implemented no sooner than January 1, 2023.

ECM provider's CalAIM Model of Care is in alignment with CalOptima's. CalOptima will also assess readiness of each ECM provider's operational, contractual and regulatory compliance to provide ECM services to each POF in accordance with CalOptima's CalAIM program. Depending on the requirements in the DHCS Program Guide for ECM, readiness assessment tools will be updated and finalized so that CalOptima staff can review and ensure that each ECM provider meets CalOptima's expectations for the CalAIM Model of Care.

Based on CalOptima Policy GA.5002: Purchasing (Purchasing Policy), CalOptima staff evaluated the most cost effective and beneficial solutions to CalOptima's immediate requirements to perform a timely and high-quality readiness assessment. Using the criteria established under the Purchasing Policy for non-medical professional services, including, but not limited to relevant experience in this area, familiarity with CalOptima, special expertise, and the fluid and evolving nature of DHCS policy guidance, CalOptima staff is recommending selection of PCG for non-medical professional services to conduct the readiness assessment of ECM providers. PCG is familiar with CalOptima's operations and has previous experience conducting readiness assessments of CB-CMEs prior to the implementation of the HHP in late 2019. The core services provided by the CB-CMEs in HHP align closely with the ECM services required in CalAIM. Due to the similarity of the readiness assessments and PCG's knowledge of CalOptima's delivery system, staff plans to follow the existing bid exception process for non-medical professional services pursuant to the Purchasing Policy to allow CalOptima and PCG to complete the ECM provider readiness assessment prior to the go-live date.

CalOptima staff proposes to fund expenses up to $200,000 to conduct the readiness assessment of its ECM providers using DHCS CalAIM Program Incentive Dollars for PY 1 (i.e., CY 2022) focusing on priority areas such as ECM/ILOS capacity building, infrastructure, and ILOS uptake. These incentive dollars will be available to fund ILOS training, technical assistance, workflow development, operational requirements, uptake, and oversight. CalOptima staff will return to the Board with more information as final guidance becomes available. In addition, CalOptima staff proposes to fund the readiness assessment activities prior to CalOptima's receipt of CalAIM Program Incentive Dollars from the State of California. DHCS is planning to release the first incentive payment in January 2022.

Fiscal Impact

The recommended action to allocate up to $200,000 in CalAIM Program Incentive Dollars for PY 1 to support readiness assessment activities of ECM providers is not expected to have any net fiscal impact to CalOptima's Fiscal Year 2021–22 Operating Budget approved by the Board on June 3, 2021. This assumes, and Staff anticipates, that all operating funds advanced to pay the vendor to complete readiness assessment activities will be replenished within the current fiscal year when CalAIM Program Incentive Dollars are received from DHCS. In the event of funding proposal changes from DHCS, staff will return to the Board with revised recommendations.

Back to Agenda

Rationale for Recommendation

The recommended action will ensure the successful completion of the needed readiness assessments of ECM providers to ensure that each one is capable of providing a whole-person approach to care that addresses the clinical and nonclinical needs of the Populations of Focus.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. CalAIM ECM Provider Readiness Assessment - Scope of Work
3. Management Report April 1, 2021, CalOptima Board of Directors, California Advancing and Innovating Medi-Cal (CalAIM)
4. Prior Board Action dated June 3, 2021: Consider Approving CalOptima's CalAIM Model of Care Approach
   - DHCS CalAIM Proposal Included
5. Vendor Contract Template

/s/ Richard Sanchez — *07/28/2021*

Authorized Signature — **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Consultant				
Name	**Address**	**City**	**State**	**Zip Code**
Public Consulting Group, Inc.	148 State Street	Boston	MA	02109

Back to Agenda

Back To Item

CalAIM Provider Readiness Assessment
Consultant - Scope of Work

1.0 BACKGROUND

1.1 CalOptima's Network Delivery Model

CalOptima currently contracts with 12 provider network groups in addition to CalOptima Direct (COD) and CalOptima Community Network (CCN), known as health networks (HNs). These networks ae available for members when selecting a HN to receive primary and specialty care services. These HNs are contracted either to take on 'full' or 'shared' financial risk for the delegated services. Through their executed contract arrangement, the HNs provide care to their assigned members (approximately 80% of CalOptima members). The remaining 20% of members are part of COD and CCN.

It should be noted that there are certain services, such as Long-Term Support and Services (LTSS), Community-Based Adult Services (CBAS), Behavioral Health, Health Education, Non-Medical Transportation and Pharmacy, are currently managed by CalOptima and Kaiser for their assigned members and are not delegated to the other HNs with some exceptions agreed upon through contract negotiation.

All HNs' and CCN members are assigned to a primary care provider (PCP), physician practicing individually or in a small group, community clinics or federally qualified health centers, to receive their needed care. Members under COD model are not assigned a PCP, allowing the member to select a physician of their choice to receive needed care.

1.2 CalAIM

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative, spanning from 2022 to 2027, by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of our population by implementing broad delivery system, as well as program and payment reform across the Medi-Cal program. The initiative leverages Medi-Cal as a tool to help address many of the complex challenges facing California's most vulnerable residents such as individuals experiencing homelessness, behavioral health care access, complex medical care for children, the growing number of justice-involved populations who have significant clinical needs and the growing aging population.

CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health.
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

To better identify and manage member risk and need for Medi-Cal and OneCare beneficiaries who may be challenged with medical and behavioral conditions, access to care as well as chronic illnesses and disabilities, DHCS is proposing a whole system, person-centered approach that will result in a better quality of life for our members, as well as long-term cost savings and avoidance. Two components of this system include:

1. A statewide Enhanced Care Management (ECM) benefit
2. Implementation of optional In Lieu of Services (ILOS)

CalAIM ECM and ILOS build upon the success of previous federal waiver programs, including but not limited to, Whole Person Care (WPC), Health Homes Program (HHP) and the Coordinated Care Initiative (CCI). Over the span of the initiative, services provided under programs such as WPC, HHP and CCI will be transitioned under CalAIM and made available to a larger portion of CalOptima's membership.

Back to Agenda

Back To Item

CalAIM Provider Readiness Assessment
Consultant - Scope of Work

Beginning January 1, 2022, CalOptima proposes to transition health networks to begin serving as ECM Providers CalOptima members authorized to receive ECM services. CalOptima's proposed Model of Care (MOC) supports and enhances its well-established provider network and maintains current, and often long-standing, providers' relationships with their CalOptima members. CalOptima will achieve this by:

- Delegating ECM services to its HNs who will continue to provide care management as ECM Providers, including coordinating care for members' ILOS needs, to their assigned and eligible members

CalOptima will work closely with its ECM Providers to ensure readiness activities are conducted collaboratively prior to the launch of CalAIM.

2.0 OBJECTIVE

CalOptima's objective is to utilize the services of a consultant to:

2.1 Assess the adequacy and capabilities of the ECM Provider network to provide the required services to transitioning as well as newly eligible members prior to ECM going live no sooner than January 1, 2021

2.2 Develop ECM Provider adequacy and readiness assessment tools and templates

3.0 CALOPTIMA'S RESPONSIBILITIES

3.1 CalOptima will assign a manager to oversee and direct all consultant's responsibilities

3.2 CalOptima will provide data as needed

3.3 CalOptima will allow resources for interviews either in-person or telephonically as appropriate

4.0 CONSULTANT QUALIFICATIONS

Selected Consultant(s) response must demonstrate:

4.1 Team knowledge and experience with respect to understanding and knowledge of:

- 4.1.1 Managed Care Plan model and responsibilities
- 4.1.2 Medi-Cal and Medicare
- 4.1.3 CalOptima's provider network delegated model
- 4.1.3 DHCS HHP proposal, the WPC Pilot initiative, including how they overlap
- 4.1.4 DHCS CalAIM proposal, all other DHCS CalAIM related guidance revisions, including readiness assessment and reporting requirements
- 4.1.5 Orange County organizations providing home and community based/social services/housing navigation and other support services
- 4.1.6 Technical and communication skills, including all Microsoft Office applications

4.2 Staff adequacy, availability, and skills to manage and deliver expectations of this Scope of Work

4.3 Ability to apply all CalOptima's business decisions/expectations on network and care delivery model readiness

4.4 Ability to supply three (3) References for whom you have done similar work

5.0 CONSULTANT RESPONSIBILITIES AND DELIVERABLES

5.1 Consultant shall prepared tools and templates such as readiness tools, data reporting templates, etc., in collaboration with CalOptima's departmental experts, by a mutually agreed upon date informed by forthcoming DHCS requirements

5.2 Consultant shall provide CalOptima a proposed timeline and and approach on completion of objectives stated in sections 2.1 and 2.2

5.3 Consultant shall facilitate distribution and education of the tools with ECM Providers, conduct appropriate follow ups to collect completed tool and supporting documentation and evaluate the submitted materials for provider readiness capability.

CalAIM Provider Readiness Assessment
Consultant - Scope of Work

5.4 Consultant shall provide a detailed report on ECM Provider network adequacy, capacity as well as their readiness assessment capability to provide ECM services.

5.5 The entire readiness assessment project will be handled in five phases:

5.5.1 **Project initiation:**

Build expertise on CalAIM ECM provider readiness requirements and outline components for the required readiness assessment tools that align with DHCS CalAIM Program requirements and deliverables, identify needed inputs to the process, and develop a proposed project timeline

5.5.2 **Readiness Assessment Tool completion:**

Finalize the readiness assessment tool/templates according to the latest CalAIM regulatory and business requirements with CalOptima leadership

5.5.3 **Readiness Assessment Facilitation:**

Provide training, distribute the tool and continue assisting ECM Providers to understand expectations

5.5.4 **Readiness Assessment Tool evaluation:**

Evaluate readiness for every ECM Provider to provide services according to the requirements of the tool

5.5.5 **Prepare and present the final readiness assessment report:**

Present the final report to CalOptima's leadership 30 calendar days prior to program going live

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CalOptima

Better. Together.

California Advancing and Innovating Medi-Cal (CalAIM)

Board of Directors

April 1, 2021

Rachel Selleck, Executive Director, Public Affairs

Back to Agenda

Back To Item

Background

Whole Person Care
(2016–21)
- Lead Entity: County of Orange
- Services:
  - Housing Navigation and Sustainability (includes housing deposits)
  - Recuperative Care

Health Homes Program
(2020–21)
- Lead Entity: CalOptima
- Services:
  - Comprehensive Care Management*
  - Housing Navigation and Sustainability

California Advancing & Innovating Medi-Cal (CalAIM)
(2022–27)
- Target Implementation Phase 1: January 2022
- Lead Entity: CalOptima
- Services:
  - Enhanced Care Management**
  - Phase 1 In Lieu of Services (ILOS):
    - Housing Transition Navigation Services
    - Housing Tenancy and Sustaining Services
    - Housing Deposits
    - Recuperative Care

*** Comprehensive Care Management:** Care management addressing primarily clinical needs

**** Enhanced Care Management:** Care management addressing both clinical and nonclinical needs

Back to Agenda

Note: Concurrently planning for Phase 2 ILOS services to launch in July 2022.

Back To Item

CalOptima
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Background (cont.)

- CalAIM Enhanced Care Management (ECM) benefit intensifies care management and builds on current Whole Person Care (WPC) pilot and Health Homes Program (HHP) for high-need Medi-Cal beneficiaries

- January 2021: Department of Health Care Services (DHCS) released revised CalAIM proposal

- Expands Medi-Cal Managed Care Plans' responsibilities and provides opportunities for enhanced care

Primary Goals of CalAIM

- Improve member and provider experience
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility
- Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation

Sources: DHCS CalAIM site: www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

CalAIM Proposal: www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-Updated-02172021.pdf

Back to Agenda

CalOptima
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Back To Item

CalAIM Initiatives

Initiatives	Implementation Date
Enhanced Care Management (ECM) Benefit	January 2022
In Lieu of Services (ILOS)	January 2022
Plan Incentive Payments	January 2022
Shared Risk/Savings (Seniors and Persons With Disabilities/Long-Term Care Blended Rate)	January 2023
Discontinue Cal MediConnect and Require Dual Eligible Special Needs Plans	January 2023
Population Health Management Program	January 2023
Regional Managed Care Capitation Rates	January 2024
National Committee for Quality Assurance (NCQA) Accreditation[1]	January 2026
Full Integration Plans[2]	January 2027

[1] CalOptima is already NCQA accredited and a top-rated plan in California

[2] CalOptima status: BH partially integrated; dental not integrated

Back to Agenda

Back To Item

CalOptima
A Public Agency

Enhanced Care Management (ECM)

- Implement a single, intensive and comprehensive ECM benefit
  - Designed to meet clinical and nonclinical needs of the highest-cost and/or highest-need beneficiaries
- Build upon current WPC and HHP delivery systems
- Use phased implementation approach

Date	Population
January 2022	Existing WPC/HHP target populations
July 2022	Additional target populations

Back to Agenda

Back To Item

ECM Target Populations

- Children and youth with complex conditions
- Individuals experiencing chronic homelessness with complex conditions
- High health care system utilizers
- Nursing facility residents
- Individuals at risk for institutionalization who are either eligible for long-term care or have co-occurring chronic conditions
- Individuals transitioning from incarceration

Note: WPC and HHP members overlap within these target populations; ECM target populations are subject to change, per DHCS guidance

Back to Agenda

CalOptima
A Public Agency

Back To Item

CalOptima's ECM Proposal

- To align with CalAIM expectations of integrating WPC and HHP under ECM:
  - Leverage HHP Community-Based Care Management Entities (CB-CMEs) to serve as ECM providers to ensure continuity of care
    - Delegate ECM to health networks as they act as CB-CME for HHP
- Allows members to stay with their health network and minimizes care disruption
- **Funding**: Anticipate State funding

Back to Agenda

CalOptima
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Back To Item

In Lieu of Services (ILOS)

- Definition of ILOS
  - Flexible wrap-around services
  - Authorized and identified in the state's Medi-Cal Managed Care Plan contracts
  - Optional for both the plan to offer and the beneficiary to accept
  - Provided as a substitute to, or to avoid, other covered services, such as hospital or skilled nursing facility admission, emergency department use or delay in discharge

DHCS ILOS Options

1. Housing Transition Navigation Services	8. Nursing Facility Transition/Diversion to Assisted Living Facilities
2. Housing Deposits	9. Community Transition Services/Nursing Facility Transition to a Home
3. Housing Tenancy and Sustaining Services	10. Personal Care and Homemaker Services
4. Short-Term Post-Hospitalization Housing	11. Environmental Accessibility Adaptations (Home Modifications)
5. Recuperative Care (Medical Respite)	12. Meals/Medically Tailored Meals
6. Respite Services	13. Sobering Centers
7. Day Habilitation Programs	14. Asthma Remediation

Refer to Appendix J: In Lieu of Services Options in the CalAIM proposal for eligibility criteria, allowable providers and restrictions/limitations

Back to Agenda

Back To Item

CalOptima
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CalOptima's ILOS Proposal

- To maintain continuity of care, CalOptima (as a carve-out) to offer the following ILOS services currently provided under WPC and HHP (Phase 1):
  - Housing Transition Navigation Services** (WPC, HHP)
  - Housing Tenancy and Sustaining Services** (WPC, HHP)
  - Housing Deposits (WPC)
  - Recuperative Care (Medical Respite) (WPC)
- **Service Providers**: Maintain current providers (through Letters of Agreement or contracts) while RFPs are developed
- **Funding**: IGT/Reserve monies (no anticipated State funding) until savings are realized

** Currently delegated to health networks through HHP

Back to Agenda

CalOptima
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Back To Item

Next Steps

April 2021	May 2021	June 2021	July 2021
Provide Overview to CalOptima Board	Present Implementation Proposal to Other Stakeholders	Present Final Plan to CalOptima Board	Submit Deliverables to DHCS

Back to Agenda

CalOptima
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Back To Item

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

35. Consider Approving CalOptima's California Advancing and Innovating Medi-Cal (CalAIM) Model of Care Approach

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Action

Approve CalOptima's proposed California Advancing and Innovating Medi-Cal (CalAIM) Model of Care (MOC) approach, effective January 1, 2022, for submission to the Department of Health Care Services (DHCS), including utilizing CalOptima's health networks as Enhanced Care Management (ECM) Providers and the launch of four In Lieu of Services (ILOS), listed below.

Background

On January 8, 2021, DHCS released the revised CalAIM proposal that takes a whole-person care approach (incorporating both clinical and non-clinical services) led by Managed Care Plans (MCP) with the goal of improving health outcomes for Medi-Cal members. CalAIM initiatives span over five years beginning January 1, 2022. The two key initiatives with a January 1, 2022, go-live are ECM and ILOS. Both require an implementation plan, called the Model of Care (MOC), to be submitted to DHCS by July 1, 2021. The MOC will describe how CalOptima plans to design, implement, and administer ECM services and ILOS to its eligible members. An important component of the MOC will be the transition of members currently participating in the CalOptima-led Health Homes program (HHP) and/or the County-led Whole Person Care (WPC) pilot. CalOptima's proposed approach to CalAIM ECM and ILOS is intended to build upon infrastructure created through the HHP and the WPC pilot, in alignment with DHCS's goals. Final regulatory guidance and associated materials will not be made available to plans until the end of May 2021. For this reason, staff are seeking Board approval on the approach for both ECM and ILOS and will return to the Board following DHCS feedback on CalOptima's proposed MOC to seek approval of final policies and related DHCS deliverables.

Discussion

ECM is the coordination of both clinical and non-clinical services and ILOS are flexible wraparound services provided as a substitute for, or to avoid, other covered services, such as hospital or skilled nursing facility admission, emergency department use or delay in discharge. ILOS are optional for MCPs to offer and members to receive. CalOptima will implement these initiatives not only for members currently enrolled in and receiving services via the HHP or the WPC pilot, but also for all MCP members who meet the Phase 1 "Populations of Focus" eligibility requirements, as defined by DHCS.

DHCS is developing definitions for the CalAIM Populations of Focus through an iterative process. Using the current eligibility parameters for each group, and subject to DHCS revision, CalOptima's ECM-eligible population on January 1, 2022 may include:

Back to Agenda

Back To Item

Populations of Focus	Projected Members as of 5/12/21
Homeless	3,302
High utilizers	12,037
Serious Mental Illness (SMI) and Substance Use Disorder (SUD)	18,277
Total	**33,616**

Estimates for ILOS utilization are not available at this time, since multiple factors impact the uptake of these services.

All WPC- or HHP-enrolled members will automatically be approved for ECM and reassessed within six months after the transition. Upon reassessment, CalOptima and its ECM providers will ensure appropriate levels of case management, non-duplication of services, evaluation of members' current needs and updates to members' plans of care to improve health outcomes.

ECM
To meet CalAIM requirements, CalOptima staff recommends leveraging the existing HHP model and proposes to transition its contracted health networks, currently acting as community-based care management entities (CB-CMEs), to serve as ECM Providers. CalOptima staff also proposes to delegate ECM services, including accompaniment services, which DHCS indicates is part of ECM services, to its contracted health networks for their assigned members. CalOptima's approach to transition the current CB-CMEs to ECM Providers will allow its members to be able to maintain relationships with their current providers, to continue receiving services and allow the ECM Providers to easily integrate ECM into their delivery system by building upon HHP infrastructure.

ILOS
To ensure a seamless transition for members, providers and community, staff recommends offering the following ILOS for Phase 1, beginning January 1, 2022, which are currently being provided to CalOptima members either through WPC or HHP:

1) Housing Transition Navigation Services: assistance for members to obtain housing, but does not constitute a housing deposit or room and board;
2) Housing Deposits: assistance with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that does not constitute room and board;
3) Housing Tenancy and Sustaining Services: assistance with maintaining a safe and stable tenancy for individuals once housing is secured; and
4) Recuperative Care (Medical Respite short-term residential care for members who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment.

In following DHCS guidance to build provider capacity, CalOptima is awaiting draft ILOS rate information from DHCS to inform future ILOS vendor contracting. Staff will return to the Board to seek authority to execute ILOS contracts, as appropriate. Concurrently, CalOptima is planning for additional ILOS services to launch later in 2022 or 2023 through surveying its community partners in addition to reviewing its own membership data to identify services that might be most beneficial for its members. Staff will return to the Board with recommendations on future ILOS to pursue later this year.

Back to Agenda

Back To Item

Prior to launch, CalOptima will conduct a readiness assessment for all ECM and ILOS contracted providers to ensure their readiness to provide the required services beginning January 1, 2022. Staff will return to the Board in late summer to seek approval on the selection of and funding for a consulting service to complete the readiness assessments. In parallel to the completion of the readiness assessment, CalOptima will provide training to all ECM and ILOS contracted providers' staff to ensure they build appropriate expertise and skills to serve members through this initiative.
To ensure the success of new CalAIM initiatives, DHCS plans to provide some start-up incentive funding to MCPs in the first two years for ECM and ILOS in order to build appropriate and sustainable capacity and improve quality performance. CalOptima anticipates receiving further information about these incentives later this year. Staff will return to the Board to request approval of the provider payment methodology for the mandatory ECM benefit and optional ILOS, later this year.

Through these CalAIM implementation efforts, CalOptima intends to minimize health disparity, increase member independence, and improve health outcomes.

Fiscal Impact
The proposed Fiscal Year 2021-22 Operating Budget, pending Board approval, assumes that CalOptima will take on financial risk for the mandatory ECM benefit and optional ILOS effective January 1, 2022. Payments related to these new benefits and services were treated as budget neutral. However, given the limited information available at this time, projected costs for these changes are difficult to predict. CalOptima will continue to advocate with DHCS to ensure these changes are adequately funded and monitor utilization and expenses related to the new benefit and services.

Rationale for Recommendation
The recommended action will enable CalOptima to successfully transition the HHP and the WPC pilot into CalAIM ECM and ILOS, effective January 1, 2022, for the required CalAIM Populations of Focus.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Board Action
2. Management Report April 1, 2021, CalOptima Board of Directors, California Advancing and Innovating Medi-Cal (CalAIM)
3. Department of Health Care Services CalAIM Proposal
4. CalOptima ILOS Fact Sheet
5. CalAIM Presentation, June 3, 2021

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

Back to Agenda

Back To Item

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Kaiser Foundation Health Plan	393 E Walnut St.	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	5785 Corporate Ave.	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
OneCare Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI/Prospect Medical Group	600 City Parkway West, #800	Orange	CA	92868
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Monarch Healthcare, A Medical Group, Inc.	11 Technology Dr.	Irvine	CA	92618
Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
County of Orange				
Name	**Address**	**City**	**State**	**Zip Code**
Orange County Health Care Agency	405 W 5th Street	Sana Ana	CA	92701

Back to Agenda

Back To Item

Back to Item

A Public Agency

CalOptima

Better. Together.

California Advancing and Innovating Medi-Cal (CalAIM)

Board of Directors Meeting

April 1, 2021

Rachel Selleck, Executive Director, Public Affairs

Back to Agenda

Background

Whole Person Care
(2016–21)
- Lead Entity: County of Orange
- Services:
  - Housing Navigation and Sustainability (includes housing deposits)
  - Recuperative Care

Health Homes Program
(2020–21)
- Lead Entity: CalOptima
- Services:
  - Comprehensive Care Management*
  - Housing Navigation and Sustainability

California Advancing & Innovating Medi-Cal (CalAIM)
(2022–27)
- Target Implementation Phase 1: January 2022
- Lead Entity: CalOptima
- Services:
  - Enhanced Care Management**
  - Phase 1 In Lieu of Services (ILOS):
    - Housing Transition Navigation Services
    - Housing Tenancy and Sustaining Services
    - Housing Deposits
    - Recuperative Care

*** Comprehensive Care Management:** Care management addressing primarily clinical needs

**** Enhanced Care Management:** Care management addressing both clinical and nonclinical needs

Back to Agenda

Note: Concurrently planning for Phase 2 ILOS services to launch in July 2022

Back To Item

CalOptima
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Back to Item

Background (cont.)

- CalAIM Enhanced Care Management (ECM) benefit intensifies care management and builds on current Whole Person Care (WPC) pilot and Health Homes Program (HHP) for high-need Medi-Cal beneficiaries

- January 2021: Department of Health Care Services (DHCS) released revised CalAIM proposal

- Expands Medi-Cal Managed Care Plans' responsibilities and provides opportunities for enhanced care

Primary Goals of CalAIM

- Improve member and provider experience
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility
- Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation

Sources: DHCS CalAIM site: www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx

CalAIM Proposal: www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-Updated-02172021.pdf

Back to Agenda

Back To Item

CalOptima A Public Agency

Back to Item

CalAIM Initiatives

Initiatives	Implementation Date
Enhanced Care Management (ECM) Benefit	January 2022
In Lieu of Services (ILOS)	January 2022
Plan Incentive Payments	January 2022
Shared Risk/Savings (Seniors and Persons With Disabilities/Long-Term Care Blended Rate)	January 2023
Discontinue Cal MediConnect and Require Dual Eligible Special Needs Plans	January 2023
Population Health Management Program	January 2023
Regional Managed Care Capitation Rates	January 2024
National Committee for Quality Assurance (NCQA) Accreditation[1]	January 2026
Full Integration Plans[2]	January 2027

[1] CalOptima is already NCQA accredited and a top-rated plan in California

[2] CalOptima status: BH partially integrated; dental not integrated

Back to Agenda
Back To Item
Back to Item

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Enhanced Care Management (ECM)

- Implement a single, intensive and comprehensive ECM benefit
  - Designed to meet clinical and nonclinical needs of the highest-cost and/or highest-need beneficiaries
- Build upon current WPC and HHP delivery systems
- Use phased implementation approach

Date	Population
January 2022	Existing WPC/HHP target populations
July 2022	Additional target populations

Back to Agenda

Back To Item

Back to Item

CalOptima
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ECM Target Populations

- Children and youth with complex conditions
- Individuals experiencing chronic homelessness with complex conditions
- High health care system utilizers
- Nursing facility residents
- Individuals at risk for institutionalization who are either eligible for long-term care or have co-occurring chronic conditions
- Individuals transitioning from incarceration

Note: WPC and HHP members overlap within these target populations; ECM target populations are subject to change, per DHCS guidance

Back to Agenda

Back To Item

CalOptima
A Public Agency

Back to Item

CalOptima's ECM Proposal

- To align with CalAIM expectations of integrating WPC and HHP under ECM:
  - Leverage HHP Community-Based Care Management Entities (CB-CMEs) to serve as ECM providers to ensure continuity of care
    - Delegate ECM to health networks as they act as CB-CME for HHP
- Allows members to stay with their health network and minimizes care disruption
- **Funding**: Anticipate State funding

Back to Agenda

Back To Item

CalOptima
A Public Agency

Back to Item

In Lieu of Services (ILOS)

- Definition of ILOS
  - Flexible wrap-around services
  - Authorized and identified in the state's Medi-Cal Managed Care Plan contracts
  - Optional for both the plan to offer and the beneficiary to accept
  - Provided as a substitute to, or to avoid, other covered services, such as hospital or skilled nursing facility admission, emergency department use or delay in discharge

DHCS ILOS Options

1. Housing Transition Navigation Services	8. Nursing Facility Transition/Diversion to Assisted Living Facilities
2. Housing Deposits	9. Community Transition Services/Nursing Facility Transition to a Home
3. Housing Tenancy and Sustaining Services	10. Personal Care and Homemaker Services
4. Short-Term Post-Hospitalization Housing	11. Environmental Accessibility Adaptations (Home Modifications)
5. Recuperative Care (Medical Respite)	12. Meals/Medically Tailored Meals
6. Respite Services	13. Sobering Centers
7. Day Habilitation Programs	14. Asthma Remediation

Refer to Appendix J: In Lieu of Services Options in the CalAIM proposal for eligibility criteria, allowable providers and restrictions/limitations

Back to Agenda
Back To Item
Back to Item

CalOptima
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CalOptima's ILOS Proposal

- To maintain continuity of care, CalOptima (as a carve-out) to offer the following ILOS services currently provided under WPC and HHP (Phase 1):
  - Housing Transition Navigation Services** (WPC, HHP)
  - Housing Tenancy and Sustaining Services** (WPC, HHP)
  - Housing Deposits (WPC)
  - Recuperative Care (Medical Respite) (WPC)
- **Service Providers**: Maintain current providers (through Letters of Agreement or contracts) while RFPs are developed
- **Funding**: IGT/Reserve monies (no anticipated State funding) until savings are realized

** Currently delegated to health networks through HHP

Back to Agenda

Back To Item

CalOptima
A Public Agency

Back to Item

Next Steps

April 2021	May 2021	June 2021	July 2021
Provide Overview to CalOptima Board	Present Implementation Proposal to Other Stakeholders	Present Final Plan to CalOptima Board	Submit Deliverables to DHCS

Back to Agenda

Back To Item

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Back to Item

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

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

California Advancing & Innovating Medi-Cal (CalAIM) Proposal

January 2021

Back to Agenda

Back To Item

Back to Item

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Back to Agenda

Back To Item

Back to Item

Table of Contents

1. Executive Summary 5

1.1 Background and Overview 5
1.2 Guiding Principles 7
1.3 Key Goals 7
1.4 Identify and Manage Member Risk and Need Through Whole Person Care Approaches and Addressing Social Determinants of Health 8
Population Health Management 8
Enhanced Care Management 9
In Lieu of Services & Incentive Payments 9
SMI/SED Demonstration Opportunity 10
Mandatory Medi-Cal Application Process upon Release from Jail and County Juvenile Facilities 11
Full Integration Plans 12
Develop a Long-Term Plan for Foster Care 12
1.5 Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility 12
Managed Care 14
Behavioral Health 15
Dental 17
County Partners 18
1.6 Advancing Key Priorities 18
1.7 From Medi-Cal 2020 to CalAIM 21
1.8 CalAIM Stakeholder Engagement 22
1.9 Conclusion 23

2. Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health 24

2.1 Population Health Management Program 24
2.2 Enhanced Care Management Benefit 43
2.3 In Lieu of Services 53
2.4 Shared Risk, Shared Savings, and Incentive Payments 56
2.5 Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity 58
2.6 Full Integration Plans 61
2.7 Long-Term Plan for Foster Care 62

3. Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility 64

Managed Care 64
3.1 Managed Care Benefit Standardization 64
3.2 Mandatory Managed Care Enrollment 66
3.3 Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans 69
3.4 NCQA Accreditation of Medi-Cal Managed Care Plans 73
3.5 Regional Managed Care Capitation Rates 75
Behavioral Health 77
3.6 Behavioral Health Payment Reform 77
3.7 Medical Necessity Criteria 81
3.8 Administrative Integration of Specialty Mental Health and Substance Use Disorder Services 86
3.9 Behavioral Health Regional Contracting 91
3.10 Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements 93

Back to Agenda

Back To Item

Back to Item

Dental 99
3.11 New Dental Benefits and Pay for Performance 99
County Partners 102
3.12 Enhancing County Eligibility Oversight and Monitoring 102
3.13 Enhancing County Oversight and Monitoring: CCS and CHDP 105
3.14 Improving Beneficiary Contact and Demographic Information 107
4. Conclusion 109
5. From Medi-Cal 2020 to CalAIM: A Crosswalk 109
5.1 Transition of PRIME to Quality Incentive Program 114
5.2 Global Payment Program Extension 116
6. Appendices 119
Appendix A: 2021 and Beyond: CalAIM Implementation Timeline 119
Appendix B: Targeted Case Management 122
Appendix C: County Inmate Pre-Release Application Process sample contracting Models 125
Appendix D: Institutions for Mental Disease/Serious Mental Illness/Severe Emotional Disturbance Demonstration Goals & Milestones 126
Appendix E: CalAIM Benefit Changes Chart 130
Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage 131
Appendix G: Global Payment Program Extension Timeline 139
Appendix H: Dental in Proposition 56 vs. CalAIM 140
Appendix I: Enhanced Care Management Target Population Descriptions 142
Appendix J: In Lieu of Services Options 168
Housing Transition Navigation Services 169
Housing Deposits 176
Housing Tenancy and Sustaining Services 182
Short-term Post-Hospitalization Housing 189
Recuperative Care (Medical Respite) 195
Respite Services 198
Day Habilitation Programs 201
Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities 204
Community Transition Services/Nursing Facility Transition to a Home 207
Personal Care and Homemaker Services 210
Environmental Accessibility Adaptations (Home Modifications) 213
Meals/Medically Tailored Meals 217
Sobering Centers 219
Asthma Remediation 222
Glossary 226

1. Executive Summary

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that targets social determinants of health and reduces health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services with the goal of improving outcomes for all Californians. Attaining such goals will have significant impact on an individuals' health and quality of life and, through iterative system transformation, will ultimately reduce the per-capita costs over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are updated proposals based on extensive stakeholder feedback. Implementation will ultimately depend on the availability of funding and the requisite federal approvals.

CalAIM implementation was originally scheduled to begin in January 2021, but was delayed due the impact of the COVID-19 public health emergency. As a result, DHCS is proposing a new CalAIM start date of January 1, 2022.

1.1 Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations, as well as state-level statutory and policy changes. During this time, DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on their needs, some beneficiaries may access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental,

Back to Agenda

Back To Item

Back to Item

developmental, In Home Supportive Services, etc.) in order to get their needs addressed. As one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate our delivery systems and align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

Together, these CalAIM proposals offer solutions designed to ensure the stability of the Medi-Cal program and allow the critical successes of waiver demonstrations such as Whole Person Care Pilots, the Health Homes Program, the Coordinated Care Initiative, and the public hospital system delivery transformation, that advance the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees.

Our vision is that people served by our programs should have longer, healthier and happier lives. There will be a whole system, person centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives. It will be an integrated “wellness” system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

The whole system, person centered approach will be equitable. Services and supports will deliver the same high quality of care, and achieve more equal health outcomes across the entire continuum of care, for all. It will improve the physical, behavioral, developmental, oral and long term services and supports, throughout their lives, from birth to a dignified end of life.

When people need support, care or treatment they will be able to access a range of services which are made seamless, and delivered as close to home as possible. Services will be designed around the individual and around groups of people, based on their unique need and what matters to them, as well as quality and safety outcomes.

To do this, we must change the expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and systemic racism. We must make the system changes necessary to close the gap in transitions between delivery systems, create opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

1.2 Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles that were refined and established as the principles for the CalAIM initiative:

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, long term services and supports, and oral health needs of all members.
- Work to align funding, data reporting, quality, and infrastructure to mobilize and incentivize toward common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities and inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve the plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

1.3 Key Goals

To achieve these principles, CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Below is an overview of the various proposals and recommendations that make up CalAIM. See **Appendix A: 2021 and Beyond: CalAIM Implementation Timeline** for more information.

1.4 Identify and Manage Member Risk and Need Through Whole Person Care Approaches and Addressing Social Determinants of Health

California continues to strengthen integration within the state's health care delivery system aimed at achieving better care and better health. In line with these objectives, DHCS is proposing reforms that would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care, chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve these goals, DHCS proposes the following whole system, person centered approach that focuses on addressing the needs of beneficiaries across the system with the overarching goal of improving quality of life and health.

- Develop a statewide **population health management** strategy and require plans to submit local population health mangement plans.
- Implement a new statewide **enhanced care management benefit**.
- Implement **in lieu of services** (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement **incentive payments** to drive plans and providers to invest in the necessary infrastructure to build appropriate enhanced care management and in lieu of services capacity statewide.
- Pursue participation in the **Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity**.
- Require screening and enrollment for Medi-Cal **prior to release from county jail**.
- **Pilot full integration** of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for **foster care children and youth**.

Population Health Management

Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes. Each managed care plan shall provide, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and

- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care Pilots, and transitions those services to this new statewide managed care benefit to provide a broader platform to build on positive outcomes from those programs.

Proposed target populations include:

- Children or youth with complex physical, behavioral, developmental, and oral health needs (e.g. California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with serious mental illness (SMI), children with serious emotional disturbance (SED) or substance use disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under California's Whole Person Care Pilots, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with care management for members at high levels of

risk and may fill gaps in state plan benefits to address medical or social determinants of health. The current list of in lieu of services includes:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for plans and optional for beneficiaries, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building incremental change to achieve integrated managed long-term services and supports (MLTSS) in the managed care program by 2027 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the state must use its ability to provide Medi-Cal managed care plans with financial incentive payments to work with their providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

SMI/SED Demonstration Opportunity

With some exceptions, federal Medicaid funding cannot be used to pay for services provided to a Medicaid beneficiary while the beneficiary is residing in an Institution for Mental Disease (IMD). This is referred to as the IMD exclusion. Generally, an IMD is a hospital, nursing home or other institution with more than 16 beds that is primarily

engaged in treating persons with mental diseases. However, the federal government has developed an opportunity for states to receive federal funding for institutional services provided to populations with a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED), similar to the flexibility the state has secured for the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots. DHCS proposes to assess county interest in pursuing the SMI/SED demonstration opportunity, as long as our systems are positioned to achieve the required goals and outcomes, including building out a full continuum of care to offer beneficiaries community-based care in the least restrictive setting. Counties would voluntarily "opt-in" to participate. The main elements of the proposed SMI/SED demonstration opportunity would include:

- Ensuring high quality of care in psychiatric hospitals and residential settings, including required audits;
- Improving care coordination and transitions to community-based care;
- Increasing access to a full continuum of care including crisis stabilization and other clinically enriched forms of housing in the community with robust support services; and
- Earlier identification and engagement in treatment including through increased integration.

In pursuing this demonstration opportunity, counties that "opt-in" should be prepared to build out a robust continuum so individuals who begin at a higher level of institutional care can be stepped down to a less restrictive, community-based, residential setting.

Mandatory Medi-Cal Application Process upon Release from Jail and County Juvenile Facilities

Justice-involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail or county juvenile facilities, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs, such as housing, transportation, and overall integration back into the community are met. Studies have shown that these types of care coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. To ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate a county inmate Medi-Cal application process by January 2023. Additionally, DHCS is proposing to mandate that jails and county juvenile facilities implement a process for facilitated referral and linkage from county institution release to county specialty mental health, Drug Medi-Cal, DMC-ODS, and Medi-Cal managed care plans when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

Full Integration Plans

DHCS would like to test the effectiveness of an approach to provide full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around issues such as eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial considerations due to the current realignment and Proposition 30 structure of behavioral health. Given the complexity of this proposal and time needed for consideration and planning, DHCS expects that the first selected full integration plans would go live no sooner than 2027.

Develop a Long-Term Plan for Foster Care

In June 2020, DHCS launched the Foster Care Model of Care Workgroup to provide an opportunity for stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. The workgroup will complete its work in June 2021. Based on input from the workgroup, DHCS and the California Department of Social Services (CDSS) will develop a plan of action, which may involve budget recommendations, waiver amendments, state plan changes or other activities.

1.5 Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services vary depending on the county one lives in. DHCS is proposing to standardize and reduce complexity by implementing administrative and financial efficiencies across the state and aligning delivery systems to provide more predictability and reduce county-to-county differences. These reforms stretch across managed care, behavioral health, dental, and other county-based services.

To achieve such goals, DHCS proposes the following recommendations.

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long-term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance (NCQA) accredited
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Medical necessity criteria
- Administrative behavioral health integration statewide
- Regional contracting
- Drug Medi-Cal Organized Delivery System (DMC-ODS) program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle for young children (0 to 6 years of age) and Silver Diamine Fluoride for young children (0 to 6 years of age) and specified high-risk and institutional populations, as described in detail below.
- Pay for Performance for two adult and 17 children preventive services codes and continuity of care through a Dental Home

County-Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contact and demographic information

Managed Care

Managed Care Enrollment

DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries by January 2022 and all full- and partial-benefit dual beneficiaries by January 2023, statewide, to be enrolled mandatorily in a managed care plan. The one exception is for those for whom managed care enrollment is not appropriate due to limited scope of benefits or limited time enrolled. The goal is to align managed care enrollment practices that currently vary by aid code, population, and geographic location.

Standardize Managed Care Benefits

DHCS proposes to standardize managed care plan benefits, so that all Medi-Cal managed care plans provide the same benefit package by 2023. Some of the most significant changes are to carve-in institutional long-term care and major organ transplants into managed care statewide.

Transition to Statewide Managed Long-Term Services and Supports

To achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative (CCI) to standardized mandatory enrollment of dual eligibles into managed care. The goal is to achieve Medi-Cal benefits integration of long-term care into managed care for all Medi-Cal populations statewide, and to transition Cal MediConnect plans to Medicare Dual-Eligible Special Needs Plans (D-SNPs). This will be done in phases:

January 2022: The Coordinated Care Initiative (CCI) proceeds as today, except that the Multipurpose Senior Services Programs benefit would be carved out of managed care. DHCS will also implement voluntary in lieu of services at this time.

January 2023: Full transition to mandatory enrollment of dual eligibles into managed care. Further, all dual and non-dual fee-for-service (FFS) Medi-Cal beneficiaries residing in a long-term care facility will be enrolled in a managed care plan effective January 1, 2023. In addition, Medi-Cal managed care plans operating in CCI counties will be required to operate Medicare D-SNPs to transition the Cal MediConnect demonstration to a permanent, ongoing federal authority and to coordinate members' Medi-Cal and Medicare benefits.

January 2025: Medi-Cal managed care plans in non-CCI counties will be required to operate Medicare D-SNPs.

The purpose of these transitions and phases is to achieve a long-term goal of implementing MLTSS statewide in Medi-Cal managed care beginning in 2027, by providing enough time and incentive to develop the needed infrastructure. This will allow many duals to receive needed MLTSS and home and community-based services statewide through their managed care plan, instead of through a variety of 1915(c) HCBS waivers that currently have capped enrollment and are not statewide.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their health plan subcontractors to achieve National Committee for Quality Assurance (NCQA) accreditation by 2026. DHCS plans to use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain state and federal Medicaid requirements.

Regional Rates

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model. The proposal to move to regional rates has two main benefits. The first benefit is a decrease in the number of distinct actuarial rating cells that are required to be submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS and allow DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging beyond the experience of plans operating within a single county. This change is fundamental to the ability of DHCS to implement and sustain the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps to continue to invest in and improve access to mental health and substance use disorder (SUD) services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS. We recognize that we need to improve quality of and access to care for children and other vulnerable populations. In order to achieve true system transformation, DHCS is committed to first achieving behavioral health payment reform, where DHCS will transition counties from a cost-based reimbursement methodology to a structure more consistent

with incentivizing outcomes and quality over volume and cost. This shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation efforts and engage in value-based payment arrangements with their health plan partners to support better coordination and integration between physical and behavioral health. This shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

Behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to advance a high-quality continuum of care for mental health and SUD services in the community.

Revisions to Behavioral Health Medical Necessity

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services. DHCS is proposing to update behavioral health medical necessity criteria to more clearly delineate and standardize requirements and to improve access for beneficiaries to appropriate services statewide.

Administrative Behavioral Health Integration

Approximately half of individuals with a serious mental illness (SMI) have co-occurring substance use and those individuals would benefit from integrated treatment. The state covers Medi-Cal SUD and specialty mental health services through separate county contracts, which makes it difficult for counties and contracted providers to offer integrated treatment to individuals with co-occurring disorders. For example, counties are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, providers offering integrated treatment to a Medi-Cal beneficiary must document SUD treatment services separately from specialty mental health services. The purpose of this proposal is to streamline the administrative functions for SUD and specialty mental health services.

Behavioral Health Regional Contracting

Small counties could optimize resources through regional administration and delivery of specialty mental health and SUD services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to provide services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such

as the local Medi-Cal managed care plan or County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, DHCS encourages counties to join the Drug Medi-Cal Organized Delivery System (DMC-ODS) or provide DMC services through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Program Renewal and Policy Improvements

DHCS proposes to update the DMC-ODS program, based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying and/or changing policies to support the goal of improved beneficiary access to care, quality of care, and administrative efficiency.

Dental

The Department set an initial goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. To continue progress toward achieving this goal, and based on lessons learned from the Dental Transformation Initiative (DTI), DHCS proposes the following statewide reforms for Medi-Cal dental coverage:

- Add new dental benefits based on the outcomes and successes from the DTI that will provide better care and align with national oral health standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high-risk and institutional populations; and

- Continue and expand Pay for Performance Initiatives initiated under the DTI that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult Medi-Cal enrollees.

County Partners

Enhancing County Oversight and Monitoring: Eligibility

This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS remains compliant with federal and state eligibility and enrollment requirements. These enhancements will be developed and implemented in direct collaboration with our county partners.

Enhancing County Oversight and Monitoring: CCS and CHDP

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 children in Medi-Cal. The state delegates certain responsibilities for these high-risk children to California's 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach). The state needs to enhance the oversight of counties to ensure they comply with applicable state and federal requirements. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the state and counties, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

Improving Beneficiary Contact and Demographic Information

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which beneficiary contact and demographic information can be updated by other entities and the means to accomplish this, while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

1.6 Advancing Key Priorities

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other -- without one, the others are neither possible nor powerful.

These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value-based and integrated delivery of care are significantly harder and potentially impossible to achieve.

These fundamental financing changes would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the possibility of future full integration pilots) is critically dependent on the success of others.

The Medi-Cal program has evolved over the multiple decades since inception with ever-increasing system and fiscal complexities. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be more effective and efficient with the finite funding available for the program.

CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medi-Cal can easily integrate, complement and catalyze the Administration's plan to respond to the state's homelessness crisis; support reforms of our justice systems for youth and adults who have significant health issues; build a platform for vastly more integrated systems of care; and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission.

Furthermore, CalAIM will translate a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for children, proliferating the use of value-based payments across our system, including in behavioral health and long-term care, into the future of the program. CalAIM will also support the ongoing need to increase oversight and monitoring of all county-based services, including specialty mental health and substance use disorder services, Medi-Cal eligibility administration, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if approved and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal. This will ensure the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal and in Medicaid nationally. CalAIM proposes enhanced care management and in lieu of services (such as housing-related services, transitions, respite, and sobering centers) that address the clinical and non-clinical needs of these high-cost Medi-Cal beneficiaries. The initiative envisions a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services. It aligns the financing of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, and access to, integrated behavioral health care.

Vulnerable Children: CalAIM is designed to improve and streamline care for medically complex children to ensure they get their physical, behavioral, developmental, and oral health needs met. It aims to identify innovative solutions for providing low-barrier, comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children, including identifying the complex impacts of trauma, toxic stress, and adverse childhood experiences through, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to the clinically-linked housing continuum for our homeless population, and would include housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.

Justice-Involved: Under the proposed Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health, and non-clinical social services for justice-involved individuals prior to and upon release from county jails and county juvenile

facilities. These efforts will support scaling of diversion and re-entry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for those who are incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services, carving in long-term care statewide, mandatory Medi-Cal managed care enrollment, and aligned enrollment for dual eligible beneficiaries in Medi-Cal and D-SNP plans would allow the state to build infrastructure over time to provide MLTSS statewide by 2027. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the California's Master Plan for Aging.

1.7 From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Medicaid Section 1115 authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating the required budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools.

In addition, given that California has significant learnings from our past Section 1115 demonstrations, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for delivery system transformation in the Medi-Cal program.

This proposal outlines all elements of the Medi-Cal 2020 waiver and how they will, or will not, be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or ability to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85% of all Medi-Cal beneficiaries receive care, to be brought into the main fold of the managed care delivery system.

In March 2020, as COVID-19 community spread accelerated, the State of California moved quickly to stem the spread by enacting one the nation's earliest stay-at-home orders. This stay-at-home order was accompanied by suspension of non-essential medical procedures, transition to telehealth for many services, transition to telework for administrative staff, and reprioritization of health care resources and training, including infection control measures, to address COVID. While the stay-at-home order and related delivery system changes slowed the spread of the virus, these changes caused significant disruption to the overall health care delivery system, and the economy, in California.

As a result, DHCS received multiple requests from organizations representing the state's health care delivery systems (e.g. counties, provider organizations, hospitals, behavioral health directors, and managed care plans). Stakeholders uniformly requested that, since providers and other partners are not able to properly prepare for CalAIM implementation given the focus and attention needed to respond to the COVID-19 emergency, the state request an extension of the Medi-Cal 2020 Section 1115 waiver.

In recognition, the Governor's revision to the state budget released in May 2020 postponed funding for CalAIM. This confluence of events prevented the state from moving ahead with the negotiation and implementation of CalAIM with a January 1, 2021 start. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost-effectiveness, of the Medi-Cal/Medicaid program.

1.8 CalAIM Stakeholder Engagement

DHCS released the original CalAIM proposal in October 2019 ahead of an intensive four-month stakeholder engagement process. Between November 2019 and February 2020, five topic-specific workgroups comprised of stakeholders across the state participated in a series of robust in-person meetings. During these discussions, Workgroup members provided real-time feedback on the proposals as they evolved and offered helpful considerations with respect to implementation and operations. The public also had the opportunity to provide feedback on the proposals, both during the workgroup sessions and in writing. This iteration of the CalAIM proposal incorporates the broad range of

feedback received during the stakeholder engagement process. It should be noted that this resulting proposal is dependent on the funding availability through the state budget process, and federal approvals.

1.9 Conclusion

CalAIM is an ambitious but necessary proposal to positively affect Medi-Cal beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, and ensuring the system more appropriately manages patients over time through a comprehensive set of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.
- Creates a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services, and aligns the financing of behavioral health with physical health, providing financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care.
- Ensures medically complex children and adults get their physical, behavioral, developmental, and oral health needs met.
- Builds capacity in a clinically-linked housing continuum via in lieu of services for California's homeless population, including housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.
- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail and county juvenile facilities.
- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the State's Master Plan for Aging.

2. Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

This section will walk through proposals to identify and manage member risk and need:

- Population Health Management Program
- Enhanced Care Management
- In Lieu of Services
- Shared Risk, Shared Savings, and Incentive Payments
- SMI/SED Demonstration Opportunity
- Full Integration Plans
- Long-Term Plan for Foster Care

2.1 Population Health Management Program

2.1.1 Background

DHCS currently does not have a specific requirement for Medi-Cal managed care plans to maintain a population health management (PHM) program, which is a model of care and a plan of action designed to address member health needs at all points along the continuum of care. Many Medi-Cal managed care plans have a population health management program – often in the context of meeting National Committee for Quality Assurance (NCQA) requirements – but some do not. In the absence of a population health management program, beneficiary engagement is often driven by a patchwork of requirements that can lead to gaps in care and a lack of coordination.

The goal of this proposal is to improve health outcomes and efficiency through standardized core population health management requirements for Medi-Cal managed care plans, including NCQA requirements and additional DHCS requirements. The population health management program will be comprehensive and address the full spectrum of care management – including assessing population level and individual member health risks and health-related social needs, creating wellness, prevention, case management, care transitions programs to address identified risks and needs, and using stratification to identify and connect adult and pediatric members to the appropriate programs. Additionally, Medi-Cal managed care plans will develop predictive analytics about which members, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports.

2.1.2 Proposal

All Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management program, where the plan will partner with contracted health care providers and community-based partners to identify and address members' health and health-related social needs. Medi-Cal managed care plans shall consult with their local public health department and county behavioral health department during the development of the population health management program.

The population health management program shall meet NCQA standards for population health, regardless of whether the plan is NCQA accredited. In addition to the NCQA accreditation processes, the population health management program description must be filed with the state via the population health management template (forthcoming). After the initial program description submission, the Medi-Cal managed care plan will submit certain portions of the program description, including any changes, to DHCS annually, but significant portions of the program description will only be required to be submitted to DHCS once every three years.

Each Medi-Cal managed care plan shall include, at a minimum, a description of how it will meet the core objectives to:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination;
- Identify and mitigate social determinants of health; and
- Reduce health disparities or inequities.

The population health management program shall:

- Include the goal to improve the health outcomes of communities and groups;
- Utilize data to analyze community and population level health and health-related social needs and set measurable goals for improvement;
- Utilize initial and ongoing assessments of data to analyze individual member's needs and identify groups and individuals within groups for targeted interventions;
- Provide assistance for members to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, slow the progression of

disease or disability, and support members with serious illness as their disease progresses;

- Coordinate care across the continuum of medical, behavioral health, developmental, oral health, and long-term services and supports, including tracking referrals and outcomes of referrals;
- Deploy strategies to address individual needs and mitigate social determinants of health;
- Deploy strategies to drive improvements in health for specific populations proactively identified as experiencing health disparities;
- Partner with appropriate community-based providers to support individual members, families, and caregivers in managing care.
- Utilize evidence-based practices in screening and intervention;
- Utilize a person-centered and family-centered approach for care planning; and
- Continually evaluate and improve on the population health management program strategy on an ongoing basis through meaningful quality measurement.

Assessment of Risk and Need

1. Initial Data Collection and Population Risk Assessment

As reflected in the NCQA Population Health program requirements and the DHCS Population Needs Assessment All Plan Letter (APL), the Medi-Cal managed care plan shall collect electronically available data sources in order to analyze data that capture the information on member health status and utilization (including physical, behavioral, and oral health), health-related social needs, and linguistic, racial, and cultural characteristics. As part of the population health management requirements, DHCS will continue to apply the existing Population Needs Assessment (PNA) APL requirements to hold the Medi-Cal managed care plans accountable for a PNA, which include requirements for analyzing health disparities and engaging external stakeholders as part of the process. DHCS will consult with NCQA to ensure the PNA APL data requirements meet NCQA data requirements for the population assessment.

The PNA requires that Medi-Cal managed care plans collect and analyze this data across the plan's entire Medi-Cal member population to identify opportunities at a population level to improve health. One example of how this might be done is through a type of analysis commonly known as "hot spotting." As noted in the PNA and NCQA

requirements, key issues Medi-Cal managed care plans must analyze in the assessment include:

- Acute, chronic, and prevention/wellness health needs;
- Areas of clinically inappropriate, over and under-utilization of health care resources;
- Opportunities for better care management and quality improvement;
- Health disparities by race, ethnicity, language, and functional status; and
- Health-related social needs at the community or local level.

The results of the PNA will inform the development of programs and strategies that the Medi-Cal managed care plan will use to address the needs of specific populations. Determining which individuals have access to these specific programs and strategies will be driven by the subsequent member-level risk stratification, population segmentation, and case management activities. Consistent with the PNA APL, Medi-Cal managed care plans must use the assessment to develop and implement an action plan to address community and population needs. DHCS does not currently plan to provide more specific requirements regarding community and population-level program development, but in the population health management template, Medi-Cal managed care plans will be asked indicate what they will be doing in this area, which also may be a focus of future learning collaborative best practice work.

2. Initial Risk Stratification, Segmentation and Tiering

Risk stratification or segmentation will enable Medi-Cal managed care plans to identify specific members who may benefit from wellness, prevention, and disease management activities; members who can benefit from case management; and members who are at risk for developing complex health issues. Consistent with NCQA Population Health program requirements, Medi-Cal managed care plans will be required to risk stratify and segment members into groups that it will use to develop and implement case management, wellness, and health improvement programs and strategies. Medi-Cal managed care plans will also be required to use DHCS-defined criteria to tier its members into four risk tier categories and report that information to DHCS.

Consistent with the NCQA Population Health program requirements, Medi-Cal managed care plans shall conduct the risk stratification and segmentation and DHCS risk tiering using an integrated data and analytics stratification process that considers at least the following sources:

- Previous screening or assessment data;
- Disengaged member reports;
- Claims or encounter data, including all fee-for-service data provided by DHCS;

- And to the extent available:
    - Available social needs data, including housing status ICD-10 data; and
    - Electronic health records.

Risk Stratification or Segmentation: Medi-Cal managed care plans will analyze each individual's data based on the minimum, mandatory list of data sources described above and will then risk stratify and segment members into meaningful sub-populations. The Medi-Cal managed care plan will use risk stratification and segmentation to identify specific members who may benefit from targeted interventions and programs designed to meet identified member needs. Risk stratification and segmentation must occur within 44 days of the effective date of plan enrollment.

The Medi-Cal managed care plan may use its own algorithm to risk stratify or segment its population or it may use the DHCS-defined risk tiers described below as a starting point for further stratification and segmentation. The design of the algorithm, including how the data is stratified and segmented as part of the algorithm, should be informed by the health needs identified through the population assessment and designed so that the Medi-Cal managed care plan can group individual members into meaningful categories and subsequently outreach to individual members within those categories for tailored interventions and programs designed to achieve specific health outcomes. Medi-Cal managed care plans will incorporate enhanced care management into their segmentation in accordance with DHCS enhanced care management target population guidance and Medi-Cal managed care plan flexibility afforded for the enhanced care management benefit. When risk stratifying its member population, Medi-Cal managed care plans must use a validated risk grouper.

Risk stratification or segmentation algorithms shall include past medical and behavioral health service utilization but must also incorporate other data such as health conditions, risk factors, and disease progressions, in order to avoid exacerbating underlying biases in utilization data that may drive health disparities. Medi-Cal managed care plans must analyze the results of its stratification/segmentation algorithm to identify and correct any biases the algorithm may introduce based on race, ethnicity, language, functional status, or other sources of health disparities. In the population health management program description, the Medi-Cal managed care plan will submit to DHCS its list of stratification/segmentation data sources, the risk stratification/segmentation algorithm (or the name of the tool if it is proprietary), and also the method of bias analysis. To promote transparency and best practices, these three pieces of information will be made available for public viewing on DHCS' website and will also be a focus of continuing Medi-Cal managed care plan learning collaborative activities.

Based on the risk stratification/segmentation and the findings from Individual Risk Assessment (IRA) described below, the Medi-Cal managed care plan will link the member with the appropriate services including, but not limited to, wellness and prevention, general case management, complex case management, enhanced care management, in lieu of services (as available) external entity coordination, and transition coordination. Specific minimum requirements for each of these categories are listed in their own sections below.

DHCS Risk Tiering Requirements. This risk tiering process, including the IRA described below, will satisfy federal Medicaid Managed Care Final Rule requirements for initial risk assessment. Medi-Cal managed care plans will use DHCS-defined criteria to assign each member into one of four risk tiers: (1) low risk; (2) medium and rising risk; (3) high risk; and (4) unknown risk. The criteria for these tiers will be developed by DHCS.

The types of criteria used will be similar (but not the same) as the DHCS criteria for risk stratifying seniors and persons with disabilities (SPDs) into low- and high-risk groups. The criteria will align with the questions that DHCS will develop for the IRA survey tool, which is addressed in the next section. “High risk” members are those who are at increased risk of having an adverse health outcome or worsening of their health status. “Medium and rising risk” members are those that are stable at a medium risk level and those whose health status suggest they have the potential to move into the high-risk category.

Members at the medium/rising and high risk levels likely require additional provider-level assessment, care coordination, and/or possibly case management, or other specific services, which will be determined by the Medi-Cal managed care plan’s population segmentation strategy and coordination with providers. “Low risk” members are those who, in general, only require support for wellness and prevention. “Unknown risk” members are those who do not have sufficient data to stratify into a risk tier and for whom the Medi-Cal managed care plan is unable to complete a member-contact screening risk assessment. The IRA survey tool will be designed to have enough information to allow for risk tier assignment on its own if there is insufficient available historical data for the member.

DHCS will develop a process to validate Medi-Cal managed care plans’ implementation of the DHCS risk tier criteria to ensure consistent application and output statewide.

3. Individual Risk Assessment Survey Tool

DHCS will develop a standardized, 10-15 question Individual Risk Assessment (IRA) Survey Tool. There will be two versions, one for children and one for adults. Medi-Cal managed care plans will use the IRA to: (1) confirm or revise the initial DHCS risk tier to which the member was assigned; (2) gather consistent information for members without sufficient data; and (3) add information that will be used as part of its own stratification/segmentation algorithms and population health management strategy.

DHCS' goal in the development of the IRA questions will be to ensure they are validated and can be used with a scoring mechanism so that the IRA information can be integrated into the Medi-Cal managed care plan's risk stratification/segmentation process. DHCS will translate the questions into the threshold languages. Medi-Cal managed care plans will have the flexibility to add questions of their choosing to the IRA and would then also translate those additional questions into all threshold languages. It is expected that Medi-Cal managed care plans will conduct subsequent and separate screenings (or add supplemental questions) to identify specific issues and priorities to address.

The IRA will replace the assessments below:

- Staying Healthy Assessment/Individual Health Education Behavioral Assessment (SHA/IHEBA)
- Health information form/member evaluation tool (HIF/MET)
- Health risk stratification and assessment survey for SPDs
- Whole Child Model Assessment
- The Initial Health Assessment (IHA) provider visit (within 120 days of enrollment) will remain a requirement, but DHCS contracts and policies will not specify provider requirements for that visit.

Medi-Cal managed care plans will continue to be required to ensure the provision of preventive and other services in accordance with contractual requirements and accepted standards of clinical care.

Members assigned to the DHCS medium/rising, high, and unknown risk tiers must be contacted within 90 (medium/rising) and 45 (high and unknown) calendar days respectively to assess their needs. The IRA may be done via multiple modalities, including phone, in-person, electronic, or mail, as long as the screening responses can be transposed into an electronic format that allows for data mining and data exchange of key elements with DHCS. Data exchange of IRA elements with DHCS is not required at this time. Medi-Cal managed care plans should use this modality flexibility to maximize successful contact. Medi-Cal managed care plans shall make at least three (3) attempts to contact a member using available modalities.

If the Medi-Cal managed care plan is unable to obtain a completed IRA from a member, it has the option to create a process for working with the member's assigned primary care provider to: 1) have the member complete the assessment with them; and 2) transfer the resulting information to the Medi-Cal managed care plan.

Medi-Cal managed care plans will use the IRA information to assign or revise the member's DHCS risk tier. Once that process is complete, Medi-Cal managed care plans will be responsible for reporting the member's assigned risk tier to DHCS in an electronic format to enable better tracking and assessment of the impacts of the population health

management program. The Medi-Cal managed care plan will also share information regarding the assigned member's risk tier to the member's assigned PCP in an electronic format. If the member transfers to another Medi-Cal managed care plan, DHCS will provide the member's risk tier to the new Medi-Cal managed care plan.

The IRA questions will align with the DHCS-specified criteria for high, medium/rising, and low risk tiers. It is DHCS's intent that the structure of the IRA will meet NCQA requirements for a Health Appraisal.

- The IRA will include 10-15 questions, which seek to identify preliminary risk information for the following elements: Behavioral, developmental, physical, Long Term Services and Supports, and oral health needs;
- Emergency department visits within the last six months;
- Self-assessment of health status and functional limitations;
- Adherence to medications as prescribed;
- Assessment of health literacy and cultural and linguistic needs;
- Desire or need for case management;
- Ability to function independently and address his/her own health needs;
- Access to basic needs such as education, food, clothing, household goods, etc.;
- Use or need for long-term services and supports;
- Availability of social supports and caregiver;
- Access to private and public transportation;
- Social and geographic isolation; and
- Housing and housing instability assessment;

4. Reassessment

At a minimum, the Medi-Cal managed care plan shall reassess risk and need, including rising risk, of all members annually both the DCHS risk tiering and its own risk stratification/segmentation process. Individual members' risk and need may need to be re-evaluated throughout the year based on a change in condition or level of care, such as an inpatient admission or new diagnosis, the availability of new data, or a case management interaction.

Medi-Cal managed care plans must describe what events or data trigger the re-evaluation process for individual members. In the population health management program description, the Medi-Cal managed care plan must inform DHCS what minimum risk groups would require regular assessment in between the annual risk stratification process. However, this does not limit the Medi-Cal managed care plan from conducting additional assessments beyond what is defined as required by DHCS.

5. Provider Referrals

Medi-Cal managed care plans must establish a process by which providers may make referrals for members to receive case management or services for other emerging needs. Referrals for case management should lead to a re-evaluation of risk stratification and DHCS risk tier assignment. Medi-Cal managed care plans must consider and integrate information received through referrals when determining members' risk stratification.

Actions to Support Wellness and Address Risk and Need

1. General Requirements and Services

The Medi-Cal managed care plan shall integrate required activities with the population health management program as appropriate including, but not limited to member services, utilization management, referrals, transportation, health/plan/benefit education, appointment assistance, warm-handoffs to community-based organizations or other delivery systems, system navigation, primary care provider member assignment, community outreach, preventive services, and screenings for all members.

The Medi-Cal managed care plan shall provide a toll-free line for primary care providers and specialists who seek technical and referral assistance when any physical or behavioral condition requires further evaluation or treatment. Available information shall include assistance in arranging for referrals, including mental health and SUD treatment referrals, developmental services referrals, dental referrals, referrals to home-based medical/social services for people with serious illness, and referrals to long-term services and supports. Communication about the availability of this consultation service shall be found on the front-page of the Medi-Cal managed care plan's website and in materials supplied to providers.

The Medi-Cal managed care plan shall provide a 24-hours-a-day, 7-days-a-week, toll-free nurse advice line for members who seek technical, clinical, and referral assistance for physical, oral, and behavioral health services to address urgent needs.

The Medi-Cal managed care plan shall demonstrate how they support practice change activities, the deployment of evidence-based tools for providers, and models of service delivery that optimize health care and coordinated health care and social services. Finally, the Medi-Cal managed care plan shall develop or provide access to a current and updated community resource directory for case managers and contracted providers.

2. Wellness and Prevention Services

The Medi-Cal managed care plan shall provide wellness and prevention services in accordance with NCQA and contractual requirements. The population health management program shall integrate wellness and prevention services for all members, regardless of risk tier, according to the benefits outlined in the managed care contract including, but not limited to, the following:

- Provide preventive health visits, developmental screenings, and services for:
  - All children (under 21 years of age) in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule.
  - All adults in accordance with US Preventive Services Task Force Grade "A" and "B" recommendations.
- Monitor the provision of wellness and preventive services by primary care providers as part of the Medi-Cal managed care plan Facility Site Review process.
- Provide health educational materials about topics such as disease management, preventive services, Early and Periodic Screening, Diagnostic, and Treatment services, how to access benefits, and other managed care plan health promotion materials.

3. Managing Members with Medium/Rising Risks

The population health management program shall:

- Provide screening for Adverse Childhood Experiences (ACEs) for children and adults, based on the recommended periodicity schedule as specified in the Medi-Cal managed care contract.
- Ensure members receive appropriate follow-up for behavioral, developmental, physical, and oral health needs including preventive care, care for chronic conditions, and referrals to long-term services and supports, as appropriate;

- Refer members identified, through assessment or re-assessment, as needing care coordination or case management to the member's case manager for follow-up care and needed services within 30 calendar days; and

- Assess individual social care needs and deploy appropriate community resources and strategies to mitigate the adverse childhood experiences (ACEs) toxic stress and impacts of social determinants of health in partnership with providers and community organizations.

Additionally, Medi-Cal managed care plans will be required to use predictive analytics to inform them about which patients, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports. To address this focus, Medi-Cal managed care plans shall incorporate the DHCS Population Needs Assessment and NCQA Population Health program requirements on this topic into their population health management strategy. Identifying and addressing the needs of specific high-risk communities and populations – sometimes referred to as "hot spotting" – will be a focus of the population health management learning collaborative and DHCS will continue to assess best practices in this area.

4. Case Management

Case management services actively assist at-risk members in navigating health delivery systems and acquiring self-care skills to improve functioning and health outcomes, slow the progression of disease or disability or prepare for the progression of a serious illness. Case management services are intended for members who are medium- or high-risk or may have rising risks that would benefit from case management services. Members determined to be low risk should continue to receive wellness and prevention services as well as other medically necessary services.

Case management services include the following, as needed and appropriate:

- Screening beyond the IRA to identify and prioritize goals and needs for case management, including both health issues, ACEs and toxic stress, and health-related social needs
- Documentation in an electronic format of the individual care plan and assigned case manager for each member (required for all case management).
- Utilization of evidence-based practices in screening and intervention.
- Ongoing review of the member's goals and care plan as well as identifying and addressing gaps in care.
- Support from an inter-professional team with one primary point of contact for the member.

- Access to person-centered planning, including advanced care planning regarding preferences for medical treatment, and education and training for providers and families.
- Continuous information sharing and communication with the member and their providers.
- Ensuring a person-centered and family-centered approach by identification of member's circle of support or caregiver(s).
- Coordination and access to medically necessary health services and coordination with entities that provide mental health, substance use disorder services, and developmental and oral health services.
- Ensuring coordination and access to community-based services, such as home care, personal care services, and long-term services and supports.
- Developing relationships with local community organizations to implement interventions that address social determinants of health (e.g. housing support services, nutritional classes, etc.).
- Coordinating authorization of services including timely approval of and arranging for durable medical equipment, pharmacy, private duty nursing, palliative care, and medical supplies.
- Promoting recovery using community health workers, peer counselors, and other community supports.
- Requesting modifications to treatment plans to address unmet service needs that limit progress.
- Assisting members in relapse and/or crisis prevention planning that includes development and incorporation of recovery action plans, and advance directives for individuals with a history of frequent mental health readmissions or crisis system utilization.
- Assisting members in care planning related to cognitive impairment, traumatic brain injury, Alzheimer's disease, and dementia.
- Performance measurement and quality improvement using feedback from the member and caregivers.
- Delivery of services in a culturally competent manner that addresses the cultural and linguistic needs by interacting with the member and his or her family in the member's primary language (use of interpreter allowed), with appropriate consideration of literacy and cultural preference.
- If the Medi-Cal managed care plan assigns a case manager outside the plan, written agreements shall define the responsibility of each party in meeting case management requirements to ensure compliance and non-duplication of services. If situations arise where a member may be receiving care coordination from multiple entities, the Medi-Cal managed care plan shall identify a lead care coordinator.

If a member changes enrollment to another Medi-Cal managed care plan, the Medi-Cal managed care plan shall coordinate transition of the member to the new plan's case management system to ensure services do not lapse and are not duplicated in the transition. The Medi-Cal managed care plan must also ensure member confidentiality and member rights are protected.

Members may be assigned to one of three types of case management based on assessment of risk and need.

The three types of case management include:

- **Basic Case Management:** Basic case management would be appropriate for members who require planning and coordination that is not at the highest level of complexity, intensity, or duration. These services are provided by the Medi-Cal managed care plan, clinic-based staff, or community-based staff, and may be provided by non-licensed staff. These services may include assignment to a certified patient-centered medical home, participation in a Medi-Cal managed care plan disease management program or participation in another Medi-Cal managed care plan population health management program.

- **Complex Case Management:** The Medi-Cal managed care plan shall provide complex case management in accordance with NCQA requirements. NCQA defines complex case management as "a program of coordinated care and services for members who have experienced a critical event or diagnosis that requires extensive use of resources." NCQA allows organizations to define "complex." Complex case management generally involves the coordination of services for high-risk members with complex conditions.

- **Enhanced Care Management:** The proposed Enhanced Care Management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals. Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The population health management program description shall describe how and when the services are utilized in conjunction with the risk stratification process, as members with changing risk and needs may require changing levels of case management. If the Medi-Cal managed care plan delegates or contracts with a provider for case management or transition of care services, it must do so in accordance with the NCQA's population health management delegation requirements.

5. In Lieu of Services

"In lieu of services" are flexible wrap-around services that the Medi-Cal managed care plan will integrate into their population health management programs. These services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. In lieu of services should be integrated with case management for members at medium-to-high levels of risk and may fill gaps in Medi-Cal State Plan benefits to address medical or other needs that may arise due to social determinants of health. DHCS is proposing the initial use of in lieu of services to serve as a transition of the work done through existing pilots (e.g. Whole Person Care, the Health Homes Program, the Coordinated Care Initiative, etc.), as well as inform the development of future potential statewide benefits that may be instituted.

Examples of the in lieu of services that DHCS proposes to cover include many of the services currently provided in the Whole Person Care Pilot program that are not covered as Medi-Cal State Plan benefits. Some of these include, but are not limited to, respite, recuperative care, medically tailored meals, supplemental personal care services, housing tenancy navigation and sustaining services, and sobering centers. Medi-Cal managed care plans will develop a network of providers of allowable in lieu of services with consideration for which community providers have expertise and capacity regarding specific types of services. See **Appendix J: In Lieu of Services Options** for more detail.

6. Coordination between Medi-Cal Managed Care Plans and External Entities

The Medi-Cal managed care plan shall describe in the population health management program description how they will coordinate with, and refer members to, health care and social services/programs including, behavioral health services, dental, and home and community-based services. Referrals must be culturally and linguistically appropriate for the member. The Medi-Cal managed care plan must coordinate with competent external entities to provide all necessary services and resources to the member. These entities should be listed as part of the population health management program description identifying specific services each named entity will provide plan members. The Medi-Cal managed care plan's population health management

program description shall include assurance of payment to Indian Health Care Providers.

7. Transitional Services

The Medi-Cal managed care plan shall ensure transitional services are provided to all members who are transferring from one setting, or level of care, to another. The Medi-Cal managed care plan shall work with appropriate staff at any hospital that provides services to its members, whether contracted or non-contracted in the case of emergency services, to implement a safe, comprehensive discharge plan. The plan must provide continued access to medically necessary covered services that will support the member's recovery and prevent readmission.

The Medi-Cal managed care plan shall have in place operational agreements or shall incorporate transitional language into existing network arrangements with the Medi-Cal managed care plan's contracted community physical and behavioral health hospitals, residential treatment facilities and long-term care facilities, as applicable, to ensure smooth transitions. Transition services shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. The operational agreements shall define the responsibility of each party in meeting the following requirements:

- Completion of a standardized discharge risk assessment tool. The tool shall assess risk for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism. Each Medi-Cal managed care plan's discharge screening tool must be approved by DHCS;
- Development of a written discharge plan, shared with the beneficiary and all treating providers, to mitigate the risk of readmission and other negative health outcomes;
- Obtain the member's permission to share information with clinical and non-clinical providers to facilitate care transitions;
- Develop discharge planning policies and procedures in collaboration with all hospitals;
- Process all hospital prior authorization requests for clinic services within two business days. Such services shall include authorizations for therapy, home care services, equipment, medical supplies, and pharmaceuticals;
- Educate hospital discharge planning staff on the clinical services that require pre-authorization to facilitate timely discharge from the hospital; and
- Prevent delayed discharges from a hospital due to Medi-Cal managed care plan authorization procedures or transition to a lower level of care.

8. Skilled Nursing Facility Coordination

The Medi-Cal managed care plan shall coordinate with hospital or other acute care facility discharge planners and nursing facility case managers or social workers to ensure a smooth transition to or from a skilled nursing facility or nursing facility. The Medi-Cal managed care plan shall coordinate with the facility to provide case management and transitional care services and ensure coverage of all medically necessary services not included in the negotiated daily rate. This includes, but is not limited to, prescription medications, durable medical equipment, intravenous medications, and any other medically necessary service or product.

- If the Medi-Cal managed care plan, in coordination with the nursing facility or skilled nursing facility, anticipates the member will be in the facility after a member no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Medi-Cal managed care plan shall assist the member in exploring all available care options. This includes potential discharge to a home or community residential setting, or to remain in the skilled nursing facility for long-term services and supports.
- If the member is discharged to a home or to a community residential setting, the Medi-Cal managed care plan shall coordinate with the facility to ensure the member is in a safe location. The plan shall ensure medically necessary services are available including, but not limited to, home health services, durable medical equipment and supplies, outpatient rehabilitation services, and any other services necessary to facilitate the member's recovery. The Medi-Cal managed care plan shall also ensure follow-up care is provided consistent with the transitional service requirements listed above.

Population Health Management Oversight

The Medi-Cal managed care plan shall have internal monitoring processes in place to ensure compliance with the population health management program requirements. Quality assurance reviews of documented population health management activities shall include:

- Case identification and assessment according to established risk stratification system;
- Electronically documented treatment plans and care plans with evidence of periodic revision as appropriate to emerging member needs;
- Referral management;
- Effective coordination of care, including coordination of services that the member receives through the fee-for-service system; and

- Identification of appropriate actions for the case manager to take in support of the member, and the case manager's follow-through in performing the identified tasks.

The Medi-Cal managed care plan shall document quality assurance reviews on an annual basis or upon DHCS' request and submit them to DHCS for review. Medi-Cal managed care plans are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters, Policy Letters, and Dual Plan Letters. These requirements must be communicated by each Medi-Cal managed care plan to all delegated entities and sub-Medi-Cal managed care plans. The Medi-Cal managed care plan must submit a population health management oversight plan in accordance with NCQA requirements for any entities to which they delegate population health management functions. Such plans would need to be reviewed and approved by the state.

Health Information Technology to Support Integrated Care and Care Coordination

The Medi-Cal managed care plan will work to implement health information technology to support population health principles, integrated care, and care coordination across the delivery system. Examples of health information technology include, but are not limited to, electronic health records, emergency department information exchange, clinical data repositories, registries, decision support and reporting tools that support clinical decision-making, and case management. An overarching goal of the population health management program is to expand interoperable health information technology and health information exchange infrastructure, so that relevant data (including clinical and non-clinical) can be captured, analyzed, and shared to support provider integration of behavioral health and medical services, case management oversight and transitional planning, value-based payment models, and care delivery redesign.

The Medi-Cal managed care plan shall develop data exchange protocols, including member information sharing protocols, before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including, but not limited to, sharing of claims and pharmacy data, treatment plans or care plans, and advance directives necessary to coordinate service delivery and care management for each member in accordance with applicable privacy laws.

Improved data collection, specifically of encounter data at the provider level, is a critical component of achieving the goals of this proposal, and DHCS will be working with plans and providers to achieve this goal.

Accountability and Oversight of Medi-Cal Managed Care Plans

In order to hold Medi-Cal managed care plans accountable for the activities proposed here, DHCS will increase its oversight and assessment of the plans to include changes

to its audit procedures and the imposition of corrective action plans and financial sanctions, when appropriate. DHCS recognizes that, through this and the other CalAIM proposals, the responsibility of Medi-Cal managed care plans will increase over time, and therefore DHCS' approach to oversight and accountability must also grow and change in conjunction with these proposals. DHCS is committed to providing Medi-Cal managed care plans technical assistance to support the smooth adoption of these changes.

Future Policy Development and Technical Assistance

As technical assistance for Medi-Cal managed care plans in development of their population health management programs, DHCS will provide submission templates and best practice examples of Medi-Cal managed care plan population health management programs from California and other states. DHCS will also create a DHCS-operated learning collaborative for Medi-Cal managed care plans to share information and promising practices. The learning collaborative will foster information sharing and address promising practices in all the DHCS-required population health management activities. The following topics that have been identified by stakeholders:

- Medi-Cal managed care plan coordination and partnerships with external entities that provide carved-out services, such as specialty mental health, Drug Medi-Cal, Regional Centers, schools, public health departments, and community-based organizations that provide social services;
- Engaging with consumers who have health and social needs but are unidentified, unengaged, and are underutilizing services, including methods to engage with these members, build trust, and obtain information from the member about their needs;
- Care transition coordination including sharing discharge risk assessment tools;
- Incorporating social determinants of health and health-related social care needs into case management and community-level population improvement activities;
- Collection of social determinants of health information for risk stratification and segmentation, and for state-level data collection for strategic planning purposes;
- Best practices in how to use population health management programs to support specific populations of interest, such as children and pregnant women, in ways that align with other DHCS initiatives;
- Use of population data for "hot spotting" and other population analysis promising practices;

- Use of general beneficiary medical record release consent to allow Medi-Cal managed care plans and providers to share data broadly for the purposes of care coordination;
- Learning best practices from California Accountable Communities for Health Initiative activities, including opportunities for partnership and elements that may be appropriate to integrate into the population health management strategies;
- Data exchange protocols and the development of health information technology/health information exchange policies; and
- Submission of housing status data to DHCS via ICD-10 coding, in alignment with the current DHCS Value-Based Payment incentive program for these codes.

The best method to advance promising practices in these areas may be to allow them to emerge through a learning collaborative and assessment of Medi-Cal managed care plan outcomes. DHCS may also standardize certain requirements after further research and consultation with stakeholders.

Continuing areas of DHCS policy development will include:

- DHCS Risk Tiering criteria;
- DHCS IRA to gather individual member information for risk tiering and stratification;
- Detailed review of alignment with NCQA Population Health program requirements, in coordination with NCQA and Medi-Cal managed care plans;
- Continued exploration into what guidance DHCS can provide regarding what can be allowed for different types of information sharing between providers and Medi-Cal managed care plans to facilitate care coordination;
- Voluntary guidance from DHCS regarding Medi-Cal managed care plan collection of social determinants of health data from ICD-10 encounter coding. The guidance, and Medi-Cal managed care plan collection of this data in accordance with the guidance, will become mandatory on January 1, 2024; and
- Setting prospective, prioritized goals to improve Medi-Cal managed care population health management over five years from the implementation date. To do this, DHCS will review of population health management program outcomes goals and measures, and their relation to the broader DHCS managed care quality metric strategy, which may be used to assess each Medi-Cal managed care plan's population health management program.

2.1.3 Rationale

The population health management program requirement will ensure that there is a cohesive plan to address beneficiary needs across the continuum of care, from prevention and wellness to complex case management. This proposal will work in conjunction with other CalAIM proposals to meet the overarching CalAIM goals of improving coordination and quality, while reducing unnecessary administrative burden and redundancy. The following CalAIM elements of the population health management program will magnify the positive impact on member outcomes:

- **NCQA Accreditation** will provide a foundation of quality best practices and an oversight structure for the population health management program and other Medi-Cal managed care plan activities;
- The new **enhanced care management** benefit will provide a critical new set of services as well as an effective case management tool to integrate within the population health management program;
- The adoption of a menu of **in lieu of services** – flexible wrap-around services designed to fill medical and social determinants of health gaps – will similarly integrate within the population health management program; and
- Making **shared risk/savings and incentive payments** available to Medi-Cal managed care plans and providers will maximize the effectiveness of the population health management program and new service options.

2.1.4 Proposed Timeline

The population health management program would be implemented as part of the new Medi-Cal managed care plan contracts, with an effective date of January 1, 2023. The date for the first population health management program description submission and other required submissions from Medi-Cal managed care plans to DHCS is to be determined.

2.2 Enhanced Care Management Benefit

2.2.1 Background

Depending on the needs of the beneficiary, some individuals may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.). Given the similarities in target populations across Medi-Cal delivery systems, beneficiaries are likely to be eligible for multiple programs that include some level of care management, depending on the efforts that are underway in their county of residence.

Additionally, as one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. The Health Homes Program and many of the Whole Person Care pilots provide such services. DHCS is proposing the implementation of a single, comprehensive enhanced care management benefit within Medi-Cal managed care. Lessons learned from the Whole Person Care pilots and the Health Homes Program will be incorporated to ensure that the new enhanced care management benefit is designed to meet the clinical and non-clinical needs for the highest cost/highest need beneficiaries in Medi-Cal and is available as a statewide benefit.

2.2.2 Proposal

The proposed enhanced care management benefit will replace the current Health Homes Program and elements of the Whole Person Care pilots, building on positive outcomes from those programs over the past several years. Based on extensive stakeholder engagement, DHCS will require that beneficiaries receiving Health Homes or Whole Person Care services are seamlessly transitioned to continue receiving care coordination services by way of the new enhanced care management benefit. Medi-Cal managed care plans will be mandated to contract with all existing local providers offering Health Homes and Whole Person Care services, with a few contractual exceptions. Medi-Cal managed care plans will be required to contract with community-based providers that have experience serving the enhanced care management target populations, and who have expertise providing the core enhanced care management services. Further, to allow non-Whole Person Care or Health Homes Program counties additional time to develop an adequate local infrastructure, a phased-in approach for implementing enhanced care management will be adopted.

It is the state's intention to implement this new initiative in a complementary, rather than duplicative manner that will build upon the strengths and foundations of these existing programs. DHCS recognizes the significant investment the Whole Person Care entities made over the past five years in building the capacity for these services. The intention is to build on those investments and infrastructure to continue the positive outcomes achieved by the Whole Person Care pilots. Additionally, as a result of extensive stakeholder feedback, DHCS has determined that Medi-Cal managed care plans will be required to coordinate enhanced care management services with county Targeted Case Management programs to ensure non-duplication of services and provide a holistic approach to care for Medi-Cal's most vulnerable beneficiaries.

The proposed enhanced care management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to

providing intensive and comprehensive care management services to targeted individuals.

Medi-Cal managed care plans will proactively identify members who meet the target population criteria and can benefit from enhanced care management services. The enhanced care management providers will be taking on the responsibility for coordinating services across all delivery systems. They are the primary responsible entity for coordinating across multiple medical and social service domains of care. Authorized members will be assigned a lead care manager that will have responsibility for interacting directly with the member and coordinating all primary, behavioral, developmental, oral health, and long-term services and supports, any in lieu of services, and services that address social determinants of health needs, regardless of setting.

Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The overarching goals for enhanced care management are:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Improving health outcomes;
- Addressing social determinants of health; and
- Decreasing inappropriate utilization.

The enhanced care management target populations include: (see **Appendix I: Enhanced Care Management Target Population Descriptions** for more detailed definitions):

- Children or youth with complex physical, behavioral, developmental, and/or oral health needs (e.g. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.

- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

Enhanced Care Management Design and Services

The enhanced care management benefit, which will be delivered by community-based providers (”ECM Providers”) contracting with Medi-Cal managed care plans, will provide multiple opportunities to engage beneficiaries by stratifying risk and need, developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for indirect care needs.

The enhanced care management benefit is fundamentally person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, members receive needed services in a supportive, effective, efficient, timely, and cost-effective manner. Enhanced care management will emphasize prevention, health promotion, continuity and coordination of care to link members to services as necessary across providers and settings and with emphasis on identifying the least restrictive and most integrated setting that will meet the needs of the beneficiary.

The role of enhanced care management is, through face-to-face visits, to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting. Enhanced care management activities shall become integrated with other care coordination processes and functions and shall assume primary responsibility for coordination of the member’s physical health, behavioral health, oral health, developmental, and long-term care needs.

Enhanced care management will be provided at a level dictated by the complexity of the health and social needs of the member. The approach to enhanced care management will be high-touch, on-the-ground, and face-to-face, with frequent contacts for persons residing in community settings and nursing facilities. Enhanced care management care managers are expected to develop relationships with members and their families, engage

members and families in needs assessment and care planning processes, and work with the primary care provider to address the member's needs in coordinating physical and behavioral health care.

The enhanced care management care managers will operate within the member's community, serve as the members' primary point of contact and are responsible for ensuring that applicable physical, behavioral, long-term care, developmental, oral, social, and psychosocial needs are met in the safest, least restrictive way possible while considering the most cost-effective way to address those needs. Care managers meet members where they are, both literally, and from a medical management and plan of care perspective. Community health workers can also be used to improve outreach and provide care coordination services for beneficiaries.

Required programmatic elements to be implemented include, but are not limited to, care coordination, health promotion, comprehensive transitional care, member and family supports and referral to community and social services. These elements include helping beneficiaries navigate, connect to and communicate with providers and social service systems; coaching beneficiaries on how to monitor their health and identify and access helpful resources; identifying and coordinating available in lieu of services such as housing services; helping beneficiaries move safely and easily between different care settings and reducing avoidable hospital admissions and readmissions; educating beneficiaries and their family/support system about their conditions to improve treatment adherence and medication management; providing referrals to community and social services; and follow-up to help ensure that beneficiaries are connected to the services they need.

Program Administration

Enhanced care management will be administered by the Medi-Cal managed care plans, who will have direct responsibility for establishing the enhanced care management benefit and criteria for their members, subject to contractual requirements and programmatic guidance provided by DHCS. DHCS intends for Medi-Cal managed care plans to build upon the expertise and infrastructure of the existing Whole Person Care pilots and Health Homes Program to achieve these outcomes and, with some exceptions, to contract directly with existing Whole Person Care providers and Health Homes Program community-based care management entities, as well as other necessary contracting with public and private providers to deliver such services.

In addition, DHCS expects that plans will work in coordination and collaboration, and even contract when appropriate, with county behavioral health systems who often are the primary providers of services to a subset of Medi-Cal beneficiaries. This proposal requests that managed care plans determine the service design and intensity based on the parameters established by DHCS. DHCS will build enhanced funding into the

capitation rates to enable Medi-Cal managed care plans to successfully provide enhanced care management benefit. The Medi-Cal managed care plans will have strong oversight and will perform regular auditing and monitoring activities to ensure that all requirements are met. If a plan proposes to keep some level of enhanced care management in-house instead of contracting with direct providers, the plan will need to demonstrate to the state that their enhanced care management benefit is appropriately community-based and provide a rationale for not contracting with existing WPC and HHP providers (per the exceptions outlined in the enhanced care management and in lieu of services Model of Care Template and managed care plan contract language.)

For individuals with a primary SMI diagnosis, SUD, children with SED, or children involved in child welfare, county behavioral health staff should be considered to serve as the enhanced care management provider through a contractual relationship, provided they agree to coordinate all the services (physical, developmental, oral health, long-term care and social needs) needed by those target populations, not just their behavioral health needs. These staff will focus on the behavioral health needs and interventions for the Medi-Cal beneficiary, act as a resource for the Medi-Cal managed care plan in managing the needs of this population and ensuring that beneficiaries are linked to appropriate county resources; as well as other resources that have more experience and documented success in working with those living with these conditions.

Targeted Case Management

Furthermore, Medi-Cal managed care plans will be expected to work with Local Governmental Agencies to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services; this approach will also help support the Department's goal of strengthening the connections across California's delivery systems. The Targeted Case Management program is an optional Medi-Cal Program funded by federal and local funds. See **Appendix B: Targeted Case Management** for which counties currently participate in the Targeted Case Management program.

DHCS may need to review and discuss other potential county funding interactions with this benefit to ensure there is no duplication of services or funding.

Transition and Coordination Plan

Medi-Cal managed care plans currently operating a Health Homes Program or operating in a county with a Whole Person Care pilot or Targeted Case Management program, will be required to submit a transition and coordination plan to DHCS by July 1, 2021. Through the transition and coordination plan, managed care plans will demonstrate how they will translate the existing programs into the enhanced care management benefit and in lieu of services and coordinate with existing Targeted Case Management programs. The

plans must also demonstrate a good faith effort to contract for enhanced care management and in lieu of services with existing Health Homes providers and Whole Person Care entities already providing such services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS information as to why such entities were not able to come to a contractual agreement.

Medi-Cal managed care plans in counties with Targeted Case Management programs will be required to submit information in the transition and coordination plan describing how they will work with the Local Government Agency to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services.

A transition and coordination plan will not be required for Medi-Cal managed care plans in counties that do not have Whole Person Care pilots, Health Homes Programs, or Targeted Case Management.

Implementation

January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.

July 1, 2022:

- Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
- All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.

January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Medi-Cal managed care plans that begin implementing on January 1, 2022 will submit an enhanced care management Model of Care proposal to DHCS for review by July 1, 2021. Draft contract provisions will be shared with plans in February 2021. Medi-Cal managed care plans that will implement enhanced care management on July 1, 2022, will submit an enhanced care management Model of Care by January 1, 2022. All plans must complete readiness activities for the mandatory target populations. Medi-Cal managed

care plans can submit to DHCS additional optional target populations, in addition to the mandatory target populations.

Federal regulations require that Medi-Cal managed care plan implementation activities shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. Through the enhanced care management Model of Care, managed care plans must demonstrate that there are sufficient Indian Health Clinics participating in their provider network to ensure timely access to services available under the contract from such providers for American Indian enrollees who are eligible to receive services. Medi-Cal managed care plans will provide a description of their coordination with tribal partners within the enhanced care management transition and coordination plan.

By July 1, 2022, all Medi-Cal managed care plans will need to submit to DHCS an enhanced care management Model of Care proposal for serving individuals transitioning from incarceration for implementation on January 1, 2023 in all counties. Re-entry transitions involve working closely with corrections departments, including probation, courts and the local county jail system to ensure connections to care once individuals are released from jail. While there is some infrastructure in place for this enhanced care management target population due to Whole Person Care Pilots, these types of arrangements require significant planning and coordination between the managed care plan, counties, sheriff, probation, and other key stakeholders.

DHCS is also looking to leverage the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act provisions that may make it possible to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release.

This aspect of enhanced care management will support the scaling of diversion efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities. In this case, Medi-Cal managed care plans can contract with county and non-profit entities that work to meet the health care needs of those who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and, thus, are at risk for incarceration and could, through care coordination and service placement, have a treatment plan built to avoid incarceration and get into community-based care and services.

Furthermore, to complement this enhanced care management benefit, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023.

Mandated County Inmate Pre-Release Application Process

In 2004, the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director letter, entitled "Ending Chronic Homelessness," that encouraged states to ensure that applications for Medicaid are processed in a timely manner so that individuals can receive Medicaid-covered services immediately upon release from a public institution.

On May 6, 2014, DHCS provided guidance in All-County Welfare Directors Letter #14-24, on the pre-release application process for state inmates who apply for Medi-Cal coverage. Subsequently, on June 25, 2014, DHCS clarified in All County Welfare Directors Letter #14-24E, that the guidance issued in the May 2014 letter is also applicable to county inmates. However, a specific pre-release process to facilitate the applications for county inmates was not defined and implementation of such process was voluntary.

The current pre-release application process varies from county to county. From a survey of some counties, DHCS learned that relatively larger counties with pre-release programs, such as Orange County and Stanislaus County, have agreements with third-party entities (e.g., community-based organizations or vendors) to streamline the pre-release application process and to provide dedicated application intake staff that visit individuals at the county jail while still in custody. Of the smaller counties surveyed, Yolo County has an agreement with the Sheriff's Department to establish communication channels and set up physical stations at the correctional facility, as well as security clearances for designated county staff to speak with the county inmate applicant directly. **Appendix C: County Inmate Pre-Release Application Process sample contracting Models** includes the three main models currently being used for various county inmate pre-release application programs.

DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023, which would include juvenile facilities. The goal of the proposal is to ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to Medi-Cal services upon release from incarceration.

Additionally, DHCS is proposing to mandate that all county jails and juvenile facilities implement a process for facilitated referral and linkage from county release to county specialty mental health, Drug Medi-Cal, Drug Medi-Cal Organized Delivery Systems, and Medi-Cal managed care providers when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community. DHCS will look to counties to implement medical record release processes that would allow medical records to be shared with the county behavioral health and Medi-Cal managed care providers, prior to or upon release from jail or county juvenile facility.

The mandated county inmate pre-release application process will standardize policy, procedures, and collaboration between California's county jails, county sheriff's departments, juvenile facilities, county behavioral health and other health and human services entities. This collaboration will ensure that eligible individuals are enrolled in Medi-Cal prior to release and will establish a continuum of care and ongoing support that may ultimately help to reduce the demand for costly and inappropriate services.

2.2.3 Rationale

DHCS continues to strengthen integration within the state's health care delivery system and is working with health promotion partners to achieve better care and better health outcomes at lower cost to the Medi-Cal program. Creating a statewide enhanced care management benefit with required target populations is consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need. The benefit will comprise an intensive set of services for Medi-Cal members who require coordination at the highest levels. Targeted individuals are beneficiaries who may be challenged with medical and behavioral conditions, access to care issues, chronic illnesses, disabilities, multiple social determinants of health, and require multidisciplinary care to regain health and function.

The enhanced care management benefit will provide Medi-Cal managed care plans with opportunities to help beneficiaries achieve improved health and well-being through stratifying risk and need and developing care plans and strategic interventions. Enhanced care management services will extend beyond standard care coordination and disease management activities. They will be concentrated on the coordination and monitoring of cost-effective, high quality, direct care services, as well as connections to needed community supports for non-direct care needs.

2.2.4 Proposed Timeline

DHCS is proposing a phased statewide implementation of the enhanced care management benefit and inclusion in Medi-Cal managed care contracts. Medi-Cal managed care plans in counties with Whole Person Care Pilots and/or Health Homes Programs will implement enhanced care management on January 1, 2022 for those target populations currently receiving Health Homes and/or Whole Person Care services. On July 1, 2022, Medi-Cal managed care plans in those counties will implement additional required target populations and counties without Whole Person Care pilots and/or Health Homes Programs will begin implementing select populations on July 1, 2022. The benefit must be implemented for in all counties all target populations, including individuals transitioning from incarceration, by January 1, 2023.

DHCS is proposing an effective date of January 1, 2023 for counties to implement a county inmate/juvenile pre-release application process. To ensure the necessary data

sharing agreements and communication plans are in place, below is detailed timeline for planning and implementation of this proposal:

- **March 1, 2021:** Establish workgroup with County Welfare Director's Association and counties to develop and vet implementation plan
- **May 1, 2021:** All county guidance development
- **November 1, 2021:** County and stakeholder feedback process
- **January 1, 2022:** Publish All County Welfare Director Letter
- **January – December 2022:** County implementation planning and technical assistance
- **January 1, 2023:** Implementation of county inmate pre-release application process

2.3 In Lieu of Services

2.3.1 Background

The Whole Person Care pilots and Health Homes Program built a foundation for an integrated approach to coordinating medical care, behavioral health, and social services to improve beneficiary health outcomes. The implementation of these programs, however, has varied across California and did not provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges.

According to federal Medicaid program rules, "in lieu of services" are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. They are typically delivered by a different provider or in a different setting than traditional State Plan services. An in lieu of service can only be covered if:

- The state determines that the service is a medically appropriate and cost-effective substitute or setting for the State Plan service;
- The services are optional for the managed care plan to provide;
- The services are optional for beneficiaries and they are not required to use the in lieu of service; and
- The in lieu of services are authorized and identified in the state's Medi-Cal managed care plan contracts.

Once adopted, Medi-Cal managed care plans will integrate in lieu of services into their population health management plans – often in combination with the new enhanced care

management benefit – to address gaps in State Plan benefit services. In lieu of services may be focused on addressing combined medical and social determinants of health needs to avoid higher levels of care. For example, in lieu of services might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays, and emergency department use. Based on extensive stakeholder feedback, DHCS has updated the in lieu of services menu of services. The feedback enhanced the overall design of in lieu of services, allowing beneficiaries receiving Health Homes or Whole Person Care services to continue receiving optional plan services. Furthermore, the additional feedback optimized the depth and capacity for serving eligible beneficiaries.

2.3.2 Proposal

DHCS is proposing to include the following fourteen (14) distinct services as in lieu of services under Medi-Cal managed care. Details regarding each proposed set of services are provided in **Appendix J: In Lieu of Services Options**:

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for Medi-Cal managed care plans and beneficiaries have the option to accept the in lieu of services or receive the State Plan services instead. Each service will have defined eligible populations, code sets, potential providers, restrictions, and limitations. However, individual in lieu of services may be used

together with other complementary in lieu of services based on individual needs and may be combined with enhanced care management services for high-risk, complex-need individuals. ILOS can be offered as an appropriate EPSDT service. Other appropriate EPSDT services should be offered in conjunction with any ILOS.

Transition and Coordination Plan

Since DHCS is building on the infrastructure developed for the Health Homes Program and parts of the Whole Person Care pilots, Medi-Cal managed care plans in counties with these programs will be required to submit a Transition and Coordination Plan to the state by July 1, 2021 demonstrating how they will transition existing programs into their enhanced care management benefit and in lieu of services. The plans must also demonstrate a good faith effort to come into agreement with and contract for enhanced care management and in lieu of services with Health Homes providers and Whole Person Care entities providing such services. DHCS recognizes the significant investment in infrastructure, as well as the existing expertise in providing these types of services, by our local county and other public/private partners and expects Medi-Cal managed care plans to partner with these entities to continue providing these critical services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS a justification as to why the plan has not contracted with such entities.

2.3.3 Rationale

Adoption of this set of in lieu of services will provide additional support to beneficiaries with complex medical and behavioral health needs who experience socio-economic conditions that impede their ability to achieve their health goals. These circumstances put them at risk of hospitalization, institutionalization, and/or in need of other higher cost services.

Currently, Medi-Cal strategies to address beneficiaries' social determinants of health vary across the state, depending on the initiatives underway in different regions. Consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need, establishing coverage of a set of in lieu of services will make a statewide offering of these critical interventions for Medi-Cal beneficiaries.

The in lieu of services framework allows for regions that do not currently have a sufficient infrastructure to provide the full array of services to build network capacity in a way that meets the unique needs of their residents. This may include partnerships to develop physical infrastructure, as well as collaborations with new provider types who have not historically worked with Medi-Cal. This will also set the stage for Medi-Cal managed care

plans to be prepared to have long-term services and supports integrated into their care program by 2027.

The stakeholder feedback was critical to ensuring that the identified services will adequately address the critical needs of beneficiaries. The final policy incorporates feedback received regarding strategies for building the necessary service infrastructure in a cost-effective manner, finalizing the eligible populations, potential restrictions and limitations, and appropriate provider types to deliver this new set of services.

2.3.4 Proposed Timeline

January 1, 2022: DHCS is proposing statewide implementation and inclusion of in lieu of services in Medi-Cal managed care plan contracts. DHCS will provide technical assistance to plans as they prepare to implement this new set of services.

2.4 Shared Risk, Shared Savings, and Incentive Payments

2.4.1 Background

The combination of carving in long-term care statewide, enhanced care management and in lieu of services provides a number of opportunities, including an incentive for building an integrated, managed long-term services and supports program by 2027 and building the necessary clinically-linked housing continuum for our homeless population.

In order for the state to be equipped with the needed MLTSS and clinically linked housing continuum infrastructure, it is important to consider potential incentives and shared savings/risk models that could be established to encourage Medi-Cal managed care plans and providers to fully engage. Incentive funding will be focused on building a pathway for Medi-Cal managed care plans to invest in the necessary delivery and systems infrastructure, build appropriate and sustainable enhanced care management and in lieu of services capacity, and achieve improvements in quality performance that can inform future policy.

2.4.2 Proposal

DHCS proposes to create a series of incentives through a multi-pronged risk strategy. Potential approaches include:

- A blended capitation rate to account for the addition of seniors and persons with disabilities and long-term care beneficiaries into managed care. The rate will be subject to a blend true-up, which will provide financial protections in case of significant differences between actual long-term care beneficiary enrollment and assumptions used during capitation rate development.

- A time-limited, tiered, and retrospective shared savings/risk financial calculation performed by DHCS. This tiered model would be available for three calendar years – 2023, 2024 and 2025.

- A prospective model of shared savings/risk incorporated via capitation rate development. DHCS proposes to implement this approach beginning in calendar year 2026, once historical cost and utilization experience is available that would reflect the implementation of in lieu of services, long-term care services, and enhanced care management benefits statewide in managed care.

DHCS will establish plan incentives linked to delivery system reform through an investment in enhanced care management and in lieu of services infrastructure. The incentive payments will also be based on quality and performance improvements and reporting in areas such as LTSS and other cross-delivery system metrics. The target of incentive payments is to drive change at the managed care plan and provider levels. DHCS anticipates managed care plans will partner and share the incentive dollars with on-the-ground providers, including our critical partners that operate Federally Qualified Health Centers, Rural Health Centers, Indian Health Service clinics, public hospital safety net systems, and county behavioral health systems and providers to work collaboratively to meet the defined targets of incentive program.

2.4.3 Rationale

In recognition of the financial uncertainties that accompany the implementation of enhanced care management, in lieu of services, and MLTSS statewide, DHCS is committed to implementing strategies that will limit excessive financial risk (losses) for Medi-Cal managed care plans, as well as for the state and federal governments. At the same time, DHCS supports the use of strategies that will result in financial gains that can be shared between Medi-Cal managed care plans and the state and federal governments. DHCS' goal is to establish financial mechanisms that will ensure a mutual commitment to the success of the proposed short- and long-term reforms and innovations within the Medi-Cal managed care program.

DHCS' proposed risk approaches are intended to strengthen financial incentives for Medi-Cal managed care plans to:

- Divert or transition beneficiaries from long-term institutional care to appropriate home and community-based alternatives, supported by the availability of in lieu of services and enhanced care management;

- Make the necessary infrastructure investments to support the goal of transitioning to an integrated long-term services and supports program; and

- Improve quality, performance measurement, and data reporting as a pathway toward realizing better health outcomes for Medi-Cal beneficiaries.

2.4.4 Proposed Timeline

Rate setting, including associated risk strategies, is a dynamic process. Therefore, DHCS will engage and collaborate with Medi-Cal managed care plans and make future refinements as determined appropriate.

- **January – December 2021:** Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Begin implementation of managed care plan incentives.
- **No sooner than January 1, 2023:** Begin implementation of a seniors and persons with disabilities/long-term care blended rate.

2.5 Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity

2.5.1 Background

On November 13, 2018, CMS issued a State Medicaid Director letter that outlines opportunities for states to design innovative service delivery systems to improve care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) who are enrolled in Medicaid.

This SMI/SED demonstration opportunity allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an institution for mental disease (IMD) (e.g., psychiatric hospitals or psychiatric health facilities that have more than 16 beds), as long as it is part of a broader effort to build a robust continuum of care allowing care in the least restrictive, community-based settings. Due to the long-standing federal exclusion of Medicaid matching funds for services provided in these settings, California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries in these settings.

2.5.2 Proposal

DHCS proposes that California pursue this SMI/SED demonstration opportunity to receive federal financial participation for services provided to Medi-Cal beneficiaries in an IMD. DHCS heard from stakeholders both positive and negative feedback regarding this proposal. Stakeholders in favor of the demonstration opportunity stated the additional federal funds could provide opportunities to improve service delivery and outcomes

across the continuum of care from inpatient to community-based settings, and the availability of additional matching funds would free up other local resources that counties could reinvest in strengthening other mental health services and further build the continuum of care in the community.

Proponents suggested that the demonstration opportunity is a critical component of solutions for the state hospital crisis (with long wait lists for people found incompetent to stand trial, as the state hospitals are full) and for achieving health equity, since increasing the number of short-term, crisis stabilization resources can divert people with mental illness to treatment instead of entering the justice system. People of color are disproportionately placed in justice settings instead of in mental health treatment, and lack of bed availability is a contributing factor. Stakeholders also expressed opposition based on concerns that the presence of the existing IMD exclusion is the primary safeguard in inhibiting county mental health departments from expanding the use of institutional settings and an important incentive to develop alternatives to those settings, and that using federal dollars to fund IMDs could divert resources from community-based services, undermining progress toward increased community integration and a community-based continuum of care.

On balance, DHCS believes the benefits outweigh the risks, and proposes that California submit an application to CMS using the usual process for submitting a Section 1115 waiver demonstration application. Similar to the state's existing 1115 demonstration to provide residential and other SUD treatment services under Medi-Cal, county participation would be voluntary.

2.5.3 Rationale

If California is approved to participate in the SMI/SED demonstration opportunity, federal financial participation would become available for mental health services provided to Medi-Cal beneficiaries in an IMD if all requirements are met. This additional funding would provide opportunities to improve service delivery and outcomes across a well-developed and robust continuum of care from inpatient to community-based settings, which is a requirement of this waiver. Availability of additional federal matching funds would free up other local resources, such as realignment funds, that counties may then reinvest in strengthening other mental health services and further build the continuum of care in the community.

The SMI/SED demonstration opportunity comes with many federal milestones and requirements. As of October 2020, Washington DC, Vermont, Indiana, and Idaho have approved applications, and Massachusetts, Oklahoma and Utah have pending 1115 waiver application to CMS. Below is a summary of key requirements, some of which may pose feasibility challenges:

- **Average Length of Stay:** The state would be required to achieve a statewide average length of stay of no more than 30 days for beneficiaries residing in IMDs. CMS developed guidance regarding calculations of average length of stay, clarifying that a short-term stay for acute care is limited to no more than 60 consecutive days, as long as the state continues to meet the statewide average length of stay of 30 days or less, and that states may not claim for *any* part of a stay (days 0 to 60) that exceeds 60 days.

- **Improving Community-based Services**: States participating in the SMI/SED demonstration opportunity will be expected to commit to taking several actions to improve community-based mental health care. These actions are linked to a set of goals for the SMI/SED demonstration opportunity and will milestones for ensuring quality of care in IMDs, to improve connections to community-based care following stays in acute care settings, to ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries, to provide a full array of crisis stabilization services, and to engage beneficiaries with SMI/SED in treatment as soon as possible.

- **Maintenance of Effort:** According to the guidance, CMS will be examining the commitment to ongoing maintenance-of-effort on funding outpatient community-based mental health services and states must provide an assessment of current availability of mental health services. The purpose of the maintenance-of-effort requirement is to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

- **Data Collection & Required Measures:** The state would need to report on a common set of measures and agree to additional measures and concepts specific to the state's demonstration parameters.

- **Health Information Technology:** The state would be required to develop and submit a health information technology plan that describes the ability to leverage technology, advance health information exchange(s), and ensure interoperability in support of the demonstration's goals. The health information technology plan would address electronic care plan sharing, care coordination, and behavioral and physical health integration.

- **Staffing and Resource Considerations:** Since DHCS does not currently pay for IMD services for this target population, pursuing the demonstration and ensuring compliance with requirements would require additional staffing and resources. Similarly, counties would likely need additional resources to implement and comply with elements required by the demonstration.

For additional information about the demonstration goals and milestones, federal application requirements, and other relevant requirements, please refer to the **Appendix E: CalAIM Benefit Changes Chart** of this proposal.

2.5.4 Proposed Timeline

The SMI/SED demonstration proposal would be developed no sooner than July 1, 2022. If the waiver proposal is approved by CMS, DHCS would work with interested counties to develop a formal implementation plan, with expected launch of the demonstration in 2023-24.

2.6 Full Integration Plans

2.6.1 Background

Currently, Medi-Cal beneficiaries must navigate multiple complex managed care and fee-for-service delivery systems to meet all of their health care needs. Beneficiaries enrolled in Medi-Cal managed care plans receive physical health care and treatment for mild-to-moderate mental health conditions from their Medi-Cal managed care plan, care for SMI/SED and SUD from the county delivery system, and dental care from a separate fee-for-service delivery system or a dental managed care plan. This fragmentation can lead to gaps in care and disruptions in treatment, cost inefficiencies, and generally fails to be patient-centered and convenient for most beneficiaries. The longevity gap among individuals with serious and persistent mental illness, and the fact that this group suffers and dies from un-or under-treated chronic physical health conditions, demonstrates the need to pilot the concept of a fully integration delivery system.

2.6.2 Proposal

DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Multiple Medi-Cal delivery systems (Medi-Cal managed care, county mental health plans, county Drug Medi-Cal and DMC-ODS programs) would be consolidated under one contract with DHCS. To further develop this concept, DHCS will be engaging in stakeholder conversations to inform the development of the various components associated with fully integrating health care services. Topics will include contractor selection criteria, strategies for consolidating contract requirements, subcontracting and network requirements, and delivery system administration issues such as care coordination, utilization management, quality monitoring, and external quality review organization functions.

2.6.3 Rationale

In alignment with CalAIM, fully integrating all or most of the Medi-Cal health care delivery systems under one contract would improve the beneficiary experience as well as health outcomes by eliminating fragmentation, duplication, and the need to navigate multiple systems. In addition, integration will improve access to health data/data sharing among providers and between the plan and DHCS. Full integration would also result in overall administrative simplification by consolidating and streamlining system infrastructure. An integrated delivery system would allow for more efficient coordination of care and create opportunities to identify and manage the risks and needs of the beneficiaries in a more holistic way.

As part of the CalAIM workgroup process, DHCS sought stakeholder feedback to understand the benefits, risks and considerations for plans and counties interested in participating in a full integration model. Discussion included realignment (county behavioral health participation would need to be voluntary), how non-Medi-Cal funding streams would be managed (such as MHSA), criteria for participation, the need for adequate planning and preparation, the importance of clearly defined outcome measures, and other considerations.

2.6.4 Proposed Timeline

DHCS acknowledges the complexity of this proposal, and for this reason, is proposing a go-live of no sooner than January 2027, to allow sufficient time for planning and preparation, in partnership with counties, plans and other stakeholders.

2.7 Long-Term Plan for Foster Care

2.7.1 Background

Children and youth in foster care often present with complex medical, behavioral, oral and developmental health problems rooted in their history of childhood trauma and adverse childhood experiences (ACEs) Navigating multiple systems of care can create inherent challenges. Under the Medi-Cal program, beneficiaries receive services through various delivery systems, including Medi-Cal managed care, fee-for-service, California Children's Services, regional centers, dental county mental health plans, Drug Medi-Cal, and DMC-ODS programs. While children and youth in foster care typically have a comprehensive team to help facilitate and oversee their care including social workers, public health nurses, and the judicial system; many challenges remain in navigating Medi-Cal delivery systems, especially if there are multiple placements that may result in the child moving from one county to another or between homes in a single county.

In recent years, California has placed a greater emphasis on the behavioral health care needs of child welfare-involved children and families through major reforms such as the

Continuum of Care Reform, Family Urgent Response System, development of short-term residential treatment providers and coordinated efforts to implement the new federal Family First Prevention Services Act in California.

2.7.2 Proposal

In assessing the challenges foster care children and youth face, in June 2020 DHCS launched a workgroup of interested stakeholders to consider whether DHCS should develop a different model of care for children and youth in foster care, including the former foster youth and youth transitioning out of foster programs and services. To facilitate this discussion and develop meaningful recommendations, DHCS invited participation from key partners including but not limited to: the Department of Social Services, the Department of Education, child welfare county representatives and state-level associations, Medi-Cal managed care plans, behavioral health managed care plans, juvenile justice and probation, foster care consumer advocates, regional centers, and judicial entities involved with matters pertaining to children who are placed into the foster care system. DHCS also commissioned focus groups with foster youth and foster parents, to hear directly from those most affected by the challenges in the current system.

2.7.3 Proposed Timeline

DHCS launched the workgroup in June 2020, and will meet every other month through June 2021. DHCS and CDSS then will take lessons learned from the workgroup and the input from stakeholders and develop a comprehensive set of recommendations and plan of action, which may involve budget recommendations, waiver amendments, State Plan changes or other activities.

3. Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

This section will walk through the proposals aimed at standardizing and reducing complexity across all delivery systems.

Managed Care

- Managed Care Benefit Standardization
- Mandatory Managed Care Enrollment
- Transition to Statewide Long-Term Services and Supports, Long-Term Care & Duals-Special Needs Plans
- NCQA Accreditation of Medi-Cal Managed Care Plans
- Regional Managed Care Capitation Rates

Behavioral Health

- Behavioral Health Payment Reform
- Medical Necessity Criteria and Other Related Changes
- Administrative Integration of Specialty Mental Health and Substance Use Disorder Services
- Behavioral Health Regional Contracting
- DMC-ODS Renewal and Policy Improvements

Dental

- New Dental Benefits and Pay for Performance

County Partners

- Enhancing County Eligibility Oversight and Monitoring
- Enhancing County Monitoring and Oversight: California Children's Services and Child Health and Disability Prevention
- Improving Beneficiary Contact and Demographic Information

Managed Care

3.1 Managed Care Benefit Standardization

3.1.1 Background

Medi-Cal delivers services through a variety of delivery systems today including fee-for-service, managed care, county mental health, Drug Medi-Cal Organized Delivery System, and Drug Medi-Cal. Most full-scope Medi-Cal beneficiaries receive their physical health

services through a Medi-Cal managed care plan. While Medi-Cal managed care exists statewide, it is operated under six different model types that currently differ based on whether certain benefits are part of the Medi-Cal managed care plan's responsibility or provided through a different delivery system.

3.1.2 Proposal

Under CalAIM, DHCS is proposing to standardize the benefits that are provided through Medi-Cal managed care plans statewide. Regardless of the beneficiary's county of residence or the plan they are enrolled in, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan.

DHCS is proposing the following changes:

Carved Out Benefits

- Effective April 1, 2021, all pharmacy benefits or services by a pharmacy billed on a pharmacy claim will be carved out from Medi-Cal managed care plans (pursuant to the Governor's Executive Order N-01-19 from January 7, 2019). This applies to all Medi-Cal managed care plans, including AIDS Healthcare Foundation, but does not apply to SCAN Health Plan, Programs of All-Inclusive Care for the Elderly (PACE) organizations, Cal MediConnect health plans, and Major Risk Medical Insurance Program (MRMIP).

- Effective January 1, 2022, the following benefits that are currently within the scope of some or all the Medi-Cal managed care plans will be carved out:

    - Specialty mental health services that are currently carved in for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties; and

    - The Multipurpose Senior Services Program which is currently included in the Medi-Cal managed care plans in the seven Coordinated Care Initiative counties.

Carved In Benefits

- Effective January 1, 2022, all major organ transplants, currently not within the scope of many Medi-Cal managed care plans, will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

- Effective January 1, 2023, institutional long-term care services (i.e. skilled nursing facilities, pediatric/adult subacute care, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, specialized rehabilitation in a skilled nursing facility or intermediate care facilities), currently

not within the scope of many Medi-Cal managed care plans will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

In order to provide a smooth transition from fee-for-service to managed care, promote access and maintain affordability, DHCS proposes to require that long-term care and transplant providers accept as payment in full and require the Medi-Cal managed care plan to pay the applicable Medi-Cal fee-for-service rate, unless the provider and plan mutually agree upon an alternative payment. This is consistent with how these transitions to managed care have occurred in the past, such as with the Coordinated Care Initiative and the Whole Child Model.

3.1.3 Rationale

The standardization of benefits delivered through Medi-Cal managed care plans statewide has two main purposes and benefits:

- Beneficiaries will no longer have to deal with the confusion that may arise when moving counties/plans and to find that different benefits are covered by their new plan or that they need to access another delivery system; and
- DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.1.4 Proposed Timeline

The benefit standardization will be effective and included in Medi-Cal managed care plan contracts by January 2023, according to **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage**.

3.2 Mandatory Managed Care Enrollment

3.2.1 Background

Currently, the Medi-Cal program provides benefits through both a fee-for-service and managed care delivery system. Enrollment into the fee-for-service delivery system or the managed care delivery system is based upon specific geographic areas, the health plan model, and/or the aid code that the beneficiary is determined to qualify for. In some cases, enrolling in managed care is optional for beneficiaries. However, more than 80 percent of Medi-Cal beneficiaries are currently served through the managed care delivery system.

3.2.2 Proposal

In an effort to enhance coordination of care, increase standardization, and reduce complexity across the Medi-Cal program, DHCS is proposing to standardize which aid code groups will require mandatory managed care enrollment versus mandatory fee-for-service enrollment, across all models of care and aid code groups, statewide. Under this proposal, beneficiaries in a voluntary or excluded from managed care enrollment aid code that are currently accessing the fee-for-service delivery system, would be required to choose a Medi-Cal managed care plan and will not be permitted to remain in fee-for-service. DHCS completed extensive data analytics to inform this proposal, for example, 73% of beneficiaries with other health coverage are already enrolled in managed care today and of non-long-term care share of cost beneficiaries, on average only 5.4% of beneficiaries meet their monthly share of cost.

DHCS is proposing implementation of this change in two phases, transitioning non-dual eligible populations in 2022 and dual eligible populations in 2023. A non-dual member is defined as a Medi-Cal member without any Medicare coverage. A dual beneficiary is defined as a Medi-Cal member with any Medicare coverage. This would include Medi-Cal members with Medicare A only or Part B only (partial duals) and members with Medicare Part A and B (full duals) regardless of enrollment in Medicare Part C or Part D. See below for a summary of changes and **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage** for more details.

Given the ability and directive of Medi-Cal managed care plans to provide case and care management not available in a fee-for-service environment, DHCS firmly believes that Medi-Cal managed care is a delivery system we should continue to invest in and rely upon. In conjunction with these new and increased responsibilities, DHCS plans to increase oversight of the plans and their delegated entities to ensure that current requirements being met but also that the additional benefits and requirements contained in CalAIM are truly being provided statewide.

Mandatory Managed Care Enrollment

Below are the populations that currently receive benefits through the fee-for-service delivery system that would transition to Medi-Cal managed care upon implementation of this proposal in 2022:

- Trafficking and Crime Victims Assistance Program (except share of cost)
- Individuals participating in accelerated enrollment
- Child Health and Disability Prevention infant deeming
- Pregnancy-related Medi-Cal (Pregnant Women only, 138-213% citizen/lawfully present)
- American Indians
- Beneficiaries with other health care coverage

- Beneficiaries living in rural zip codes

Below are the populations that currently receive benefits through the fee-for-service delivery system except in COHS and CCI counties that would transition to the Medi-Cal managed care system upon implementation of this proposal in 2023:

- All dual and non-dual individuals eligible for long-term care services (includes long-term care share of cost populations)
- All partial and full dual aid code groups, except share of cost or restricted scope, will be mandatory Medi-Cal managed care, in all models of care starting in 2023

Mandatory Fee-for-Service Enrollment

This proposal would also move the following populations from mandatory managed care enrollment into mandatory fee-for-service enrollment upon implementation of this proposal in 2022:

- Omnibus Budget Reconciliation Act (OBRA): This population was previously mandatory managed care in Napa, Solano, and Yolo counties.
- Share of Cost: beneficiaries in county organized health systems (COHS) and Coordinated Care Initiative counties excluding long-term care share of cost.

Therefore, beneficiaries in the following aid code groups will have mandatory fee-for-service enrollment:

- Restricted scope
- Share of cost (including Trafficking and Crime Victims Assistance Program share of cost, excluding long-term care share of cost)
- Presumptive eligibility
- State medical parole, county compassionate release, and incarcerated individuals
- Non-citizen pregnancy-related aid codes enrolled in Medi-Cal (not including Medi-Cal Access Infant Program enrollees)

DHCS recommends keeping enrollment requirements for foster care children and youth in place until the Foster Care Workgroup makes recommendations on the future delivery system for foster care children and youth.

3.2.3 Rationale

Moving to mandatory managed care enrollment will standardize and reduce the complexity of the varying models of care delivery in California. Populations moving between counties will have the same experience when it comes to receiving services through a managed care plan. Transitioning current populations to mandatory managed care enrollment will also allow for Medi-Cal managed care plans to provide more

coordinated and integrated care and provide beneficiaries with a network of primary care providers and specialists.

Additionally, DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.2.4 Proposed Timeline

- **January 1, 2022:** Non-Dual and pregnancy related aid code group, and population-based transitions, except for LTC aid codes.
- **January 1, 2023:** Dual aid code group transition, including LTC aid codes for both non-dual and dual beneficiaries.

3.3 Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans

3.3.1 Background

Under CalAIM, DHCS is proposing to transition CMC and the CCI to a statewide MLTSS and dual eligible special needs plan (D-SNP) structure. This policy is intended to help meet the statewide goals of improved care integration and person-centered care, under both CalAIM and the California Master Plan for Aging.

The Coordinated Care Initiative has been underway in seven California counties and is comprised of two parts: 1) Cal MediConnect, a demonstration project that combined acute, primary, institutional, and home and community-based services into a single benefit package for individuals who are fully or partially eligible for Medicare and Medicaid; 2) mandatory Medi-Cal managed care enrollment for dual eligibles for all Medi-Cal benefits, including managed long-term services and supports.

The Governor's 2017-2018 budget determined that the Coordinated Care Initiative was not cost-effective due to the financing of the In-Home Supportive Services benefit, which was carved out to fee-for-service effective January 1, 2018. DHCS will carve out Multipurpose Senior Services Program services to fee-for-service effective January 1, 2022 for all Medi-Cal members. CMS approved an extension for the remaining program elements – Cal MediConnect and mandatory managed long-term services and supports enrollment – until December 31, 2022.

While the Coordinated Care Initiative and Cal MediConnect offer the promise of better integrated care for California's dual eligibles, the program is only available in seven out of 58 counties. Additionally, Cal MediConnect has been a complex program to administer.

DHCS is implementing a new approach to take the key lessons learned and innovative strategies from these programs and make them more broadly available across the State.

3.3.2 Proposal

Aligned Enrollment

DHCS will use selective contracting to move toward aligned enrollment in D-SNPs; beneficiaries will enroll in a Medi-Cal managed care plan and D-SNP operated by the same parent company to allow for greater integration and coordination of care.

- In CCI counties, aligned enrollment will begin in 2023. Cal MediConnect members will transition to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product.
- Aligned enrollment will phase-in in non-CCI counties as plans are ready. DHCS will require managed care plans to apply for aligned D-SNPs to be effective no later than contract year 2025.
- Dual eligible beneficiaries already enrolled in a non-aligned D-SNP (a D-SNP that is not affiliated with their managed care plan) when aligned enrollment takes effect in their county will be in that D-SNP (allowing the beneficiary to stay in the non-aligned D-SNP). New enrollment in those non-aligned D-SNPs will be closed.

In conjunction with the aligned enrollment approach, starting in 2022 CMS will limit enrollment into Medicare Advantage (MA) plans that are D-SNP “look-alikes.” These are MA plans that offer the same cost sharing as D-SNPs, but do not offer integration and coordination with Medi-Cal or other benefits targeted to the dual eligible population, such as risk assessments or care plans.

As outlined in the CMS Contract Year 2021 Medicare Advantage and Part D Final Rule:

- CMS will not enter into contracts with new MA plans that project 80 percent or more of the plan's enrollment will be entitled to Medicaid starting in 2022; and
- CMS will not renew contracts with MA plans (except SNPs) that have enrollment of 80 percent or more enrollees who are entitled to Medicaid (unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals).

DHCS will also allow plans in CCI counties with managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans to transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP in 2022, prior to the end of CCI. This will provide better coordination of care, without reducing enrollment in Cal MediConnect plans, and is in alignment and preparation for the CMC transition to D-SNP aligned enrollment in 2023.

D-SNP Integration Requirements

DHCS will require that all D-SNPs use a model of care addressing both Medicare and Medi-Cal services to support coordinated care, high-quality care transitions, and information sharing. DHCS will work with CMS to incorporate new CalAIM model of care requirements into the D-SNP model of care, as appropriate.

As DHCS implements aligned enrollment, DHCS will require D-SNPs to:

- Develop and use integrated member materials.
- Include consumers in their existing advisory boards.
- Work with CMS to establish quarterly joint contract management team meetings for aligned D-SNP and managed care plans.
- Include dementia specialists in their care coordination efforts.
- Coordinate carved-out LTSS benefits including IHSS, MSSP, and other HCBS waiver programs.

Additionally, DHCS will work with CMS to coordinate audit timing, to avoid a D-SNP/managed care plan being audited by both agencies at the same time.

Long-Term Care Carve In

In conjunction with mandatory Medi-Cal managed care enrollment, DHCS will require statewide integration of LTC into managed care for Medi-Cal populations by 2023. This means that full- and partial-benefit duals in LTC facilities in counties or plans that do not already include LTC will be enrolled in Medi-Cal managed care by 2023.

D-SNP Transitions and Enrollment Policies

DHCS will encourage aligned enrollment of dual eligibles into matching managed care plans and D-SNPs to promote more integrated care. During all transitions, DHCS will work with CMS to ensure beneficiaries receive continuity of care protections.

Mandatory Enrollment into Medi-Cal Managed Care Plans

DHCS is committed to providing beneficiary and provider education, as well as technical assistance around Medi-Cal managed care plan requirements, for mandatory enrollment of dual eligibles into Medi-Cal managed care. As part of this work, DHCS will:

- Review and make any needed updates to education and enrollment materials used to assist dual eligibles in enrolling into a managed care plan or PACE for their Medi-Cal benefits.

- Help educate providers about necessary billing practices as well as the processes that will not change, building on materials and best practices previously developed under CCI.

3.3.3 Rationale

Individuals dually eligible for Medicare and Medi-Cal are among the highest need populations. However, lack of coordination between Medicare and Medi-Cal can make it difficult for individuals enrolled in both programs to navigate these separate systems of care. California has made significant progress in building integrated systems through the implementation of CCI and CMC in seven counties (Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara). As part of the CalAIM initiative, DHCS is leveraging the lessons and success of CCI to develop policies to promote integrated care through D-SNPs and MLTSS across California. This includes mandatory enrollment for dual eligibles into managed care plans for their Medi-Cal benefit and increasing the availability of aligned D-SNPs. This will allow duals to voluntarily enroll for their Medicare benefits into the D-SNP that is aligned with their managed care plan.

In addition, to promote integrated, person-centered care, the D-SNP and MLTSS policies will rely on California's robust and diverse array of HCBS providers across the state who serve older Californians and people with disabilities. In support of this effort, DHCS plans to submit a request for supplemental funding through the federal Money Follows the Person grant to accelerate LTSS system transformation design and implementation, and to expand HCBS capacity. The one-time supplemental funding would be used to develop a multi-year roadmap for implementing strategies and solutions for strengthening HCBS and MLTSS programs and provider networks. DHCS' intent is that the roadmap will provide a unified vision to integrate CalAIM MLTSS, D-SNP policy and the related in lieu of services policy, other components of the Master Plan on Aging, and all of HCBS, to expand and better link those HCBS to Medi-Cal managed care and D-SNP plans.

3.3.4 Proposed Timeline

- **January 1, 2021:** All existing D-SNPs must meet new regulatory integration standards effective 2021.

- **January 1, 2022**: Voluntary in lieu of services in all Medi-Cal managed care plans and CMC plans. Multipurpose Senior Services Program (MSSP) carved out of managed care in CCI counties. Plans in CCI counties with existing managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans may transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP.

- **December 31, 2022**: Discontinue CMC and CCI.

- **January 1, 2023**: Statewide mandatory enrollment of full- and partial- benefit dual eligible beneficiaries into managed care plans for Medi-Cal benefits, including dual and non-dual eligible LTC residents and statewide integration of LTC into Medi-Cal managed care. Aligned enrollment begins in CCI counties and managed care plans in those counties must stand up D-SNPs. All CMC members cross-walked to matching D-SNP and managed care plans, subject to CMS and state requirements.

- **January 1, 2025**: Aligned enrollment begins in non-CCI counties; All managed care plans required to begin operating D-SNPs (voluntary enrollment for dual eligibles' Medicare benefit).

- **January 1, 2027**: Implement MLTSS statewide in Medi-Cal managed care.

3.4 NCQA Accreditation of Medi-Cal Managed Care Plans

3.4.1 Background

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that offers accreditation to health plans and other health care-related entities (e.g., accountable care organizations) in the areas of quality improvement, population health management, network management, utilization management, credentialing and re-credentialing, and member experience. NCQA also develops quality performance measures known as the Healthcare Effectiveness Data and Information Set (HEDIS) measures, which provide a standardized method for comparing health plan performance. Currently, 26 states require NCQA accreditation for their contracted Medicaid managed care plans.

DHCS conducts annual medical audits of all Medi-Cal managed care plans, but does not currently "deem," or use information obtained from a national accreditation review, to satisfy mandatory external quality review activities, with the exception of the credentialing requirement of the annual medical audit. Federal regulations permit the state to deem this information for credentialing purposes.

DHCS does not currently require Medi-Cal managed care plans to be accredited by NCQA. Out of 24 full scope Medi-Cal managed care plans in the state, 17 health plans currently have NCQA accreditation. Medi-Cal managed care plans that provide private coverage through Covered California are required to be accredited by either NCQA, the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC).

3.4.2 Proposal

To streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their

health plan subcontractors to be NCQA accredited by 2026. DHCS may use NCQA findings to certify or deem that Medi-Cal managed care plans meet particular state and federal Medicaid requirements. However, numerous stakeholders have shared with DHCS their concerns around DHCS deeming any elements of its current oversight of the managed care plans. Before DHCS recommends deeming of elements of its annual medical audits of the plans, DHCS will solicit feedback on the proposed deemable elements. If deeming does occur, DHCS will post information on the deeming elements and the corrective action plan for NCQA oversight findings on its website. DHCS will not accept accreditation from entities other than NCQA (e.g. URAC). Additional information on proposed deeming is below.

DHCS will also require Medi-Cal managed care plan NCQA accreditation to include the LTSS Distinction Survey subsequent to all health plans operating a D-SNP by 2027; the exact effective date for the LTSS Distinction Survey will be determined at a later date. Requiring the LTSS Survey will align with the state's effort to carve-in long-term care services and expand in lieu of services to make MLTSS a statewide benefit.

While DHCS is interested in the potential future addition of the Medicaid (MED) module to routine NCQA health plan accreditation, as it could potentially maximize the opportunity for streamlining state compliance and deeming, DHCS has determined that it is premature to require the MED module at this point, given how new it is for NCQA.

Finally, DHCS had considered requiring Medi-Cal managed care plans to ensure any non-health plan subcontractors to whom certain contractual elements are delegated are NCQA accredited for that function. DHCS will not require this in its contracts with the Medi-Cal managed care plans at this time; Medi-Cal managed care plans will need to determine if they will require any accreditation of their non-health plan subcontractors. If DHCS decides to deem particular elements of NCQA health plan accreditation standards, and any Medi-Cal managed care plans elect to require NCQA accreditation of their subcontractors, the Medi-Cal managed care plans will have the option to offer deeming on those same elements, if applicable, with their subcontractors.

3.4.3 Rationale

One of the three objectives of CalAIM is to reduce variation and complexity across Medi-Cal delivery systems, including standardization of the Medi-Cal managed care benefit. requiring NCQA accreditation of its managed care plans and following the NCQA framework, DHCS can potentially increase standardization throughout the state and reduce redundancies in various processes and assessments, in areas such as care coordination, which DHCS currently requires. Further, NCQA accreditation can assist in streamlining DHCS monitoring and oversight of managed care plans, particularly with regard to the annual medical audits, by increasing the number of elements in which DHCS may consider deeming Medi-Cal managed care plans. This would allow the annual medical audits to focus on other DHCS priority areas not reviewed by NCQA.

The addition of the LTSS Distinction Survey aligns with DHCS' goal of making LTSS a statewide benefit. DHCS recognizes that the addition of this survey to routine NCQA accreditation may be difficult for Medi-Cal managed care plans that are not already NCQA accredited, so DHCS will determine a timeframe for requiring the LTSS Distinction Survey that falls after all managed care plans have achieved routine NCQA plan accreditation.

3.4.4 Proposed Timeline

DHCS will require all Medi-Cal managed care plans and their health plan subcontractors to be NCQA accredited by 2026.

- DHCS will review and consider elements of NCQA health plan accreditation standards for deeming in relation to the annual A&I compliance audits.
    - DHCS will ensure that a complete crosswalk of federal and state Medicaid requirements and NCQA health plan accreditation standards is available online for comment prior to finalizing any deeming decisions.
    - DHCS will ensure that any NCQA health plan accreditation elements selected for potential deeming are vetted with stakeholders prior to finalizing any deeming decisions.
- DHCS may consider implementing deeming of the select elements sooner than 2026 for Medi-Cal managed care plans that already have NCQA accreditation. DHCS will align all applicable processes in its Medi-Cal managed care plan contract and All Plan Letters with the following six NCQA health plan accreditation categories to correspond with the requirement for accreditation by 2026:
    - Quality Improvement;
    - Population Health Management;
    - Network Management;
    - Utilization Management;
    - Credentialing; and
    - Member Experience.

3.5 Regional Managed Care Capitation Rates

3.5.1 Background

DHCS currently develops, certifies, and implements managed care capitation rates on an annual basis for contracted Medi-Cal managed care plans. DHCS develops distinct rates for each contracted managed care plan by county/region and population group. Due to the complexities of the Medi-Cal managed care program, which includes varied and intricate financing mechanisms, DHCS calculates multiple rating components for each capitation rate for a total of more than 4,000 rating components on an annual basis as of

state fiscal year 2018-19. The excessively large number of rating components DHCS must develop on an annual basis is administratively burdensome and contributes to lengthy annual federal review and approval timeframes. It also limits DHCS' ability to advance value-based and outcomes-focused rate setting methodologies. With the changes contemplated in CalAIM, DHCS views the need for simplified methodologies with a reduced number of components as necessary to achieving our broader goals of improving care delivery, access, quality and outcomes for our Medi-Cal beneficiaries.

3.5.2 Proposal

A regional rate-setting methodology provides a pathway toward simplification of the rate-setting process for the Medi-Cal managed care program. The proposed simplification will afford DHCS the flexibility to continue to pursue strategies that support advancements and innovations within the program.

To ensure a successful transition, DHCS proposes a two-phased approach:

Implement Regional Rates in Targeted Counties (Phase I)

- DHCS would implement Phase I for calendar years 2022 and 2023 (at a minimum) for targeted counties and Medi-Cal managed care plans;
- DHCS would advance new regional rate-setting approaches and streamline rate processes and methodologies;
- DHCS would utilize Phase I as a means of identifying strategies and further improvements that will support a seamless transition to regional rate setting statewide; and
- DHCS would engage and collaborate with contracted Medi-Cal managed care plans and industry associations as part of this process.

Fully Implement Regional Rates Statewide

- DHCS proposes to fully implement regional rates statewide no sooner than calendar year 2024, to align with the end of Phase I; and
- DHCS will consider health care market dynamics, including but not limited to health care cost and utilization data, across counties when determining regional boundaries.

3.5.3 Rationale

The proposed transition to regional rates statewide offers four main benefits:

- Regional rates would reduce the number of distinct rating components that DHCS must develop on an annual basis, and thereby permit DHCS to utilize a more flexible rate structure model. This flexibility is essential to DHCS' ability to pursue

advancements and innovations in the Medi-Cal managed care program, including CalAIM, and to explore new, innovative ideas.

- Regional rates would simplify the presentation of rates to CMS, which may expedite federal review and approval of the Medi-Cal managed care capitation rates. DHCS could implement rate-setting approaches that promote efficiency, including cost-averaging processes, across Medi-Cal managed care plans.
- These approaches would continue to incentivize Medi-Cal managed care plans to operate efficiently as rates will be based upon costs across the multi-county region. In effect, each Medi-Cal managed care plan will be incentivized to compete to be more efficient than other plans in their region.
- Regional rates would provide a larger, multi-county base for averaging, and thereby alleviate some of the criticisms regarding the process currently used by DHCS.

3.5.4 Proposed Timeline

Rate setting is a dynamic process. Therefore, DHCS will proceed methodically, engage and collaborate with Medi-Cal managed care plans, and make future refinements as determined actuarially appropriate.

- **Calendar Year 2020 and 2021:** Develop regional rate-setting methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Implement Phase I for targeted counties and Medi-Cal managed care plans.
- **Calendar Year 2023:** Evaluate and continue to refine the rate-setting process prior to the implementation of regional rates statewide.
- **No sooner than January 1, 2024:** Fully implement regional rates statewide.
- **Post-implementation:** Continue to evaluate and refine the rate-setting process and regions.

Behavioral Health

3.6 Behavioral Health Payment Reform

3.6.1 Background

Through realignment efforts in 1991 and 2011, funding for the majority of the non-federal share of costs associated with the specialty mental health and substance use disorder (SUD) services became the responsibility of the counties. Currently, counties are reimbursed for the federal and state portion of costs for services and administration of these programs via Medicaid Certified Public Expenditure (CPE) methodologies. Under

CPE methodologies, reimbursements to counties are limited to costs incurred by the counties and are subject to a lengthy and labor-intensive cost reconciliation process.

For specialty mental health services, counties pay with non-federal funds at the time of service and when incurring costs to administer the programs. The counties then submit CPEs to DHCS so that the state can draw down eligible federal Medicaid matching funds. In accordance with the CMS-approved CPE protocol, mental health plans receive interim reimbursement of federal financial participation on a fee-for-service basis, pursuant to interim rates approved by the state on an annual basis for approved units of service for allowable procedure codes. The state completes the interim reconciliation of interim Medicaid payments no later than 24 months after the close of each state fiscal year. The final cost reconciliation of mental health plan interim Medicaid payments occurs within 36 months after the certified, reconciled, state-developed cost reports are submitted.

The Drug Medi-Cal portions of the State Plan establishes the interim payment methodology for both Narcotic Treatment Program and non-Narcotic Treatment Program services. Generally, this methodology requires an interim reimbursement at the statewide maximum allowable or uniform statewide daily dosing rate. DHCS also provides an interim reimbursement to counties for costs incurred to administer DMC-ODS or DMC programs. After the fiscal year ends, DHCS performs a settlement with counties for the cost of administering the SUD services (either through DMC State Plan or through DMC-ODS). These cost reconciliations occur years after the close of the state fiscal year to allow time for claims run out as well as for DHCS to complete its cost reconciliation audits.

To incentivize additional investment in the delivery systems and reduce overall burden on counties and the state, DHCS is proposing to reform behavioral health payment methodologies for counties. Under the current CPE methodology, counties are not able to retain revenue when implementing cost-reduction efforts, thereby limiting the ability to fully invest in the delivery system to improve access and quality. These reforms will allow not only for more timely review and final payment, but will enable the county behavioral health system, for the first time, to participate in and design true outcomes and value-based reimbursement structures that reward better overall results and quality of life for Medi-Cal beneficiaries.

3.6.2 Proposal

The state is proposing to reform its behavioral health payment methodologies via a multi-phased approach with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives. This proposal would move reimbursement for all inpatient and outpatient specialty mental health and substance use disorder services from CPE-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county-supplied non-federal share. DHCS proposes to implement the shift in methodology in two initial phases:

- In order to establish appropriate payment rates, DHCS proposes to transition specialty mental health and SUD services from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as Current Procedural Terminology (CPT) coding, when possible; and
- DHCS will establish reimbursement rates, as well as an ongoing methodology for updating rates, for the updated codes with non-federal share being provided by counties via intergovernmental transfer instead of CPEs, eliminating the need for reconciliation to actual costs.

Transition from HCPCS Level II Coding to CPT Coding

DHCS is proposing to transition from existing HCPCS Level II coding to CPT coding in all cases where a suitable CPT code exists. If a suitable CPT code does not exist, DHCS would identify an appropriate HCPCS Level II code.

For specialty mental health services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: therapy, assessments, treatment planning, rehabilitation, prescribing medication, administering medication, patient education, and crisis intervention. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Services that currently receive a bundled rate, such as psychiatric inpatient hospital services, adult residential treatment, crisis residential treatment, psychiatric health facility services, crisis stabilization, day treatment, and day rehabilitation, would continue to be reimbursed using a bundled rate.

For SUD services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: assessment, case management, crisis intervention, discharge planning, group counseling, individual counseling, medical psychotherapy, prescribing medication, administering medication, recovery services, and treatment planning. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Narcotic Treatment Programs would continue to be reimbursed a daily rate for each encounter.

Rate Setting Methodology

For the establishment of reimbursement rates, DHCS is proposing to set rates by peer grouping. Each peer group would be made up of counties with similar costs of doing business to best reflect local needs. Rates would include a service component as well as an administrative component and a utilization management/quality assurance component, which would be percentages on top of the service component. Additionally,

DHCS is proposing to establish a methodology to provide, at a minimum, an annual update to established rates to ensure that reimbursement continues to reflect the cost of providing services, administration, and required utilization management/quality assurance activities.

To start, DHCS is proposing to process intergovernmental transfers and make payments to counties on a monthly basis. Eventually, DHCS plans to transition to quarterly intergovernmental transfers and payments to reduce the administrative burden tied to processing intergovernmental transfers and payments for 58 counties on a monthly basis. The state will discuss with the counties the appropriate time to transition from monthly to quarterly payments.

3.6.3 Rationale

Under CPE-based methodologies, all reimbursement is limited to the actual cost of providing services, which does not allow for value-based arrangements or incentives to reduce costs and share in the savings. The shift from CPE to intergovernmental transfer-based methodologies will allow DHCS, in collaboration with county partners, to:

- Establish rates for reimbursement that are not limited to cost and instead focus on the quality and value of services;
- Provide more flexibility to counties to explore provider reimbursement arrangements that incentivize quality and value;
- Create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal managed care plans and counties, without limiting financial benefits for the county; and
- Reduce state and county administrative burden and allow counties to close their accounting records closer to the end of a fiscal year by eliminating the lengthy and labor-intensive cost-reconciliation process.

Finally, the shift from HCPCS Level II coding to HCPCS Level I coding will allow for more granular claiming and reporting of services provided, creating the opportunity for more accurate reimbursement to counties/providers. The shift in coding will also allow counties and DHCS to better report performance outcomes and measures. In turn, the increased reporting will provide counties and DHCS with more accurate, useful information on health care quality to inform policy decisions.

3.7.4 Proposed Timeline

Given the need to ensure county readiness for this change in approach, DHCS is looking forward to working with counties and stakeholders to establish the timeline for adoption of the HCPCS Level I. DHCS proposes to work with counties and stakeholders to evaluate county readiness and develop a strategy to support them in making this transition. However, the earliest date the shift would occur would be July 1, 2022.

The transition from cost-based reimbursement to an established rate schedule would take place concurrently with the adoption of the HCPCS Level I coding. DHCS would, initially, establish separate rate schedules for specialty mental health and substance use disorder services, with the goal of aligning rate schedules when these services are administratively integrated into a single behavioral health managed care program. DHCS would begin the intergovernmental transfer-based reimbursement at the start of a state-county fiscal year to ease the transition.

3.7 Medical Necessity Criteria

3.7.1 Background

Current medical necessity criteria for specialty mental health services are outdated and confusing and can lead to challenges for beneficiaries in accessing appropriate care. Current diagnosis requirements can prevent beneficiaries from receiving urgently needed care, especially for children, who are entitled to care before developing a mental health condition, or for people with a co-occurring substance use disorder whose diagnosis may not be immediately clear. DHCS requirements for provider documentation are confusing and may lead to provider burden and risk of payment disallowance during audits.

Currently, DHCS does not standardize screening practices to determine where a beneficiary should initially seek mental health care. As a result, counties and plans have a variety of approaches to determine where beneficiaries should initially access care, whether with county Mental Health Plans (for specialty mental health services) or with Medi-Cal Managed Care or Fee for Service delivery systems (for beneficiaries not meeting criteria for specialty mental health services). DHCS does not currently standardize how beneficiaries transition across these delivery systems when their status changes, leading to inconsistent practices. In addition, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) protection for beneficiaries under age 21 is inconsistently interpreted and leads to confusion and variation in practice.

3.7.2 Proposal

With the CalAIM initiative, DHCS aims to design a coherent plan to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes. The goal is to ensure beneficiary access to the right care in the right place at the right time.

In CalAIM, DHCS proposes to update and clarify medical necessity criteria for specialty mental health services for both adults and children, including allowing reimbursement of treatment before diagnosis and clarifying that treatment in the presence of a co-occurring SUD is appropriate and reimbursable when medical necessity is met.

DHCS proposes to clarify EPSDT protections for beneficiaries under age 21, and create criteria for children to access specialty mental health services based on experience of trauma and risk of developing future mental health conditions, such as involvement in child welfare or experience of homelessness.

DHCS proposes to develop a standardized screening tool to facilitate accurate determinations of when care would be better delivered in the specialty mental health delivery system or in the Medi-Cal managed are or fee for service system. In addition, DHCS proposes to develop a standardized transition tool, for when a beneficiary's condition changes, and they would be better served in the other delivery system.

DHCS proposes to implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system where they seek care. This policy would allow beneficiaries who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services, even if the beneficiary is ultimately transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, beneficiaries may receive non-duplicative services in multiple delivery systems, such as when a beneficiary has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other.

DHCS also proposes to simplify and streamline mental health documentation requirements, to align with medical provider requirements, improve efficiency, and decrease provider burnout.

With respect to inpatient specialty mental health services, DHCS proposes to update the criteria for psychiatric inpatient medical necessity currently provided in Title 9 of the California Code of Regulations. To facilitate improved communication between mental health plans and hospitals, and to decrease variation in clinical documentation requests across counties, DHCS will develop, in consultation with hospital and county stakeholders, documentation standards and concurrent review protocols to allow efficient and streamlined communication of clinical information during concurrent review.

Division of Services Between Mental Health Plans and Medi-Cal Managed Care Plans

To ensure beneficiaries with behavioral health needs are guided to the most appropriate delivery system to address their needs, DHCS is proposing to update its medical necessity criteria and processes, which would be organized as described below:

California provides Medi-Cal mental health services through Managed Care Plans, Fee for Service (FFS), and county mental health plans. The delivery system responsible to provide the mental health service depends on the degree of a beneficiary's impairment from the mental health condition and other criteria described below. Beneficiaries may receive mental health services prior to diagnosis in any of these delivery systems under certain conditions, even if ultimately the beneficiary is determined not to have a mental disorder. Beneficiaries may initiate medically necessary mental health services in one delivery system and receive ongoing services in another system. Beneficiaries whose degree of impairment changes may transition between the delivery systems, or under some circumstances may receive medically necessary mental health services in more than one delivery system. Care shall be coordinated between the delivery systems and services shall not be duplicated.

Medi-Cal Managed Care Plan responsibilities:

The following nonspecialty mental health services are covered by managed care plans:

a) Individual and group mental health evaluation and treatment (including psychotherapy and family therapy);
b) Psychological 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 (note: the pharmacy benefit will be carved out of managed care plans contracts and transitioned to fee for service delivery under Medi-Cal Rx as of 4/1/2021).

Medi-Cal managed care plans are responsible to provide the above nonspecialty mental health services to adult beneficiaries 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. Managed care plans are also required to provide non-specialty mental health services to children under the age of 21. Managed care plans are also responsible to provide mental health services to beneficiaries with potential mental health disorders

These services are also available in the FFS mental health delivery system for beneficiaries not enrolled in Medi-Cal managed care.

County Mental Health Plan responsibilities:

For beneficiaries 21 years and over, Mental health plans are responsible to provide specialty mental health services for beneficiaries who meet (A) and (B) below:

(A): The beneficiary must have one of the following:

(i) Significant impairment ("impairment" is defined as distress, disability or dysfunction in social, occupational, or other important activities), OR
(ii) A reasonable probability of significant deterioration in an important area of life functioning.

(B): The beneficiary's condition in (A) is due to:

(i) A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), OR

(ii) A suspected mental disorder that has not yet been diagnosed.

For beneficiaries under age 21[1],
Mental health plans are responsible to provide specialty mental health services to beneficiaries who meet either Criteria 1 **or** Criteria 2:

Criteria 1: The beneficiary is at high risk for a future mental health disorder due to experience of trauma, evidenced by: scoring in the high-risk range on a DHCS-approved trauma screening tool, or involvement in the child welfare system, or experience of homelessness.

Criteria 2: The beneficiary must meet both (A) and (B), below:

(A): The beneficiary must have at least one of the following:

I. Significant impairment, or
II. A reasonable probability of significant deterioration in an important area of life functioning, or
III. iii. A reasonable probability a child will not progress developmentally as appropriate, or
IV. Less than significant impairment, but requires mental health services that are not included within the mental health benefits that managed care plans are required to provide.

(B): The beneficiary's condition in (A) is due to:
I. A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), or
II. A suspected mental disorder that has not yet been diagnosed.

Mental health plans provide the following specialty mental health services

1. Crisis Residential Treatment Services
2. Adult Residential Treatment Services
3. Crisis Interventions
4. Crisis Stabilization
5. Day Rehabilitation
6. Day Treatment Intensive
7. Medication Support Services
8. Psychiatric Health Facility Services

[1] The Early and Periodic Screening, Prevention and Treatment protection entitles beneficiaries under age 21 to services necessary to correct or ameliorate a mental illness and condition recommended by a qualified provider operating within his or her scope of practice, whether or not the service is in the state plan.

9. Psychiatric Inpatient Hospital Services
10. Targeted Case Management/Intensive Care Coordination
11. Mental Health Services and Intensive Home-Based Services (including the following service interventions: Assessment, Plan Development, Therapy, Rehabilitation, and Collateral)
12. Therapeutic Behavioral Services
13. Therapeutic Foster Care Services

Substance Use Disorder Services

As with the current SMHS medical necessity criteria, the current Section 1115 waiver for SUD services requires beneficiaries to be diagnosed with a SUD to meet criteria for reimbursement, preventing the provision of treatment services prior to a definitive diagnosis.

As for mental health, DHCS proposes that substance use disorder treatment services may be provided and reimbursed prior to the determination of a diagnosis, including providing services to beneficiaries with co-occurring mental health disorders.

In addition, DHCS heard many comments from stakeholders about how to improve the Drug Medi-Cal Organized Delivery System, which are reflected in the "DMC-ODS Program Renewal and Policy Improvements" section of this proposal.

Documentation Requirements for Specialty Mental Health and Substance Use Disorder Services

Documentation requirements for SUD and SMHS are currently stringent. Stakeholders report that concern about disallowances result in providers spending an excessive amount of time "treating the chart instead of treating the patient." With the goal of aligning standards across physical and behavioral health programs, DHCS is proposing to update documentation requirements for specialty mental health and substance use disorder treatment to simplify and streamline requirements. For example, DHCS proposes to eliminate the requirement for a point-in-time treatment plan signed by the client, with progress notes tying to the treatment plan. Evidence does not show that shared decision-making is achieved through signature requirements, and the requirement that every note and every intervention must tie to a treatment plan is inefficient and inconsistent with documentation requirements in the medical (physical health) system. DHCS proposes to align behavioral health and medical documentation requirements in Medi-Cal by requiring problem lists and progress notes to reflect the care given and to align with the appropriate billing codes. DHCS also proposes to revise the clinical auditing protocol, to use disallowances when there is evidence of fraud, waste, and abuse, and to use quality improvement methodologies (such as oversight from the External Quality Review Organization) for minor clinical documentation concerns. These documentation changes will align with behavioral health payment reform, as the use of Level 1 HCPCS codes comes with national documentation standards and expectations.

Technical Corrections

DHCS proposes to make other technical corrections to address outdated references to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), rather than the more current DSM-V, and reflect federal diagnostic coding requirements related to use of International Classification of Diseases (ICD) code sets.

3.7.3 Rationale

Updates to medical necessity criteria for specialty mental health and SUD services, and related policy proposals, are required to achieve more up-to-date clinical practices and better clarity for oversight.

3.7.4 Proposed Timeline

DHCS recommends making changes to the specialty mental health and substance use disorder medical necessity criteria and related processes, as applicable, effective January 1, 2022 with the approval of the Section 1115 and 1915(b) waivers.

3.8 Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

3.8.1 Background

California's mental health plans operate under the authority of a Section 1915(b) waiver, while DMC-ODS plans operate under the authority of a Section 1115 demonstration, and Drug Medi-Cal fee-for-service programs are authorized through California's Medicaid State Plan.

For mental health plans and DMC-ODS plans, DHCS contracts with counties to act as prepaid inpatient health plans to provide, or arrange for the provision of, specialty mental health services and DMC-ODS treatment services to beneficiaries. While the specialty mental health services program is a statewide benefit, the DMC-ODS managed care program is only covered in counties that have "opted-in" and are approved to participate by DHCS and CMS.

Fifty-six mental health plans administer the SMHS program, including two joint arrangements in Sutter/Yuba and Placer/Sierra. For SUD services, 37 counties administer the DMC-ODS program, covering more than 90 percent of the Medi-Cal population. Seven of these counties contract with a local Medi-Cal managed care plan to provide an alternative regional model for DMC-ODS. The remaining 21 counties provide SUD treatment services through Drug Medi-Cal.

Medi-Cal specialty mental health and SUD treatment services are currently administered through separate, unique structures at the county level. Beneficiaries with co-occurring mental health and SUD treatment needs must navigate multiple systems to access care.

Beneficiaries must review multiple handbooks and provider directories, navigate separate intake and assessment processes, and often travel to multiple locations to receive care. Counties and providers face challenging documentation and coding requirements, especially for beneficiaries with both SUDs and mental health conditions.

At the system level, counties must demonstrate compliance with two sets of requirements and are subject to multiple reviews. For DMC-ODS counties, administering two distinct prepaid inpatient health plans must demonstrate compliance with federal managed care requirements twice, essentially running two almost entirely separate managed care programs with duplicative processes for quality improvement and performance measurement, beneficiary appeals, and program integrity.

3.8.2 Proposal

DHCS is proposing administrative integration of specialty mental health and SUD services into one behavioral health managed care program. This proposal is distinct from the Full Integration Plan which will integrate physical, behavioral and oral health care into comprehensive managed care plans. The goal is to improve outcomes for beneficiaries through coordinated treatment across the continuum of care. An additional goal and benefit would be to reduce administrative and fiscal burdens for counties, providers, and the state.

For counties participating in DMC-ODS managed care, DHCS is interested in working toward integrating the two behavioral health programs/prepaid inpatient health plans into a single behavioral health plan structure. The result would be a single prepaid inpatient health structure in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD treatment services for all Medi-Cal beneficiaries in that county or region. Participating counties would benefit from streamlined state requirements and the elimination of redundancy. Consolidating operations and resources into one behavioral health managed care plan would allow counties to successfully meet state and federal requirements and significantly decrease their administrative burden.

Additionally, Drug Medi-Cal fee-for-service counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for fee-for-service verses prepaid inpatient health plans.

Clinical Integration

1. Access Line

Counties are required to have a 24-hour access line for mental health plans and for DMC-ODS. Some Drug Medi-Cal counties may also have 24-hour access lines, although it is not a requirement. Many counties already use their access lines in an integrated manner to triage, screen, and refer beneficiaries for both specialty mental

health and SUD treatment services; however, some counties maintain separate lines. Under an integrated model, the goal would be for all counties to have an integrated, 24-hour access line for beneficiaries seeking either specialty mental health and/or SUD services.

2. Intake/Screening/ Referrals

Processes for intake, screening, and referral vary by county. Optimally, counties would have standardized and streamlined intake processes that are timely, emphasize a positive beneficiary experience, and use a "no wrong door" approach to help beneficiaries access mental health and substance use disorder services. While assessments are performed by clinicians and tailored to the needs of the client, and may vary based on setting, DHCS proposes to move forward with a standardized statewide screening tool for beneficiaries 21 and over, and one for beneficiaries under 21, to ensure beneficiaries receive prompt care in the right delivery system.

3. Assessment

Assessment processes and tools for specialty mental health and SUD services also vary by county. For example, the American Society of Addiction Medicine placement tool is used to make level of care determinations DMC-ODS. However, an assessment tool is not required in Drug Medi-Cal counties. For SMHS, the Child and Adolescent Needs and Strengths tool is required for children and youth; however, there is not a required tool for adults. More research will be needed to determine which aspects, authorities, or requirements need to be addressed to integrate clinical assessments for mental health and SUDs.

4. Treatment Planning

Currently, treatment planning for specialty mental health and SUD treatment services is conducted separately and is not integrated. Beneficiaries receiving both types of services can have multiple treatment plans that include different documentation requirements. To improve efficiency, counties would integrate treatment planning for both specialty mental health and substance use disorder services with simplified and aligned documentation requirements. The goal would be to develop a new, simplified, more client-centered and strength-based approach to behavioral health treatment planning and to align treatment planning and documentation standards with physical health care. Additionally, DHCS will provide counties with relevant Medi-Cal services data, which may include managed care encounter and pharmacy claims data, to allow for better coordination of care and treatment planning.

5. Beneficiary Informing Materials

Currently, beneficiaries who receive services through mental health plans and DMC-ODS receive two beneficiary handbooks. The handbooks are not the same, but both

address elements that are required by federal managed care regulations, such as language regarding the grievance, appeals and state fair hearing processes. The goal is to consolidate beneficiary information materials to streamline them into one user-friendly handbook, reduce confusion, increase access, and achieve administrative efficiencies.

Consideration would need to be given to implementing this element in Drug Medi-Cal counties, since they are not currently required to have a beneficiary handbook.

Administrative Integration

1. Contracts

Currently, there are three separate contract types between DHCS and counties: mental health plans, DMC-ODS and Drug Medi-Cal counties. Under an integrated system, the goal would be to have only one contract in every county that would cover both all Medi-Cal specialty mental health and SUD treatment services.

2. Data Sharing / Privacy Concerns

Counties are responsible for managing data-sharing at two levels: within and across county plans, and at the provider level. Data sharing and privacy concerns need to be explored to determine what areas can be addressed, since there are different considerations and regulations pertaining to data sharing for SMHS and SUD services. Addressing these concerns will be critical in determining whether and when counties can integrate assessments, treatment plans, and electronic health records, among other processes. A thorough assessment of the various barriers and solutions to stringent patient privacy protections will be required. There will need to be a thorough assessment by the state and counties to identify the various barriers and solutions to stringent patient privacy protections built into federal regulations.

3. Electronic Health Record Integration and Re-Design

Many counties currently operate separate electronic health records (EHRs) or maintain differently configured and separate records for specialty mental health and substance use disorder services. This is largely in response to federal regulations, but also due to historical bifurcation of the two programs and different documentation and data-reporting requirements for the specialty mental health and substance use disorder programs. Timelines for integrating different components of administrative integration will depend on counties' ability to arrive at a record design that is compliant and then collaborate with their vendors to make multiple, timely modifications to their electronic health records.

4. Cultural Competence Plans

Mental health plans are required to have a plan for culturally responsive care for specialty mental health services. DMC-ODS plans are also required to have a culturally responsive care plan. Under an integrated system, counties would have only one integrated plan for culturally responsive care instead of two, separate plans.

Considerations would need to be given to how this element would be implemented in Drug Medi-Cal counties since they are currently not subject to these same requirements.

Integration of DHCS Oversight Functions

1. Quality Improvement

Some counties have integrated quality improvement and performance measurement programs for specialty mental health and substance use disorder services. However, most programs – or components of them – are still separate. Under an integrated system, counties would develop and operationalize a consolidated quality improvement plan, have a single quality improvement committee, and develop a comprehensive list of performance measures for specialty mental health services and substance use disorder services.

2. External Quality Review Organizations

Pursuant to federal Medicaid managed care requirements, an external quality review is required for both mental health plans and DMC-ODS. Currently, Behavioral Health Concepts is the contractor that acts as the External Quality Review Organization for both programs. However, there are separate contracts, review processes, timelines, and protocols. In addition, counties must develop separate performance improvement plans for each program. The goal is to implement a combined external quality review process, which would result in one external review and integrated performance improvement plans, and ultimately having one single External Quality Review Organization (EQRO) report for each county. Since an external quality review is not required for Drug Medi-Cal counties, further exploration will be needed to determine the extent to which these elements would play a role under an integrated model.

3. Compliance Reviews

Current compliance reviews conducted by DHCS for mental health plans, DMC-ODS, and Drug Medi-Cal counties are separate. Under an integrated model, the goal would be to consolidate compliance reviews into a single review with an integrated protocol. A particular focus of this effort will be on streamlining documentation requirements for behavioral health providers to allow integrated behavioral health care.

4. Network Adequacy

Network adequacy certification processes are separate for specialty mental health plans and DMC-ODS. Under an integrated model, DHCS would certify one network for specialty mental health and substance use disorder managed care services for each county, instead of certifying two networks as currently required.

5. Licensing & Certification

Existing requirements and processes for licensing and certification are different and separate for specialty mental health and substance use disorder providers. The goal is to streamline licensing and certification requirements, processes, and timeframes across the behavioral health managed care system, where appropriate. Successful implementation of integrated care models would also necessitate a discussion on non-administrative changes that may be needed, such as workforce development, cross-training of existing providers, and adoption of new evidence-based practices.

3.8.3 Rationale

About half of individuals with a SMI have a co-occurring substance use and those individuals benefit from integrated treatment. Since the state provides Medi-Cal-covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, it is difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties with both DMC-ODS and mental health plans are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. The purpose of this proposal is to make changes to streamline the administrative functions for SUD and SMHS.

3.8.4 Proposed Timeline

The goal would be to submit for a single, integrated behavioral health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD services under the next 1915(b) waiver in 2027. Both state-level and county-level activities will be required to achieve this goal. Successful implementation will require careful sequencing and planning and a phased-in approach where cohorts are considered.

3.9 Behavioral Health Regional Contracting

3.9.1 Background

State law allows two or more counties acting jointly to deliver or subcontract for the delivery of specialty mental health services. Furthermore, participating DMC-ODS counties are permitted to develop regional delivery systems for required modalities or to act jointly to deliver covered services, with approval from DHCS and CMS, as applicable.

3.9.2 Proposal

DHCS encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program or the local Medi-Cal managed care plan, to create administrative efficiencies across multiple counties.

Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. DHCS is interested in discussing how counties not currently seeking DMC-ODS participation may be more interested in doing so through a regional approach and/or how services provided under Drug Medi-Cal might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

3.9.3 Rationale

Acting jointly through regional contracts would allow counties to pool their resources, which can improve access and availability of services for Medi-Cal beneficiaries in their region and allow for increased county administrative efficiencies. Although regional contracting is currently allowed under state law, only a few counties have taken advantage of this opportunity. Regional contracting would give counties opportunities to share workforce and jointly invest in administrative infrastructure such as electron health records, billing and claiming systems, and oversight/quality assurance and improvement.

Regional contracts offer numerous potential advantages. For example, network adequacy certification requires significant administrative infrastructure to develop and maintain policies and procedures for tracking network resources, and counties must identify and contract with additional qualified providers when network gaps are identified. Both functions (tracking and finding new providers) can prove challenging in some counties that may have fewer local providers. Through regional contracts, counties could reduce duplication and standardize administrative processes, such as beneficiary handbooks, provider directories, and grievance and appeal processes.

For Drug Medi-Cal counties, regionalization could potentially enable smaller counties to participate in DMC-ODS, providing a broader set of services to their residents when it would not be otherwise feasible. By participating in DMC-ODS, these counties could then create a single, integrated behavioral health plan, as described in the CalAIM Administrative Integration of Specialty Mental Health and Substance Use Disorder Services proposal.

In addition, Medi-Cal managed care plans, mental health plans, and DMC-ODS plans must meet the full array of state and federal requirements applicable to prepaid inpatient health plans under the federal Medicaid managed care regulations. Among these are network adequacy, quality assessment and performance improvement, beneficiary rights and protections, and program integrity. For individual counties, entering into regional contracting agreements would reduce the administrative burden of meeting Medicaid managed care requirements. Counties could better utilize resources to focus on improving access, quality of care, and beneficiary outcomes, while mitigating the risk of audit exceptions and administrative and financial sanctions.

3.9.4 Proposed Timeline

DHCS seeks input from county partners and other stakeholders regarding an estimated timeframe for establishing regional contracting agreements.

3.10 Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements

3.10.1 Background

One of the key goals of the Drug Medi-Cal Organized Delivery System (DMC-ODS) was to treat more people more effectively by reorganizing the delivery system for substance use disorder (SUD) treatment through Medi-Cal. California's Drug Medi-Cal Organized Delivery System (DMC-ODS) was the nation's first SUD treatment demonstration project under Section 1115, approved by CMS in 2015. Since then, more than 20 other states have received approval for similar substance use disorder treatment demonstrations. The program has established a continuum of care modeled after the American Society for Addiction Medicine (ASAM) criteria. These criteria are the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction.

The benefits under the DMC-ODS, which counties administer as pre-paid inpatient health plans (PIHPs), include all of the standard SUD treatment services covered in California's Medicaid State Plan (outpatient, intensive outpatient, perinatal residential, narcotic treatment programs and naltrexone), plus case management, multiple ASAM levels of residential substance use disorder treatment, withdrawal management services, recovery services, physician consultation and if the county chooses, additional medication assisted treatment, and partial hospitalization.

Also included in the current program is the expenditure authority to allow federal Medicaid reimbursement for short-term residential SUD treatment stays in an Institution for Mental Disease (IMD). The IMD exclusion has historically prohibited federal reimbursement for residential and inpatient mental health and SUD treatment for Medicaid enrollees age 21-64, in facilities with more than 16 beds. This exclusion deterred most providers in the State who found it financially unviable to operate facilities with so few beds. Allowing for reimbursement of residential SUD treatment services through the Medi-Cal program, with

no limitation on the number of beds, means that counties can receive federal matching funds for services that were previously unavailable.

Currently, DMC-ODS is not a statewide benefit since the program operates only in counties that "opt in" to participate and are approved to do so by both DHCS and CMS. There are currently 37 counties participating in the DMC-ODS demonstration, providing access to SUD treatment services for 96 percent of the Medi-Cal population. Seven of these counties are working with a local managed care organization to implement a regional model. Medi-Cal beneficiaries in the 21 counties not participating in the program provide their SUD treatment services through fee-for-service as authorized through the Drug Medi-Cal State Plan. The fee-for-service benefit is more limited than the DMC-ODS benefit in terms of covered services and that it is not a managed care program.

3.10.2 Proposal

DHCS proposes to update and improve the DMC-ODS, based on experience from the first several years of implementation. Accordingly, DHCS proposes to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency.

DHCS aims to design a cohesive plan to address beneficiaries' SUD treatment needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and to promote long-term recovery. This requires developing new approaches to care delivery and system administration that will improve the beneficiary experience, increase efficiency, ensure cost-effectiveness, and achieve positive health outcomes.

The 37 counties that have implemented the DMC-ODS have made tremendous strides in improving the continuum of care for Medi-Cal beneficiaries with SUD treatment needs. Implementation across 37 California counties has also yielded lessons learned and opportunities to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency. DHCS also acknowledges that for many counties, the DMC-ODS model of care is still very new since implementation was phased in over several years.

Accordingly, DHCS solicited input from stakeholders on the following proposed policy clarifications and changes, which have been thoughtfully constructed to balance system improvements while minimizing disruptions at the local level.

DHCS also intends to provide counties with another opportunity to opt-in to participate in the DMC-ODS in hopes of promoting DMC-ODS participation across the state. While participation in DMC-ODS will not be mandatory for counties, DHCS would like to work with counties not currently participating in the DMC-ODS to explore ways to encourage the remaining counties to opt-in.

Residential Treatment Length-of-Stay Requirements

Currently, within a 365-day period, adult residential SUD treatment services may be authorized for two non-continuous stays, for up to 90 days for each stay, with one 30-day extension permitted for one of the stays. Similarly, within a 365-day period, adolescent residential treatment services may be authorized for two non-continuous stays; however, stays for adolescents are limited to 30 days each stay, with one up to 30-day extension allowed for one of the stays.

Residential length-of-stay should be determined based on the individual's condition, medical necessity, and treatment needs. Given that the two-episode limit is inconsistent with the clinical understanding of relapse and recovery from SUDs, DHCS proposed in the 12-month extension request to remove this limitation and base treatment on medical necessity.[2] DHCS will further propose that there be no distinction between adults and adolescents for these particular requirements.

Note: DHCS must obtain approval from CMS regarding all components of the Section 1115 extension and renewal. CMS is currently only approving SUD 1115 demonstrations with a residential benefit average length-of-stay of 30 days. While some states may show average lengths of stay that are close to the 30-day target, these are likely to include numerous treatment episodes that may have terminated prematurely, before the client achieved positive clinical outcomes. Including these shorter stays in the calculation may lower the average and give the impression that shorter lengths of stay are universally feasible and appropriate.

As such, DHCS will examine the possibility of tracking and documenting the average length-of-stay for only those DMC-ODS enrollees that achieve positive treatment outcomes. Furthermore, with the substantial rise in methamphetamine usage and overdose deaths in California, DHCS will work closely with CMS to negotiate a residential treatment benefit that accounts for the increased clinical needs of individuals utilizing stimulants.

[2] Proposed changes to the DMC-ODS program included in the Medi-Cal 2020 12-month extension request: 1) Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period, 2) Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis, 3) Clarify that recovery services benefit, 4) Expand access to MAT, and 5) Increase access to SUD treatment for American Indians and Alaska Natives.

Residential Treatment Definition

The current definition of residential treatment in California does not clearly define the amount, duration, and scope of covered services, and there are different treatment standards and limitations for adults and adolescents.

DHCS proposes that the definition of residential treatment be updated to remove the adolescent length-of-stay limitations, and to add mandatory provisions for referral to medication assisted treatment. DHCS would also propose to remove the distinction between adults and adolescents for these requirements, with the exception of Early and Periodic Screening, Diagnostic, and Treatment services.

Recovery Services

As part of Dimension 6 (Recovery Environment) of the ASAM criteria, during the transfer/transition planning process, beneficiaries shall be linked to applicable recovery services. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed, or as a preventive measure to avoid relapse.

DHCS proposed in the 12-month extension to clarify the following policies related to recovery services:

- Specify the services included in the benefit (e.g., group, education sessions, and assessment);
- Establish when and how beneficiaries may access these services, including language to encourage the use of recovery services for justice-involved individuals: and
- Define the term “after completing their course of treatment,” to not inadvertently prohibit beneficiaries receiving long-term medication assisted treatment from having access to recovery services.

If these proposed changes are not ultimately approved in the 12-month extension, they will be included in the demonstration renewal request that DHCS will submit in 2021, for a five year renewal from January 1, 2022-December 31, 2026.

Additional Medication Assisted Treatment

Counties are required to cover opioid treatment program services, also called Narcotic Treatment Programs. Currently counties may elect to cover additional medication assisted treatment, which includes the ordering, prescribing, administering, and monitoring of all medications for SUD treatment.

DHCS proposed in the 12-month extension request to keep the additional medication assisted treatment (MAT) services as an optional benefit but clarified the coverage provisions to require that all substance use disorder managed care providers demonstrate that they either directly offer, or have referral mechanisms to medication assisted treatment. The goal is to have a county-wide multi-delivery system of coverage.

Clinician Consultation Services

Currently, physician consultation services cover time spent by the DMC-ODS physicians consulting with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. The name of the benefit will change to Clinician Consultation Services and be expanded to include consultation services for, and by, licensed clinicians including Nurse Practitioners and Physician Assistants. Coverage of consultation services is designed to help clinicians seek expert advice on designing treatment plans for beneficiaries. Clinician consultation services can only be billed and reimbursed by providers in DMC-ODS provider sites.

DHCS proposes to clarify the terms of clinician consultation, particularly with regard to how and who can claim this activity. DHCS proposes to remove the limitation that clinician consultation services can only be billed by certified Drug Medi-Cal providers. Counties may contract with SUD clinicians not certified by Drug Medi-Cal. DHCS' telehealth policy will be used to guide this effort.

Evidence-Based Practice Requirements

Currently, providers are required to implement at least two of the following evidence-based treatment practices based on a timeline established in the county implementation plan: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho Education. The two evidence-based practices are a per-provider per-service modality.

DHCS proposes to retain the five (5) current evidence-based practices and add Contingency Management to the renewal proposal. Providers are not limited to providing only the six evidence-based practices.

DHCS Provider Appeals Process

Following a county's protest procedure, a provider may currently appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.

DHCS proposes removing this process from as it is convoluted, has rarely been used, and it is already addressed by the network adequacy requirements. All providers have a right to appeal under the federal 438 requirements.

Tribal Services

DHCS proposed in the 12-month extension to take several actions to increase access to SUD treatment for American Indians and Alaska Natives, including:

- Providing an allowance for specific cultural practices for Tribal 638 and Urban clinics, reimbursement, and definitions of scope of practice for the workforce of traditional healers and natural helpers, and culturally specific evidence-based practices.

- Requiring Indian health care providers to use at least two evidence-based practices as defined in the DMC-ODS and/or from a list developed by DHCS in consultation with Tribal and Urban partners.

These changes are requested to ensure American Indians and Alaska Natives have access to culturally appropriate and evidence-based substance use disorder treatment.

Treatment after Incarceration

The current language requiring the ASAM criteria, may be underestimating the level of care necessary to serve individuals being released from incarceration, since their substance use was either not possible during incarceration or because individuals under parole/probation supervision are likely hesitant to admit to substance use.

Because inmates are at a high risk of relapse and overdose upon release from incarceration, whether or not there was active use in the last 12 months, DHCS plans to clarify access language for individuals leaving incarceration who have a known substance use disorder.

Billing for Services Prior to Diagnosis

Currently, counties may not begin billing for SUD services until a beneficiary has been diagnosed (i.e., counties may not bill for time spent conducting substance use disorder assessments). Since it takes time for clinicians to evaluate a beneficiary for a substance use disorder, and sometimes presenting symptoms are due to a combination of mental illness, substance use disorder, or both, DHCS proposed in the Medi-Cal 2020 extension to clarify the waiver Special Terms and Conditions to allow reimbursement for SUD assessments (even if it takes multiple visits) before a final diagnosis is determined, which aligns with requirements around assessments for specialty mental health services.

Medical Necessity for Narcotic Treatment Programs (NTPs)

DHCS proposes to update and align the STCs with best practices to allow a physician's history and physical to determine medical necessity for NTP services as required by

federal licensing laws. In addition, DHCS would clarify requirements for the initial assessment and medical necessity determinations in other settings.

Early Intervention (Level 0.5)

DHCS proposes to add ASAM 0.5 level of care for beneficiaries under 21, to allow early intervention as an organized service that may be delivered in a wide variety of settings. This service is designed to explore and address problems or risk factors related to substance use, and to help the individual recognize the harmful consequences of high-risk substance use. This includes engagement activities (including screening, assessment, brief interventions such as motivational interviewing and counseling) for beneficiaries at high-risk for developing substance-related or addictive behavior problems, or those for whom there is not yet sufficient information to document a substance use disorder.

3.10.3 Proposed Timeline

The following changes would go into effect on January 1, 2021, subject to federal approval of the Medi-Cal 2020 12-month extension request:

- Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period
- Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis
- Clarify that recovery services benefit
- Expand access to MAT
- Increase access to SUD treatment for American Indians and Alaska Natives.

The remaining changes outlined above would go into effect January 1, 2022, subject to federal approval.

Dental

3.11 New Dental Benefits and Pay for Performance

3.11.1 Background

DHCS is committed to improving the accessibility of Medi-Cal dental services and improving oral health outcomes for Medi-Cal members. To demonstrate that commitment, three initiatives and policy changes have been implemented in recent years:

- The Dental Transformation Initiative under the current Medi-Cal 2020 Section 1115 demonstration;

- Proposition 56 supplemental provider payments; and

- Restoration of the optional adult dental benefit under Medi-Cal.

These efforts have been successful in increasing preventive dental service utilization for children, as well as increasing adult utilization of dental care. While two of the initiatives share a common theme – financial incentives for positive outcomes – they are time-limited. DHCS has included a chart (see **Appendix H: Dental in Proposition 56 vs. CalAIM**) that reflects the dental codes with financial incentives available under CalAIM and Proposition 56.

3.11.2 Proposal

The Department set a goal to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children. In order to progress toward achieving that goal and based on lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide provide better care and align with national dental care standards. The proposed new benefits include:

- Caries Risk Assessment Bundle for young children; and
- Silver Diamine Fluoride for young children; and specified high-risk and institutional populations; and
- Expanded pay-for-performance initiatives that a) reward increasing the use of preventive services and b) reward establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult enrollees.

These expanded initiatives would be available statewide for children and adult enrollees.

New Dental Benefits

DHCS proposes adding coverage of a Caries Risk Assessment Bundle for children ages 0 to 6 years. The Caries Risk Assessment bundle would include nutritional counseling (D1310) to educate and influence behavior change. Based on risk level associated with each individual Medi-Cal beneficiary ages 0 to 6, the benefit would allow the following frequency of services:

- Low – comprehensive preventive services 2x/year (D0601)
- Moderate – comprehensive preventive services 3x/year (D0602)
- High – comprehensive preventive services 4x/year (D0603)

Additionally, DHCS proposes to add coverage of Silver Diamine Fluoride for children ages 0 to 6 years and persons with underlying conditions such that nonrestorative caries treatment may be optimal, which may include adults living in a Skilled Nursing Facility/ Intermediate Care Facility (SNF/ICF) or part of the Department of Developmental Services (DDS) population. The Silver Diamine Fluoride benefit would provide two visits per member per year, for up to ten teeth per visit, at a per tooth rate and a maximum of four treatments per tooth.

Pay for Performance

To increase statewide preventive service utilization for children and adults, DHCS is proposing to provide a flat rate performance payment for each paid preventive service rendered by a service office location.

Additionally, the state proposes to provide an annual flat rate performance payment to a dental service office location that maintains dental continuity of care by establishing a dental home for each patient and perform at least one annual dental exam/evaluation (D0120/D0150/D0145) for two or more years in a row.

3.11.3 Rationale

These policy proposals align with the legislature's charge to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children, CMS Oral Health Initiative goals for Medicaid (increase by ten percentage points the proportion of Medicaid and CHIP children ages one to 20 who receive a preventive dental service), and our lessons learned from the Dental Transformation Initiative (DTI).

For example, in the DTI - Domain 1, incentive payments were made to service office locations that increased the utilization of the top eleven preventive services available to children. As a result, not only has utilization of preventive services continued to increase year after year, but since the baseline year of 2014, the number of services has increased eight percent and the number of services per member has also increased by seven percent.

Furthermore, data comparing a control group of children in Dental Transformation Initiative counties who did not receive Caries Risk Assessment with children who did receive Caries Risk Assessment over two calendar years yielded staggering results. The Medi-Cal children who had a Caries Risk Assessment received over 300 percent more preventive services compared to 189 percent for non-Caries Risk Assessment children. Additionally, in this same period, the number of restorative services was almost half that of the control group. Medi-Cal children receiving Caries Risk Assessment had a 263 percent increase in restorative services while the control group with no Caries Risk Assessment had a 475 percent increase in restorative services.

3.11.4 Proposed Timeline

DHCS is currently evaluating a timeline for implementation as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration.

County Partners

3.12 Enhancing County Eligibility Oversight and Monitoring

3.12.1 Background

The implementation of the Affordable Care Act (ACA) marked a monumental overhaul of the Medi-Cal program by financing a coverage expansion to populations that previously did not qualify, in addition to streamlining eligibility requirements for some populations. County social service agencies strived to acclimate to the vast changes in regulations while managing an unprecedented surge in Medi-Cal applications submitted statewide. To afford counties the opportunity to modify business processes to effectively administer the Medi-Cal program post Affordable Care Act, counties were held harmless by DHCS for performance standards.

Federal, state, and DHCS audits of Medi-Cal eligibility determinations conducted since the implementation of the Affordable Care Act in 2014 have identified several issues that must be addressed and resolved. Audit findings include performance issues related to timeliness of application processing and timeliness of annual eligibility renewal processing. Discrepancies between the Medi-Cal Eligibility Data System (MEDS), and the county Statewide Automated Welfare System (SAWS) also resulted in audit findings, which in part were caused by system-related issues connected to the implementation of the California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS).

Audit findings, recommendations, and corrective action plans imposed upon DHCS require the State to implement additional oversight activities needed to increase the administrative integrity of the Medi-Cal program. Federal audit findings have also levied fiscal penalties upon DHCS, requiring the state to repay the federal matching funds that were claimed because of erroneous Medi-Cal eligibility determinations.

3.12.2 Proposal

DHCS recommends a phased-in approach to working with the counties to increase program integrity with respect to eligibility and enrollment.

- **Reinstate County Performance Standards**: In response to audit findings, DHCS will reinstate the county performance standards required under state law as a means of addressing and correcting error rates and issues which may have a future impact on the timeliness and accuracy of Medi-Cal eligibility determinations. DHCS plans to implement a series of oversight programs throughout the course of the next 24 months. This includes the implementation of a statewide MEDS alerts monitoring program.

- **Develop an Updated Process for the Monitoring and Reporting of County Performance Standards**: In collaboration with CWDA, SAWS and the counties, DHCS will define roles, responsibilities, and develop an updated written process for the monitoring and reporting of the existing county eligibility performance standards. This process will clearly outline DHCS' performance expectations, taking into consideration the issues that are beyond the counties' control, but including potential consequences if standards are not met.

- **Ensure DHCS/County Partnership through Regular Meetings and Open Lines of Communication:** DHCS will work collaboratively with CWDA, counties, and SAWS to develop a communications plan that articulates a process for receiving and responding to county requests for technical guidance and assistance as necessary and appropriate to support counties through this transition. DHCS will look at leveraging existing meetings, and/or developing dedicated meetings to further open lines of communication related to county oversight and monitoring. DHCS will continue to encourage county feedback in identifying gaps or needed clarifications in policy guidance and automation issues. DHCS will also work closely with counties, SAWS and CalHEERS to identify and pursue needed automation changes to support counties in the effective administration of the Medi-Cal program.

- **Develop a Tiered Corrective Action Approach**: DHCS will work with county partners to establish a tiered corrective action approach that would require the submission of a Corrective Action Plan for counties that do not meet established performance expectations. DHCS remains committed to supporting counties and providing timely policy guidance, along with technical assistance, as needed, in addressing and correcting error trends.

- **Incorporate Fiscal Penalties as Part of the Tiered Corrective Action Approach**: For counties that do not demonstrate sufficient improvement in performance, DHCS will take disciplinary action that could range from technical assistance to requiring corrective action plans to imposing financial penalties on counties that fail to show significant improvement and/or are unresponsive to CAPs.

- **Incorporate Findings/Actions in Public Facing Report Cards**: DHCS will work with CWDA, counties and the SAWS to further develop county performance reports that are publicly posted on the California Health and Human Services (CHHS) Open Data Portal and increase accountability by issuing annual public-facing report cards to all 58 counties.

3.12.3 Rationale

This proposal is envisioned to be a crucial step toward achieving DHCS' larger vision for CalAIM by ensuring Medi-Cal enrollment processes are applied in a standardized and consistent manner statewide. This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS is compliant with federal and state requirements.

3.12.4 Proposed Timeline

Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

- **June 1 – August 31, 2021**: DHCS will reinstate County Performance Standards, including incorporation of MEDS alert monitoring statewide.

- **September 1 – December 30, 2021:** DHCS will develop and publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CAPs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties.

- **January 1 – March 31, 2022:** DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.

- **April 1 – June 30, 2022:** DHCS will implement the county performance monitoring dashboard (a public facing report card). The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.

- **July 1 – September 30, 2022:** DHCS will begin publishing the county performance monitoring dashboard on the CHHS Open Data Portal.
- **July 1 – December 31, 2023:** DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.

3.13 Enhancing County Oversight and Monitoring: CCS and CHDP

3.13.1 Background

The California Children's Services program serves as a proxy of Medi-Cal for case management services and provides diagnostic and treatment services, physical and occupational therapy services to children and youth with eligible medical conditions. The Child Health and Disability Prevention program delivers periodic health assessments and services to low-income children and youth; and provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

California Children's Services and Child Health and Disability Prevention beneficiaries are best served when their care is delivered in a standardized and consistent manner. It is the State's responsibility to ensure that the same high-quality standard of care is compliant with federal and State guidelines for all beneficiaries. To remain proactive with emerging trends, technology, medical advances, and interventions, it is essential the State continue to evolve its efforts accordingly.

3.14.2 Proposal

DHCS intends to provide enhanced monitoring and oversight of all 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach) to ensure continuous, and unwavering optimal care for children. To implement the enhanced monitoring and oversight of California Children's Services and Child Health and Disability Prevention in all counties, DHCS will develop a robust strategic compliance program. Effective compliance programs begin with ascertainable goals, performance measures, and metrics capturing all federal and State requirements. Ongoing quality assurance and data reviews are fundamental to ensuring compliance and continued improvements in program operations and beneficiary care.

Initial efforts will entail a review of all current standards and guidelines for both programs. Once the internal policy review is complete, DHCS will develop initial auditing tools to assess current county/city operations and compliance. DHCS will then evaluate and analyze the findings gathered during audits to identify gaps and vulnerabilities across the State within the programs. The information gathered will be the cornerstone for future efforts, and the basis for the development of the strategic compliance program.

County/City variances in program operations and compliance with federal and State laws are also identified by tracking trends. DHCS will refine and update oversight policies and procedures and implement best practices. DHCS, along with input from our county partners and other stakeholders, will establish goals, metrics, performance measures, and milestones to ensure counties/cities are providing the necessary provider oversight and medical/ dental care for beneficiaries. DHCS will provide training and technical assistance with internal and external partners to achieve statewide consistency of the compliance requirements and goals. In addition, DHCS will conduct ongoing quality assurance reviews, develop, and create county/city program specific dashboards, as necessary to meet internal and external reporting needs.

In alignment with technology trends, the State plans to shift counties/cities from annual hardcopy submission of Plan and Fiscal Guidelines budgets to a more efficient and streamlined automated electronic submission process. Training and overview of the electronic submission process conducted for the counties ensures understanding prior to implementation of the automated system. More rigorous annual review of all county budgets will further efficiencies, contain costs, and improve outcomes.

To better manage this population's health care and ensure targeted interventions are implemented, each county/city and state will enter into a Memorandum of Understanding (MOU) with DHCS. The MOU, in conjunction with other supportive policies (information notices, numbered letters, etc.), will detail how the state will monitor county/city activities, policies and procedures, conduct audits, and implement corrective action plans. This MOU will be developed utilizing information obtained during the audits with the intent of having signed agreements with all counties/cities.

After initial deployment of the enhanced monitoring and oversight, DHCS will continue to conduct ongoing audits, stay proactive with emerging developments, and monitor trends to ensure high-quality consistent care. DHCS will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. DHCS will continue compliance oversight to preserve and improve the overall health and well-being of these vulnerable populations.

3.13.3 Rationale

Enhancing monitoring and oversight will eliminate disparities in care to beneficiaries and reduce vulnerabilities to the state, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

3.13.4 Proposed Timeline

- **Phase I: August 2020 – June 2021**
    - Review of current standards, policies, and guidelines

  - Development of goals, performance measures, and metrics
  - Revision of current Plan and Fiscal Guidelines guidance document
  - Continuation of the establishment of an electronic submission portal for the annual county/city budgets.

- **Phase II: July - September 2021**
  - Development of auditing tools
- **Phase III: October 2021 – September 2022**
  - Shift to an electronic automated PFG submission by the counties/cities
  - Develop training documents
  - Evaluate and analyze findings and trends
  - Identify gaps and vulnerabilities
- **Phase IV: October 2022- Ongoing**
  - Initiate Memorandum of Understanding between State and counties
  - Continuous monitoring and oversight
  - Continuous updates to standards, policies, and guidelines

3.14 Improving Beneficiary Contact and Demographic Information

3.14.1 Background

Medi-Cal has approximately 13 million enrolled beneficiaries; approximately 80 percent are enrolled in the managed care delivery system and 20 percent are enrolled in the fee-for-service delivery system. County social services departments are delegated by DHCS to process Medi-Cal applications and renewals, as well as to generally provide case management services. Counties use Statewide Automated Welfare Systems (SAWS_ to support and maintain Medi-Cal enrollment processes. The SAWS, of which there are currently three, contain contact and demographic information on enrolled individuals. The systems maintain electronic interfaces with the state-level eligibility and enrollment system (California Healthcare Eligibility, Enrollment, and Retention System) and the state-level eligibility database, the Medi-Cal Eligibility Data System. The Medi-Cal Eligibility Data System is the system of record for purposes of Medi-Cal eligibility information, claims payment, and health plan assignment, among other things.

When a beneficiary has a change in circumstances that affects their eligibility, the beneficiary is required to report changes to their county eligibility worker within ten calendar days of the change. Such changes include but are not limited to address and contact information updates, family size (increases or decreases), access to other health insurance, changes in income, and death. County eligibility workers are then responsible

for ensuring the data maintained in the local county eligibility system is accurate and up to date. Under current state law, Medi-Cal managed care plans have the ability to report updated contact information to the county when they have obtained consent from the beneficiary for such reporting.

Accurate contact and demographic information is critical for purposes of ongoing program enrollment and care management for beneficiaries. This information is used by Medi-Cal fee-for-service providers and Medi-Cal managed care plans, as well as other providers of care, for purposes of effective communication and interaction with Medi-Cal beneficiaries, including deploying care management strategies based on individual needs.

Given the substantial volume of individuals in the process of enrolling in or renewing Medi-Cal coverage, it is critical that DHCS, counties and plan and provider partners have accurate contact and demographic information. A more effective and efficient process for keeping this information up to date in California's systems is needed.

3.14.2 Proposal

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services program, Medi-Cal beneficiaries, managed care plans, and the provider community.

3.14.3 Rationale

As DHCS seeks to make improvements in its approach to population-based health care and drive innovation in health care delivery, it is critical that our Medi-Cal providers, managed care plans, county partners, and others have access to accurate, up-to-date contact and demographic information for beneficiaries. County eligibility workers play a key role in ensuring contact information is current; however, there are other entities that interact with Medi-Cal beneficiaries on a regular basis who may have access to more current information. As a result, DHCS would like to leverage and explore the possibility of other entities having the opportunity to also update contact and demographic information about Medi-Cal beneficiaries.

3.14.4 Proposed Timeline

DHCS proposes to engage with key partners during 2022-23 to develop thoughtful and realistic recommendations for implementing improvements in how contact and demographic information can be updated by other entities in addition to county eligibility

workers. Such changes may be effectuated through updates to the Medi-Cal application, use of eligibility online portals and/or other means. As part of the workgroup effort, DHCS will also seek input in terms of timing of implementation, taking into consideration current system migrations, consolidations and/or modernization efforts.

4. Conclusion

DHCS developed these CalAIM proposals with a view toward the future and what will be necessary to more effectively and positively impact Medi-Cal beneficiaries' quality of life. These proposals were drawn from more than a year-long effort by DHCS leadership and staff, as well as engagement with critical partners and experts across the State and the nation. These ambitious proposals represent a long-term vision for advancing and improving the Medi-Cal program in fundamental ways that build upon the foundations established in prior waivers and expansion efforts. The success of the thinking behind CalAIM will fundamentally rest on the collaboration and coordination of DHCS, our plan, provider, county, and legislative partners, and the entire stakeholder community. DHCS recognizes that these proposals will likely require significant time and fiscal investment and look forward to working with our partners and through the budget process to most effectively implement the concepts proposed in this initiative. These efforts are not limited to a single year, but represent DHCS' current vision for what Medi-Cal might be able to achieve over the next five to ten years, and beyond.

5. From Medi-Cal 2020 to CalAIM: A Crosswalk

California is embarking on a new and system-wide initiative to transform how beneficiaries' access Medi-Cal services. As the Medi-Cal program has expanded under the Affordable Care Act and through other state-led initiatives, and with over 80% of beneficiaries now being served through managed care plans, it is an opportune time to consider the patient experience from an even more global perspective. Currently, beneficiaries may need to access six or more separate delivery systems (managed care, fee-for-service, specialty mental health, substance use disorder, dental, In Home Supportive Services, etc.) in order to receive the care they need. This combination of system fragmentation and clinical complexity, and the likelihood of decreased beneficiary capacity, makes access to effective care coordination even more critical.

As such, the state is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers. CMS, in recent

guidance, has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools. These factors, combined with new federal managed care regulations, have encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

In the spring of 2020, in response to the COVID-19 public health emergency, DHCS determined that additional time would be needed to prepare Medi-Cal managed care plans, counties, and a wide array of stakeholders for the transition from the Section 1115 waiver to the CalAIM structure. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

The following table outlines the proposed approach under CalAIM for each of the key Medi-Cal 2020 waiver elements:

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Medi-Cal Managed Care	X	Transition to new 1915(b) waiver.	The general authority for various Medi-Cal managed care will be shifted from 1115 to 1915(b). This would include PACE models needing waiver approval and Whole Child Model.	January 1, 2022
Whole Person Care Pilots	X	Transition to new 1915(b) waiver and managed care plan contract authority.	Medi-Cal managed care plans would provide a new enhanced care management benefit. Additionally, Medi-Cal managed care plans will have the option to provide a menu of approved in lieu of services. The majority of Whole Person Care services will continue to be available as both enhanced care management and in lieu of services via Medi-Cal managed care plans, and ultimately will be expanded to Medi-Cal managed care plans in non-Whole Person Care counties.	January 1, 2022
PRIME		Transition to managed care directed payment under the Quality Incentive Pool (QIP) Program.	The existing PRIME funding structure was transitioned into QIP directed payments effective July 1, 2020. Network Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPHs) will have the opportunity to participate in and receive directed QIP payments from their contracted Medi-Cal managed care plans for reporting on a set of quality improvement measures through the QIP program.	Phase I: July 1 – December 31, 2020 Phase II: January 1, 2021
Health Homes Program	X	Transition to new 1915(b) waiver as Enhanced Care Management.	Medi-Cal managed care plans would provide a new enhanced care management benefit similar to the benefits included in the Health Homes Program. Medi-Cal managed care plans will have the option of providing a menu of approved in lieu of services. Services currently provided to populations with complex health needs under the HHP will become available under the managed care delivery system structure.	January 1, 2022

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Coordinated Care Initiative and Cal MediConnect	X	Managed care authority to new 1915(b) waiver; Extension of 1115A demonstration for Cal MediConnect through 2022; eventual Medicare-Duals Special Needs Plans (D-SNPs).	Transition to standardized mandatory enrollment of dual eligibles into Medi-Cal managed care plans. Multipurpose Senior Services Programs will be carved out; long-term care will be carved in statewide. All Medi-Cal managed care plans will be required to offer coverage through D-SNPs for care coordination and integration of benefits.	CCI program with end date of December 31, 2022
Drug Medi-Cal Organized Delivery System (DMC-ODS)	X	Expenditure authority for residential SUD treatment remains in 1115 waiver; Services and delivery system move to new 1915(b) waiver.	The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care for substance use disorder treatment.	Implementation continues January 1, 2022
Global Payment Program	X	1115 waiver renewal.	Continuation of existing program, with discontinuation of Safety Net Care Pool funds, using only Medicaid Disproportionate Share Hospital (DSH) allotment funds.	January 1, 2022.

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Dental Transformation Initiative	X	Transition authority to Medi-Cal State Plan.	New dental benefits and provider payments: • Caries Risk Assessment Bundle for ages 0-6; • Silver Diamine Fluoride for ages 0-6, and specified high-risk and institutional populations Pay for Performance incentives for preventive services and establishing continuity of care through dental homes	January 1, 2022
Community-Based Adult Services (CBAS)	X	1115 waiver renewal.	Services for eligible older adults and those with disabilities to restore or maintain their optimal capacity for self-care. The goal is to delay or prevent inappropriate or personally undesirable institutionalization.	January 1, 2022
Eligibility Authorities	X	1115 waiver renewal.	Full Scope Benefit for Pregnancy Related Beneficiaries with FPL 109-138% and Out of State Former Foster Care Youth.	January 1, 2022
Rady CCS Pilot	X	Not included.	The demonstration project tested two healthcare delivery models for children enrolled in the California Children's Services (CCS) Program.	Expires December 31, 2021
Designated State Health Programs (DSHP)	X	Not included.	Financing mechanism under 1115 waiver which has permitted federal funding for certain State health programs not traditionally allowed for federal funding	Expires December 31, 2020
Tribal Uncompensated Care	X	Not included.	The state makes supplemental payments to Indian Health Service (IHS) and tribal 638 facilities to take into account their responsibility to provide uncompensated care. DHCS will work to implement Tribal FQHCs by January 1, 2021, which will account for the remaining services being billed for under Tribal Uncompensated Care.	Expires December 31, 2021

5.1 Transition of PRIME to Quality Incentive Program

5.1.1 Background

The California Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program built on other delivery system transformation efforts focused on strengthening patient-centered primary and specialty outpatient care, improving care coordination, and providing the right care in the most appropriate settings. A total of 17 Designated Public Hospitals and 34 District and Municipal Public Hospitals participated in PRIME. PRIME was designed to accelerate efforts by participating entities to change care delivery, maximize health care value, and strengthen their ability to successfully perform under risk-based alternative payment models. PRIME was intentionally designed to be ambitious in scope and time limited. Using evidence-based quality improvement methods, the initial work required the establishment of performance baselines followed by target-setting, and the implementation and ongoing evaluation of quality improvement interventions.

In 2017, California created a Quality Incentive Program (QIP) – a managed care directed payment program – for the state's Designated Public Hospitals. The state directs Medi-Cal managed care plans to make QIP payments tied to designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP measures do not directly overlap with any of the quality measures being used in PRIME, rather they are designed to be complementary. The QIP promote access to care, value-based purchasing, and to tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The QIP also creates incentives to build data and quality infrastructure and ties funding directly to these goals, allowing the state to pay for quality and build capacity.

5.1.2 Proposal

DHCS is in the process of transitioning the quality improvement work and funding that has been available through PRIME into the QIP and permitting the District and Municipal Public Hospitals to begin participating in the program, which has enabled hospitals to continue quality improvement efforts underway at all 51 PRIME entities after PRIME expired on June 30, 2020. This transition promotes value-based purchasing, ties funding to quality outcomes, and aligns PRIME entities' transition to the QIP with California's transition to the calendar year rating period for Medi-Cal managed care plans.

There are two key phases in the PRIME-to- QIP transition:

- **Phase I:** Alignment with the calendar year health plan rating period, July 1, 2020 through December 31, 2020

- **Phase II:** Merge to QIP, January 1, 2021 through December 2021, and beyond.

Phase I: Alignment with Calendar Year Rating Period

All 51 PRIME entities transitioned into a six-month transitional program on July 1, 2020 to calibrates the new program to end on the same date as Bridge Period 2019-20, an 18-month rate year for Medi-Cal managed care plans that ended on December 31, 2020. For performance on both the original QIP quality metrics (for Designated Public Hospitals) and the PRIME transition metrics (for Designated Public Hospitals and 34 District and Municipal Public Hospitals) during this period, the 51 entities will be paid through Medi-Cal managed care plans, via state-directed Medi-Cal managed care plan payments. CMS approval for this six-month program was obtained on September 14, 2020.

To earn funds for PRIME transition metrics, all 51 PRIME entities will continue to report to DHCS on quality improvement projects and measures from PRIME. The six-month transition will use a twelve-month measurement period to ensure that performance can be fairly compared to benchmarks set by DHCS. Due to the COVID-19 public health emergency, entities will use the March 1, 2019 to February 29, 2020 measurement period and be held to achieving the minimum performance benchmark established by DHCS from PRIME Demonstration Year 15. The Designated Public Hospitals will also continue activities on the original QIP quality metrics during this six-month period, utilizing the same modifications due to the COVID-19 public health emergency outlined for PRIME above.

Phase II: Merge to QIP

Subject to obtaining the necessary federal approvals, January 1, 2021 will be the start of QIP Year 4 and will include the Designated Public Hospitals and 34 District and Municipal Public Hospitals, totaling 51 QIP entities. Similar to Phase I, payments to the 51 QIP entities will be directed payments through the Medi-Cal managed care plans. Program Year 4 will align with Rate Year 2021, corresponding to calendar year 2021.

PRIME Policy Letters and associated PRIME reporting guidance will no longer apply to QIP. DHCS will review all prior PRIME Policy Letters and QIP Policy Letters for relevance and issue updated Policy Letters and reporting guidance to Designated Public Hospitals and District and Municipal Public Hospitals.

DHCS worked with stakeholders to develop a revised metric set for Program Year 4 that prioritizes CMS Adult and Child Core Set measures, HEDIS measures, other nationally vetted and endorsed measures, and measures in wide use across Medicaid quality initiatives. The measures align with well-established benchmarks and State, Medi-Cal managed care plan, and hospital system goals. The Program Year 4 metric set meaningfully reflects the goals and priorities of CalAIM.

5.1.3 Rationale

The QIP Program is intended to promote access to care, value-based payments, and tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The PRIME to QIP transition will engage both Designated Public Hospitals and 34 District and Municipal Public Hospitals to continue quality improvement work for select priority metrics in QIP As such, this proposal will help achieve the following goals of CalAIM:

- Enhance coverage expansion to address health disparities among vulnerable populations;
- Drive delivery transformation across Designated Public Hospitals and District and Municipal Public Hospitals toward value-based care and away from volume-based care, and
- Reduce variation and complexity across hospital systems through alignment of quality measures with those required of health plans.

5.1.4 Proposed Timeline

January 1, 2021: Complete transition from PRIME to QIP for Designated Public Hospitals and District and Municipal Public Hospitals using new CMS Adult and Child Core Set measures, HEDIS measures, and other nationally-vetted and endorsed measures

5.2 Global Payment Program Extension

5.2.1 Background

The Global Payment Program is a five-year pilot program included in California's Medi-Cal 2020 Section 1115 demonstration waiver. The Global Payment Program establishes a statewide pool of funding by combining a portion of California's federal Disproportionate Share Hospital (DSH) allotment with available uncompensated care funding. These funds support public health care system efforts to provide health care for California's uninsured population and promotes the delivery of more cost-effective and higher-value care to the uninsured.

Global budgets are allocated to public health care systems based on available funding and service point thresholds to be achieved. Public health care systems can achieve their hospital specific global budget by meeting a service point threshold that incentivizes movement from high cost, avoidable services to providing higher value and preventive services in the most appropriate setting.

The Global Payment Program's requirements are established in the Special Terms and Conditions for California's Medi-Cal 2020 Section 1115 demonstration and the program

funding is authorized December 31, 2021 under the one year Medi-Cal 2020 extension proposal, submitted to CMS on September 16, 2020.

5.2.2 Proposal

DHCS proposes to extend the Global Payment Program under CalAIM through a renewal of the Medi-Cal Section 1115 waiver demonstration. The Global Payment Program will operate under the following assumptions:

- The start date of Program Year 7 will begin on January 1, 2022, and end on December 31, 2022. The Global Payment Program was originally approved through June 30, 2020. On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a waiver amendment extending the program and authorizing Program Year 6A for the period of July 1, 2020 through December 31, 2020. The Medi-Cal 2020 one-year extension proposal extended the program through December 31, 2021.
- The Global Payment Program under CalAIM will be funded solely by a portion of the State's Designated Public Hospital Disproportionate Share Hospital allotment allocation and will no longer incorporate uncompensated care funding;
- The percentage of Designated Public Hospital Disproportionate Share Hospital allotment funds to be split amongst University of California hospitals and Global Payment Program public health care systems will remain constant for the entirety of the waiver with 78.104% allocated to the Global Payment Program and 21.896% allocated to University of California hospitals;
- The Global Payment Program will include an evaluation to continue to assess whether the program is achieving its stated goals;
- The Global Payment Program will continue the shifting of point values for specific services to incentivize the provision of care in the most appropriate and cost-effective settings;
- DHCS may recalibrate the initial point thresholds for each hospital. Some public health care systems consistently exceed their thresholds, while others do not. Recalibration of the initial point thresholds will serve to minimize payment adjustments; and
- All other facets of the Global Payment Program in the CalAIM period will operate per the Medi-Cal 2020 waiver Special Terms and Conditions.

5.2.3 Rationale

The Global Payment Program was established to accomplish the following goals:

- To improve health of the remaining uninsured through coordination of care and to move away from the cost-based payment methodology restricted to mostly hospital settings to a more risk-based and/or bundled payment structure;
- To encourage public healthcare systems to provide greater primary and preventive services, as well as alternative modalities such as phone visits, group visits, telemedicine, and other electronic consultations; and
- To emphasize the value of coordinated care and alternative modalities by recognizing the higher value of primary care, ambulatory care, and care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stay.

DHCS collaborated with the RAND Corporation to conduct an evaluation of the Global Payment Program from the onset of the program through March 2019. The evaluation assessed whether and to what extent, changing the payment methodology resulted in a more patient-centered system of care. Results show that there has been an increase in outpatient services, an increase in access to care for the uninsured, an improvement in the coordination of care, advancements in data collection and tracking, and an appropriate allocation of resources to effectively tailor care to more appropriate settings.

These findings provide strong support for the argument that the Global Payment Program is a powerful catalyst in helping the public health care systems deliver more cost-effective and higher-value care to the State's remaining uninsured individuals and will continue to move in this direction over the next five years.

5.2.4 Proposed Timeline

DHCS proposes to extend the Global Payment Program for the next five years according to the schedule in **Attachment G.**

6. Appendices

Appendix A: 2021 and Beyond: CalAIM Implementation Timeline[3]

Date	Implementation Activity
July 1, 2020	**PRIME transitions to Quality Incentive Program**
January 1, 2021	12-month extension of Medi-Cal 2020 demonstration
April 2021	**Submission of Section 1915(b) and 1115 waiver requests** **Pharmacy Carve-Out Effective**
June 2021	**County Oversight[4]:** DHCS will engage with counties by forming a working group that will focus on developing new county performance standards monitoring and reporting mechanism. The reinstatement of County Performance Standards will include incorporation of MEDS alert monitoring statewide **County oversight (CCS, CHDP):** Development of auditing tools. **Foster Care Model of Care Workgroup** completed
October 2021	**County oversight (CCS, CHDP):** Shift to automated Plan and Fiscal Guideline submission process, develop training documents, evaluate and analyze findings and trends, and identify gaps and vulnerabilities.
November-2021	**County Inmate Pre-Release Application Process:** Stakeholder process
December 2021	**County Oversight**: DHCS will publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CPAs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties. **Goal approval date of Section 1915(b) and 1115 waiver requests**
2022	

[3] Implementation date TBD: IMD SMI/SED waiver, regional contracting (will vary), improving beneficiary contact and demographic information

[4] Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

Date	Implementation Activity
January 1, 2022	**Managed Care Authority:** Shifts to 1915(b) authority **Implementation of the following CalAIM proposals:** • Enhanced care management/In lieu of services (existing WPC and/ or HHP target populations) • Incentive payments • Dental benefits and pay for performance (implementation date TBD as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration) • Managed care benefit standardization continues • Mandatory managed care • Regional Rates Phase I • DMC-ODS renewal and policy improvements • Changes to behavioral health medical necessity • Multipurpose Senior Services Program carved-out of managed care • D-SNP look-alike enrollment transition in CCI counties **County Inmate Pre-Release Application Process:** Publication of guidance and begin Technical Assistance (through December 2022)
March 2022	**County Oversight**: DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.
June 2022	**County Oversight**: DHCS will implement the County Performance Monitoring Dashboard. The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.
July 2022	**Behavioral Health Payment Reform** **Enhanced care management:** • Implementation of additional enhanced care management Target Populations in HHP/WPC Counties. • Managed care plans in non- WPC and/or HHP counties begin implementing enhanced care management target populations
September 2022	**County Oversight**: DHCS will begin publishing the County Performance Monitoring Dashboard on the CHHS Open Data Portal.
October 2022	**County oversight (CCS, CHDP):** Initiate Memorandum of Understanding between State and counties, continuous monitoring and oversight, and continuous updates to standards, policies, and guidelines
December 31, 2022	**Cal MediConnect:** End of program
2023	
January 2023	**Aligned Enrollment:**

Date	Implementation Activity
	• Require statewide mandatory enrollment of dual eligibles in Medi-Cal managed care[5] • All Medi-Cal health plans in CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as an Medi-Cal managed care plan, including dual eligible LTC residents • Require statewide mandatory enrollment for eligible LTC residents for both non-dual and dual beneficiaries **County Inmate Pre-Release Application Process:** Implementation **Shared Risk/Shared Savings** (at the earliest) **Enhanced care management:** Implementation of all enhanced care management target populations, including Individuals Transitioning from Incarceration.
December 2023	**County Oversight**: DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.
2024	
January 2024	**Regional Rates, Phase II** (at the earliest)
2025	
January 2025	**Aligned Enrollment:** • All Medi-Cal health plans in non-CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as a Medi-Cal managed care plan.
2026	
January 2026	**NCQA:** All Medi-Cal managed care plans required to be NCQA accredited
2027	
January 2027	**Behavioral Health Administrative Integration:** submit for a single, integrated behavioral health managed care plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder services under the 1915(b) waiver **Long-Term Services and Supports, Long-Term Care, Dual Eligible Special Needs Plans:** Full implementation **Full Integration Plan:** Go Live (no sooner than)

[5] Mandatory Managed Care enrollment: See **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage.**

Appendix B: Targeted Case Management

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Alameda County	X	X	X	X		
Alpine County						X
Amador County						X
Butte County				X		
Calaveras County						X
Colusa County						X
Contra Costa County	X	X	X	X	X	
Del Norte County						X
El Dorado County						X
Fresno County						X
Glenn County						X
Humboldt County	X	X		X	X	
Imperial County						X
Inyo County						X
Kern County				X		
Kings County						X
Lake County						X
Lassen County						X
Los Angeles County	X			X		

Back to Agenda

Back To Item

Back to Item

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Madera County				X		
Marin County						X
Mariposa County	X	X	X	X	X	
Mendocino County	X	X	X	X	X	
Merced County						X
Modoc County						X
Mono County						X
Monterey County	X	X		X		
Napa County	X	X		X		
Nevada County						X
Orange County	X	X	X	X	X	
Placer County		X	X	X		
Plumas County						X
Riverside County	X	X	X	X	X	
Sacramento County				X		
San Benito County						X
San Bernardino County						X
San Diego County	X	X	X	X	X	
San Francisco County						X
San Joaquin County						X

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
San Luis Obispo County	X	X		X		
San Mateo County	X	X		X		
Santa Barbara County						X
Santa Clara County	X	X	X	X	X	
Santa Cruz County	X	X		X		
Shasta County		X		X		
Sierra County						X
Siskiyou County						X
Solano County	X	X		X	X	
Sonoma County	X	X	X	X	X	
Stanislaus County	X	X	X	X	X	
Sutter County	X	X	X	X	X	
Tehama County						X
Trinity County				X		
Tulare County						X
Tuolumne County	X	X	X	X		
Ventura County	X	X	X	X	X	
Yolo County						X
Yuba County						X
City of Berkeley	X	X	X	X	X	
City of Long Beach	X	X	X	X	X	
Total	**23**	**24**	**16**	**30**	**15**	**30**

Back to Agenda

Back To Item

Back to Item

Appendix C: County Inmate Pre-Release Application Process sample contracting Models

Contracting Model	Counties Currently Using a Similar Process
County Contracts with County Sheriff's Office	Butte Kern San Bernardino San Diego San Francisco Tuolumne Ventura Yolo
County Contracts with County Jail	Glenn Santa Barbara
County Contracts with Multiple Entities (e.g. Community Based Organizations and County Sheriff's Office)	Contra Costa Imperial Placer Sacramento San Luis Obispo San Mateo Solano Sutter

Back to Agenda

Back To Item

Back to Item

Appendix D: Institutions for Mental Disease/Serious Mental Illness/Severe Emotional Disturbance Demonstration Goals & Milestones

Below is a summary of demonstration goals as outlined in CMS SMD Letter #18-011:

- Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with serious mental illness or serious emotional disturbance while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with serious mental illness or serious emotional disturbance including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Below is a summary of demonstration milestones as outlined in CMS SMD Letter #18-011:

- Ensuring quality of care in psychiatric hospitals and residential settings. Involves facility accreditation, unannounced visits, use of a utilization review entity, facilities meeting federal program integrity requirements, and facilities having the capacity to address co-morbid physical health conditions;
- Improving care coordination and transitions to community-based care. Involves implementation of a process to assess housing situations, requirement that facilities have protocols to contact beneficiaries within 72-hours after discharge, strategies to prevent or decrease lengths of stays in emergency departments, and strategies to develop and enhance interoperability and data sharing;
- Increasing access to continuum of care including crisis stabilization services. Involves annual assessments of availability of mental health services across the state, commitment to an approved finance plan, strategies to improve the state's

capacity to track available beds, and implementation of an evidence-based assessment tool; and

- Earlier identification and engagement in treatment including through increased integration. Involves strategies for identifying and engaging individuals in treatment sooner, increased integration of behavioral health care in non-specialty settings and establishing specialized settings and services.

Federal Application Requirements

States wishing to pursue this demonstration opportunity must first submit an application to CMS. CMS will consider a state's commitment to ongoing maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state's proposed demonstration project to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Below is a summary of required elements for the application;

- A comprehensive description of the demonstration, including the state's strategies for addressing the goals and milestones discussed above for this demonstration initiative;
- A comprehensive plan to address the needs of beneficiaries with serious mental illness or serious emotional disturbance, including an assessment of how this demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams;
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration, to the extent such provisions would vary from the state's current program features and the requirements of the Social Security Act;
- A list of the waivers and expenditure authorities that the state believes to be necessary to authorize the demonstration;
- An estimate of annual aggregate expenditures by population group impacted by the demonstration, including development of baseline cost data for these populations.
- Specifically, CMS requests that states' fiscal analysis demonstrate how the proposed changes will be budget neutral, i.e., will not increase federal Medicaid spending. CMS will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary;

- Enrollment data including historical mental health care coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration;
- Written documentation of the state's compliance with the public notice requirements at 42 CFR 431.408, with a report of the issues raised by the public during the comment period and how the State considered those comments when developing the final demonstration application submitted to CMS;
- The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, and a general plan for testing the hypotheses including, if feasible, the identification of appropriate evaluation indicators; and
- An implementation plan describing the timelines and activities necessary to achieve the demonstration milestones including a financing plan. The implementation plan can be submitted with the application, or within 90 days of application approval from CMS.

Other Demonstration Requirements

In addition to the required application elements above, states must also develop the following:

- Demonstration monitoring reports including information detailing the state's progress toward meeting the milestones and timeframes outlined in the implementation plan, as well as information and data so that CMS can monitor budget neutrality.
- A Health IT plan (health information technology plan) that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals.
- Monitoring protocols that identify expectations for quarterly and annual monitoring reports including agreed upon performance measures (see SMD #18-011 for a list of potential measures), measure concepts, and qualitative narrative summaries. The monitoring protocol will be developed and finalized after CMS approval.
- Interim and final evaluations that will draw on the data collected for the milestones and performance measures, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes and a cost analysis. An evaluation design will be developed by the state, with technical assistance from CMS, to be finalized within 180 days of the demonstration approval.

States that fail to submit an acceptable and timely evaluation design as well as any monitoring, expenditure, or other evaluation reporting are subject to a $5 million deferral per deliverable.

Key Resources

- State Medicaid Director Letter #18-011: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf
- Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity Technical Assistance Questions & Answers: https://www.medicaid.gov/federal-policy-guidance/downloads/faq051719.pdf

Appendix E: CalAIM Benefit Changes Chart

Benefit Changes Effective April 1, 2021	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Pharmacy	All pharmacy benefits or services billed by a pharmacy on a pharmacy claim, which includes covered outpatient drugs (including Physician Administered Drugs), medical supplies, and enteral nutrition products. This also includes drugs currently "carved-out" of the managed care delivery system, (e.g., blood factor, HIV/AIDS, antipsychotics, and drugs used to treat substance use disorder), which are currently carved-in to some county operated health systems and AIDS Healthcare Foundation. This does not include any pharmacy benefits or services billed on medical and/or institutional claims.
Benefit Changes Effective January 1, 2022	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Specialty Mental Health Services	Currently full benefit in Partnership Solano (Kaiser members only) and Kaiser Sacramento
Multipurpose Senior Services Program	Currently full benefit in CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside)
Benefits to be Carved-In to Managed Care Statewide	
Major Organ Transplant	Currently full benefit in county operated health systems counties; non-county operated health systems counties currently only cover kidney transplants
Benefit Changes Effective January 1, 2023	
Benefits to be Carved-In to Managed Care Statewide	
Long Term Care	Long Term Care Umbrella • ICF-DD Disabled (excluding beneficiaries in an ICF-DD Waiver center), Disabled Habilitative, and Disabled Nursing • Pediatric Subacute Care Services • Skilled nursing facility • Specialized Rehabilitative Services in skilled nursing facility and ICF • Subacute Care Services Currently full benefit in county operated health systems and CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside); in non-county operated health systems/non-CCI counties, Medi-Cal managed care plans are responsible for the month of admission and the month following

Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage

Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Adult Expansion	7U, L1, M1	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Non-Disabled Adults (19 & Over)	01, 02[8], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[8], 82, 83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A

[6] Members residing in a LTC facility in a non-LTC aid code subject to the LTC benefit carve-in will be transitioned into managed care based on the Non-Dual/Dual Mandatory and Voluntary timeline.
[7] Non-Dual/Dual Definitions: (1) Non-Dual – A Medi-Cal only beneficiary or a Medi-Cal only beneficiary with Medicare Part A **or** Part B only; (2) Dual – Medi-Cal only beneficiary with Medicare Part A **and** Part B or Medicare Part A, B, and D.
[8] Aid code can have a SOC or no SOC

Back to Agenda
Back To Item
Back to Item

Managed Care Enrollment

Aid Code Group Coverage

			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Aged	10[9], 14, 16, 1E, 1H, 1X, 1Y	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, K4, K8, L6	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Non-Dual	COHS, CCI	N/A	All Other Models	COHS, CCI	N/A	All Other Models	All Models	N/A	N/A
Foster Children	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 2P, 2R, 2S, 2T, 2U,	Non-Dual	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A

[9] Aid codes 10, 20, 60 are Supplemental Security Income (SSI)/State Supplemental Payment (SSP). Medi-Cal beneficiaries in these three aid codes have mandatory and voluntary enrollments based on different managed care models. These beneficiaries are mandatory in COHS, voluntary in San Benito, voluntary in GMC/Regional/Two-Plan for duals, and mandatory in GMC/Regional/Two-Plan for non-duals.

Back to Agenda

Back To Item

Back to Item

Managed Care Enrollment Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
	4A, 4C, 4F, 4G, 4H, 4K, 4L, 4M, 4S, 4T, 4W, 5K, 5L										
Omnibus Budget Reconciliation Act (OBRA) Restricted Scope Only	58	Non-Dual	Napa, Solano, and Yolo counties	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[8], 83, 85, 87, 89, 02[8], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Non-Dual	COHS & CCI	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Non-Disabled Adults (19 & Over)	01, 02[8], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[8], 82 ,83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Non-Disabled Children (Under 19)	30, 32, 33, 34, 35, 37, 38, 39, 47, 54, 59, 72, 82, 83, 2C, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4N, 4U, 5C, 5D, 5E, 6P,	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A

Managed Care Enrollment

Aid Code Group Coverage

			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
	7A, 7J, 7T, 7W, 7X, 8P, 8R, 9H, E6, E7, H1, H2, H3, H4, H5, M5, P5, P7, P9, T1, T2, T3, T4, T5										
Aged	10[2], 14, 16, 1E, 1H, 1X, 1Y	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, L6, K4, K8	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[8], 83, 85, 87, 89, 02[8], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Dual	COHS, CCI	N/A	Non-COHS & Non-CCI	N/A	N/A	All Models	N/A	N/A	All Models

Back to Agenda

Back To Item

Back to Item

Managed Care Enrollment

Aid Code Group Coverage

			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Presumptive Eligibility (Hospital and CHDP PE)	2A, 4E, 8L, 8W, 8X, H0, H6, H7, H8, H9, P1, P2, P3	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Trafficking and Crime Victims Assistance Program (TCVAP)	2V, 4V, 5V, 7V, R1	Both	N/A	N/A	All Models	All Models	N/A	TCVAP SOC	All Models	N/A	TCVAP SOC
Accelerated Enrollment (AE)	8E	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
Child Health and Disability Prevention (CHDP) Infant Deeming	8U, 8V	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
State Medical Parole/County Compassionate Release/Incarcerated Individuals	F1, F2, F3, F4, G0, G1, G2, G3, G4, G5, G6, G7, G8, G9, J1, J2, J3, J4, J5, J6, J7, J8, K2, K3,K4, K5, K6, K7, K8, K9, N0, N5, N6, N7, N8, N9	N/A	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Limited/Restricted Scope Eligible	48, 50, 53, 55, 58, 69, 71, 73, 74, 76, 77, 80, 0L, 0R, 0T, 0U, 0V, 0X, 0Y, 1U, 3T, 3V, 5J, 5R, 5T, 5W, 6U, 7C, 7F, 7G,	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models

Back to Agenda

Back To Item

Back to Item

Managed Care Enrollment											
Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	Aid Codes[6]	Non-Dual/ Dual[7]	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
	7H, 7K, 7M, 7N, 7P, 7R, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1, L7, M0, M2, M4, M6, M8, P0, P4, P6, P8, T0, T6, T7, T8, T9, F1, F2, F3, F4, G1, G2, G3, G4, G5, G6, G7, G8, G9, J3, J4, J6, J8, K3, K5, K7, K9, N0, N5, N6, N7, N8, N9										

Pregnancy Related Aid Codes							
	Citizen/Lawfully Present				**Non-Citizen**		
	Aid Codes	**Current**	**Proposed (2021)**		**Aid Codes**	**Current**	**Proposed (2021)**
Title XXI (SCHIP) 213-322%	86, 87, 0E	Full Scope/MC	Full Scope/MC	Title XXI (SCHIP) 213-322%	0E	Full Scope/MC	Full Scope/MC
Title XIX (PRS/ES) 138-213%	44, M9	Limited Scope/FFS	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 138-213%	48, M0	Limited Scope/FFS	Limited Scope/FFS
Title XIX (PRS/ES) 0-138%	M7	Full Scope/MC	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 0-138%	D8, D9, M8	Limited Scope/FFS	Limited Scope/FFS

Population Exclusions									
Populations	**Current**			**2022**			**2023**		
	Mandatory	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
American Indian[10]	COHS	Non-COHS	N/A	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries with Other Healthcare Coverage (OHC)	COHS	N/A	Non-COHS	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries in Rural Zip Codes[12]	COHS	Non-COHS	Non-COHS	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries in Home and Community Based Services Waivers	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	All Models[11]	N/A	N/A

[10] American Indian Beneficiaries will be enrolled into a managed care plan, but they will have the option to opt out of enrollment if they choose to remain in FFS
[11] Would align with Mandatory/Voluntary/Excluded MC Enrollment by aid code, no special exclusions from enrollment solely based on zip code, OHC, American Indian or 1915c Waiver Enrollment
[12] The following zip codes are currently excluded from enrollment or are voluntary for enrollment: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 9359293555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304,92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398

Back to Agenda
Back To Item
Back to Item

Appendix G: Global Payment Program Extension Timeline

Program Year	Calendar Year	Federal Fiscal Year	Service Period Dates
6[13]	2021	2021	January 1, 2021-December 31, 2021
7	2022	2022	January 1, 2022 – December 31, 2022
8	2023	2023	January 1, 2023 – December 31, 2023
9	2024	2024	January 1, 2024 – December 31, 2024
10	2025	2025	January 1, 2025 – December 31, 2025
11	2026	2026	January 1, 2026 – December 31, 2026

[13] *PY 6 is part of Medi-Cal 2020 demonstration extension through 12/31/21*

Appendix H: Dental in Proposition 56 vs. CalAIM

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D0120	Periodic oral evaluation – established patient	No	Yes
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No	Yes
D0150	Comprehensive oral evaluation – new or established patient	No	Yes
D0601	Caries risk assessment and documentation, with a finding of low risk (children ages 0-6)	No	Yes
D0602	Caries risk assessment and documentation, with a finding of moderate risk (children ages 0-6)	No	Yes
D0603	Caries risk assessment and documentation, with a finding of high-risk (children ages 0-6)	No	Yes
D1110	Prophylaxis – adult	Yes	No
D1120	Prophylaxis - child	No	Yes
D1206	Topical application of fluoride varnish (child)	No	Yes
	Topical application of fluoride varnish (adult)	Yes	No
D1208	Topical application of fluoride – excluding varnish (child)	No	Yes
	Topical application of fluoride – excluding varnish (adult)	Yes	No
D1310	Nutritional counseling for the control of dental disease (child)	No	Yes

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D1320	Tobacco counseling for the control and prevention of oral disease (adult)	No	Yes
D1351	Sealant – per tooth (child)	No	Yes
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (child)	No	Yes
D1354	Interim caries arresting medicament application – per tooth (children ages 0-6 and restricted adult populations)	No	Yes
D1510	Space maintainer – fixed, unilateral – per quadrant (child)	No	Yes
D1516	Space maintainer – fixed, bilateral, maxillary (child)	No	Yes
D1517	Space maintainer – fixed, bilateral, mandibular (child)	No	Yes
D1526	Space maintainer – removable, bilateral, maxillary (child)	No	Yes
D1527	Space maintainer – removable, bilateral, mandibular (child)	No	Yes
D1551	Re-cement or re-bond space maintainer – bilateral space maintainer, maxillary (child)	No	Yes
D1552	Re-cement or re-bond space maintainer – bilateral space maintainer, mandibular (child)	No	Yes
D1553	Re-cement or re-bond space maintainer – unilateral space maintainer – per quadrant (child)	No	Yes
D1556	Removal of fixed unilateral space maintainer – per quadrant (child)	No	Yes
D1557	Removal of fixed bilateral space maintainer – maxillary (child)	No	Yes
D1558	Removal of fixed bilateral space maintainer – mandibular (child)	No	Yes
D1575	Distal shoe space maintainer – fixed unilateral – per quadrant (child)	No	Yes
D1999	Unspecified preventive procedure, by report (adult)	No	Yes

Appendix I: Enhanced Care Management Target Population Descriptions

Enhanced care management is designed for populations who have the highest levels of complex health care needs as well as social factors influencing their health. To be eligible for enhanced care management, members must meet criteria below in addition to any criteria specific to the respective enhanced care management population:

1. Have complex physical or behavioral health condition with inability to successfully self-manage AND
2. Limited activity or participation in social functioning as defined by at least one of the following:
    a. Establishing and managing relationships;
    b. Major life areas, including education, employment, finances, engaging in the community

Candidates for enhanced care management have an opportunity for improved health outcomes if they receive high-touch, in-person care management and are connected to a multidisciplinary team that manages physical health, behavioral health (substance use and/or mental health), oral health, developmental disabilities, and health-related non-clinical needs as well as any needed long-term services and supports.

Enhanced care management will be implemented in phases:

- January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.
- July 1, 2022:
    - Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
    - All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.
- January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Characteristics of ECM target populations are set forth below and detailed further in this document. Risk stratification is the responsibility of the Medi-Cal managed care plans,

which will determine member needs and apply criteria to determine eligibility and facilitate ECM services. Medi-Cal managed care plans may propose additional populations to receive ECM or propose expansions of criteria within populations. ECM target populations are subject to further refinement by DHCS.

Medi-Cal managed care plans may propose additional populations to receive enhanced care management, for example to allow the transition for members receiving services under a Whole Person Care pilot. At a minimum, Medi-Cal managed care plans must provide enhanced care management to the below list of mandatory target populations:[14]

- Children and youth with complex physical, behavioral, and/or developmental health needs (i.e. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization, eligible for long-term care.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children and youth with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD).
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

These target population descriptions are intended as guidance for Medi-Cal managed care plans. Managed care plans will determine criteria for population identification and stratification in accordance with this guidance.

Settings

For all populations, the role of enhanced care management is to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the

[14] Individuals transitioning from incarceration must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

Back to Agenda

Back To Item Back to Item

member, including participating in the care planning process, regardless of setting. This benefit is intended to provide primarily face-to-face services whenever possible.

Services should be offered where the members live, seek care or prefer to access services, essentially meeting the member (and, for children and youth, their family, caretaker or circle of support) where they are within the community. This may include different settings based on the target population. For example, for individuals experiencing homelessness, enhanced care management care managers may conduct street outreach or coordinate with shelters, hotels or motels including those participating in Project Homekey, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals in these settings. For individuals with SMI and/or SUDs, initial contact may be in settings such as psychiatric inpatient units, Institutions for Mental Disease (IMDs) or residential settings. Children and youth may receive services in a variety of community settings, including homes and schools, where appropriate. These are examples of how enhanced care management settings will reflect individualized needs of the target populations.

Risk Stratification

Enhanced care management is the highest tier of case management and is intended for members at the highest risk level who need long-term coordination for multiple chronic conditions, social determinants of health issues, and utilization of multiple service types and delivery systems. As part of their plan submitted to DHCS, Medi-Cal managed care plans will detail the algorithms, processes, and partnerships they will use to identify those individuals who have the highest levels of complex health care needs and social factors influencing their health, and who present the best opportunity for improved health outcomes through enhanced care management services.

Algorithms and data sources may vary by population. For example, some individuals may be identified using claims data and/or other health assessment information to identify multiple complex conditions or a history of utilization of high-cost services.

However, for a variety of reasons, claims data may be insufficient to identify other good candidates for enhanced care management. For some members, access to care issues and multiple social factors may limit the utility of claims data in identifying health risks. Therefore, managed care plans must also use data sources that capture social determinants of health as well as referrals. For individuals experiencing homelessness, data systems such as the Homeless Management Information System (HMIS) may be used. For individuals transitioning from incarceration, data sharing agreements with city and county jail systems to identify those at highest risk may be considered

For many populations, referrals and partnerships will be a critical method to identify enhanced care management candidates. Entities such as health care providers, community-based organizations, social services agencies, tribal partners, and local governments are important partners in identifying individuals who are at high risk of significant health care utilization and who would benefit from enhanced care management. Medi-Cal managed care plans are encouraged to partner with these entities to ensure enhanced care management benefits are highly coordinated with other service types. Medi-Cal managed care plans should also plan to establish clear protocols to receive and consider enhanced care management referrals from external entities.

Core Components of Enhanced Care Management Services

The types of supports and services provided through enhanced care management may vary based on the needs of the target populations. In the individual target population descriptions, this document describes examples of interventions that enhanced care management may support for each unique target population. However, core components of enhanced care management that are universal for all target populations include:

- Comprehensive Assessment and Care Management Plan:
    - Engage with Members authorized to receive the enhanced care management Benefit primarily through in person contact;
        - *When in-person communication is unavailable or does not meet the needs of the Member, use alternative methods to provide culturally appropriate and accessible communication.*
    - Develop a comprehensive, individualized, person-centered care plan by working with the Member, and as appropriate their chosen family/support persons, to assess strengths, risks, needs, goals, and preferences
    - Incorporate into the Member's care plan needs in the areas including, but not limited to physical and developmental health, mental health, SUD, community-based Long-Term Services and Supports (LTSS), oral health, palliative care, trauma-informed care, necessary community-based and social services, and housing;
    - Ensure the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in need.
- Enhanced Coordination of Care:
    - Organize patient care activities as laid out in the care plan, share information with the Member's key care team, and implement the Member's care plan;

- Be continuous and integrated among all service providers and refer to primary care/physical and developmental health, mental health, SUD treatment, community-based LTSS, oral health, palliative care, trauma-informed care, necessary community-based and social services, and, housing, as needed;
- Provide support for Member treatment adherence including coordination for medication review/reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, identifying barriers to adherence, ensuring continuous enrollment in Medi-Cal, and maintaining social services benefits, and accompaniment to key appointments;
- Communicate Members' needs and preferences timely to all members of the Members' care team in a manner that ensures safe, appropriate, and effective person-centered care;
- Be in regular contact with the Member, consistent with the care plan;

- Health Promotion:
  - Work with Members to identify and build on resiliencies and potential family or community supports;
  - Provide services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health;
  - Support the Member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.
- Comprehensive Transitional Care
  - Perform engagement activities that seek to reduce avoidable Member admissions and readmissions;
  - For Members that are experiencing or are likely to experience a care transition:
    - Develop and regularly update a transition plan for the Member, and incorporate it into the Member's care plan;
    - Evaluate a Member's medical care needs and coordination of any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;

- Track each Member's admission or discharge to/from an emergency department, hospital inpatient facility, skilled nursing facility, residential/treatment facility, incarceration facility, or other treatment center and communicate with the appropriate care team members;
- Coordinate medication review/reconciliation; and
- Provide adherence support and referral to appropriate services.

- Member and Family Supports:
  - Document a Member's chosen caregiver or family/support person;
  - Include activities that ensure that the Member and chosen family/support persons, including as guardians and caregivers, are knowledgeable about the Member's condition(s) and care plan with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management;
  - Serve as the primary point of contact for the Member and their chosen family/support persons;
  - Identify supports needed for the Member and chosen family/support persons to manage the Member's condition and direct them to access needed support services, including peer supports when applicable and available; and,
  - Provide for appropriate education of the Member, family members, guardians, and caregivers on care instructions for the Member.
- Coordination of and Referral to Community and Social Support Services:
  - Determine appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services that are offered by managed care plan as an ILOS;
  - Coordinate and referring Members to available community resources and following up with Members to ensure services were rendered (i.e. "Closed loop referrals").

Target Populations

A description of each population is outlined below. Beneficiaries must be enrolled in Medi-Cal managed care to receive enhanced care management. In general, for all target populations, individuals who, after multiple outreach attempts, using different modalities, opt not to participate in enhanced care management services or whose assessment

(completed or confirmed by the managed care plan) indicates they would not benefit from the services, would not be good candidates for enhanced care management. The number of outreach attempts and approaches will vary based on the populations and individualized needs.

Enhanced care management is designed to provide support to individuals who require high levels of intensive interventions. Individuals who are receiving or who would benefit from other existing types of interventions (e.g., end of life care, standard case management, disease management or other care coordination efforts) would not be appropriate candidates for enhanced care management unless those interventions are not successful. Medi-Cal managed care plans and/or their subcontractors or contracted providers will evaluate individuals for enhanced care management and not all individuals will be good candidates. For example, individuals with the following circumstances may not be good candidates for enhanced care management:

- Individuals who have a well-treated chronic disease and are compliant with their care plan and have unavoidable or expected admissions due to the condition.
- Individuals who refuse to engage in any telephonic or face to face case management after multiple outreach attempts using different modalities.
- Individuals receiving services that the managed care plan determines to be duplicative of enhanced care management, such as 1915(c) Home and Community Based Services (HCBS) Waiver programs.

All Medi-Cal beneficiaries currently receiving care management through the Health Homes Program and Whole Person Care shall be transitioned to enhanced care management through one of the target populations listed and will be reassessed.

The populations eligible for enhanced care management are those with the highest needs who use multiple delivery systems and services, who need ongoing coordination across medical, behavioral and social needs, and who are part of the mandatory target populations described below. Note that some enhanced care management candidates will meet criteria for multiple target populations. Medi-Cal managed care plans will assign these individuals authorized to receive enhanced care management services to an enhanced care management provider that has appropriate competencies and experience for the needs of the beneficiary. For example, individuals with SMI or SUDs may also be homeless or high utilizers. These members may be assigned to an enhanced care management provider that has the necessary skills and experience to work with individuals with SMI and SUDs.

Children and Youth

Target Population:

Children and youth (up to age 21, or foster youth to age 26) with complex physical, behavioral, and/or developmental health needs, with significant functional limitations and social factors influencing their health outcomes (e.g., California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).

For example:

- Children/Youth with complex health needs who are medically fragile or have multiple chronic conditions. This may include children with a history of trauma and children who are engaged or have history with the child welfare system. These children often access care across multiple service delivery systems and require significant coordination to ensure their needs are being met.

- Children/Youth with significant functional limitations and multiple social factors influencing their health outcomes.

Enhanced Care Management Services:

Enhanced care management can be used to assess gaps in both health care and social support needs and develop a care plan that addresses the whole health needs of the child. While Medi-Cal managed care plans may use claims data to identify good candidates, referrals will be an important mechanism to identify children and youth who would benefit from enhanced care management. Health care providers, the child welfare system, schools, community-based organizations, California Children's Services (CCS), county behavioral health, and social services agencies are examples of other important potential referral partners for children/youth. Medi-Cal managed care plans should establish a process for providers to refer for enhanced care management based on a needs assessment, behavioral health screens, other EPSDT screening, and/or ACE score which includes consideration of the community supports available for the children and their families and caretakers, as well as social factors impacting their health.

Services should be offered where the members live, seek care or where the family, caretaker, or circle of support prefers to access services, essentially meeting the member and family/caretaker/support where they are within the community. Activities may include coordination in school-based settings if permitted by the schools. Services should be offered by culturally and linguistically aligned trauma-informed providers.

For this population, enhanced care management services include (but are not limited to):

- Helping families, caretakers, and circles of support access resources such as information, coordination, and education about the child's conditions.
- Identifying coordinating, and providing (when appropriate) services that will help families, caretakers, and circles of support with the health needs of their children, which may include referrals for services those individuals need to enable them to support their children's health (e.g., referral to behavioral health, including SUD services, for a parent, or housing-related services for households experiencing homelessness, either of which could be critical to ensure the parent can support the health needs of the child).
- Referral to housing related services for youth experiencing homelessness.
- Coordination of services across various health, behavioral health, developmental disability, housing and social services providers, including facilitating cross-provider data- and information-sharing and member advocacy to ensure the child's whole person needs are met and needed services are accessible.
- Assistance with accessing respite care as needed.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health.
- Coordination of other services as required by EPSDT.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health

Homeless

Target Population:

Individuals experiencing homelessness or chronic homelessness, or who are at risk of experiencing homelessness (as defined below), with complex health and/or behavioral health needs, for whom coordination of services would likely result in improved health outcomes and decreased utilization of high-cost services.

For example:

- Individuals with complex health care needs as a result of medical, psychiatric or SUD-related conditions, who may also experience access to care issues (resulting in unmet needs or barriers to care) and multiple social factors influencing their health outcomes.
- Individuals with repeated incidents of avoidable justice involvement, emergency department use, psychiatric emergency services or hospitalizations.

Homeless: Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution). For the purpose of enhanced care management, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

A. In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

B. By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

1. A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

    i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

    ii. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

2. An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

(1) An individual or family who:

(i) Has an annual income below 30 percent of median family income for the area, as determined by HUD;

(ii) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

(iii) Meets one of the following conditions:

(A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(B) Is living in the home of another because of economic hardship;

(C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

(D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

(E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

(F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

(G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

(2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

(3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who meet the State’s No Place Like Home definition for a person with SMI and/or SED “at risk of chronic homelessness,” which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with

significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Enhanced Care Management Services:

Individuals experiencing or at risk of homelessness are among the highest-need individuals in Medi-Cal. They often lack access to necessities such as food and shelter that are critical to attaining health. Individuals often have high medical needs that are difficult to manage due to the social factors that influence the individual's health. This often results in high utilization of costly services such as emergency departments and inpatient settings.

Engagement for this population may include street outreach or coordinating with shelters, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals.[15] As individuals are connected to resources, the enhanced care management care coordinator will meet the member in the community or at provider locations.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. This includes (but is not limited to):

- Utilizing housing-related in-lieu-of services (ILOS) to identify housing and prepare individuals to for securing and/or maintaining stable housing.
- Coordinating short-term post-hospitalization housing and recuperative care services as appropriate.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to ensure progress towards regaining health and function continues.
- Coordinating and collaborating with various health and social services providers, including Regional Centers, including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to

[15] These same entities will be important referral partners to identify potential enhanced care management candidates

Back to Agenda

Back To Item

Back to Item

public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.

- Addressing barriers to housing stability by connecting member to housing, health, and social support resources.
- Utilize best practices for Member who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care

Back to Agenda

Back To Item

Back to Item

High Utilizers

Target Population:

High utilizers are Members with multiple hospital admissions, OR multiple short-term skilled nursing facility stays, OR multiple emergency room visits that could be avoided with appropriate outpatient care or improved treatment adherence.

For example:

- Individuals that have impactable conditions or opportunities for interventions that have the potential to decrease inappropriate utilization or can be performed at an alternative location.
- Individuals with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement. Individuals with multiple chronic or poorly managed conditions requiring intensive coordination, beyond telephonic intervention.
- Significant functional limitations and/or adverse social determinant of health that impede the ability of the individual to navigate their healthcare and other services.

Enhanced Care Management Services:

Enhanced care management will provide multiple opportunities to engage individuals by stratifying risk and need and developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Medi-Cal managed care plans will identify the algorithms they will use to identify individuals who are high utilizers of medical services. DHCS expects Medi-Cal managed care plans will rely on available healthcare research related to appropriate identification of high utilizers and will leverage the managed care plan utilization data to identify members that meet the respective criteria established by the managed care plans.

For this population enhanced care management may include, but is not limited to:

- Frequent follow up visits, culturally and linguistically appropriate education and care coordination activities to ensure the member's needs are being met where they are.
- Connection to culturally and linguistically appropriate community-based organizations, programs and resources that will meet the member's needs.
- Improving member engagement to improve adherence to the member's treatment plan, including through more culturally and linguistically aligned approaches toward member and provider education and tools on how to increase adherence.

- Medication review, reconciliation, assistance obtaining medications, and culturally and linguistically appropriate reinforcement with medication adherence.

Back to Agenda

Back To Item

Back to Item

Risk for Institutionalization – Long Term Care

Target Population:

Individuals at risk for institutionalization, eligible for long-term care services. Medi-Cal beneficiaries who, in the absence of services and supports would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF) would qualify.

Individuals must meet NF level of care criteria AND be able continue to live safely in the community with wrap around supports. \

Examples include, but are not limited to:

- Seniors and persons with disabilities who reside in the community but are at risk of being institutionalized.
- Individuals in need of increasing assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
- Possibly, individuals with changes to family or caregiver status.
- Possibly, individuals with medical or surgical setbacks resulting in a decrease in functional, cognitive, or psychological status.
- Possibly, individuals showing early signs of dementia with few or no natural supports.
- Possibly, individuals who are noncompliant with their prescribed medical regime.
- Possibly, individuals who are not appropriately engaged to take advantage of necessary health care services.
- Possibly, individuals who lack a family or community support system to assist in appropriate follow-up care at home.

Would not include:

- Individuals with complex needs but who are not at risk of institutionalization.

Enhanced Care Management Services:

Services include preventing skilled nursing admissions for individuals with an imminent need for nursing facility placement. For this population enhanced care management may include, but is not limited to:

- Assessment to determine natural supports available, risk factors, social determinants of health, and other factors to determine safety and feasibility of continued stay in the community. Assessments should be conducted face-to-face whenever possible.
- Connection to needed supportive services, including ILOS such as meals, environmental accessibility adaptations (home modifications), and personal care.
- Frequent follow up visits (including regular home visits), culturally and linguistically appropriate education and care coordination activities to ensure the member and family/caregiver needs are being met where they are.
- Connection to appropriate culturally and linguistically aligned community-based organizations, programs and resources that will meet the member's needs.
- Placement of wrap-around services to maintain the member in their current, community setting.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, ensuring connection to public benefits, coordinating transportation, identifying barriers to adherence, and accompanying members to appointments as needed.

Nursing Facility Transition to Community

Target Population:

Individuals who are currently residing in a Nursing Facility (NF) but desire to return to living in the community. Transition from the NF to community is strictly voluntary. Individuals have the option to transition to the community when that can be done in a cost-effective manner. Individuals must be able to transition safely to the community.

Individuals must have an identified support network system and housing available to them. The support network system may consist of care providers, community-based organizations, family members, primary care physicians, home health agencies, members of the individual's medical team, licensed foster parent, or any other individual who is part of

the individual's circle of support. The individual's circle of support may consist of family members, legal representative/legally responsible adult, and any other person named by the individual.

Would not include:

- Individuals not interested in moving out of the institution.
- Individuals who are not medically appropriate to live in the community (high acuity).
- Individuals whose total projected costs outside the institution are greater than the cost of institutionalization.
- Individuals who do not have the supports to reside safely in the community.
- Individuals who would be at a high risk of re-institutionalization or experiencing homelessness.

Enhanced Care Management Services:

The care team will help individuals move safely between different care settings, such as entering or leaving a hospital or nursing facility and returning to their own home.

Services include facilitating nursing facility transition back into a homelike and community setting with the necessary wrap-around services, community supports, and natural supports when available.

Enhanced Care Manager care manager visits will occur face to face at the facility throughout the transition process. An in-person home visit will occur prior to the

individual's move to ensure the health and safety of the new residence. Post-transition individuals will then be visited in person at a determined schedule at their home or community placement.

Back to Agenda

Back To Item

Back to Item

SMI, SED and SUD Individuals at Risk for Institutionalization

Target Population:

Individuals who are at risk for institutionalization who have co-occurring chronic health conditions and:

- Serious Mental Illness (SMI, adults);
- Serious Emotional Disturbance (SED, children, and youth); or
- Substance Use Disorder (SUD).

Potential candidates include:

- Individuals who have the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions with co-occurring chronic health conditions, who may also experience access to care issues and have multiple social factors influencing their health outcomes and as a result of these factors are at risk for institutionalization.
- Individuals with repeated incidents of emergency department use, psychiatric emergency services, psychiatric inpatient hospitalizations, including stays at psychiatric health facilities, or short-term skilled nursing facility stays who could be served in community-based settings with supports.

Enhanced Care Manager Services:

For individuals with SMI or SUD, or children and youth with SED, enhanced care management will coordinate across the delivery systems through which members access care. For these individuals, Medi-Cal managed care plans may pursue contracts with county behavioral health systems to perform enhanced care management activities, but this must include coordination of all available services including medical care, behavioral health and long-term services and supports. When managed care plans do not contract with county behavioral health, enhanced care management service providers for this population should have experience and competency in working with individuals with SMI and SUDs as well as a plan to adequately coordinate enhanced care management and behavioral health services and supports across the managed care plan and county behavioral health. Initial engagement may be in treatment settings such as psychiatric inpatient units, IMDs or residential settings.

For children and youth with SED, activities may include coordination in school-based settings if permitted by the schools.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. Medi-Cal managed care plans should closely coordinate these

enhanced care management services and supports with county behavioral health to avoid duplication and ensure adequate communication and care coordination. This includes (but is not limited to):

- Provide post-hospitalization or post-residential medical treatment care planning to connect individuals with the supports they need to avoid rehospitalization including identifying appropriate culturally and linguistically appropriate community placements. These services should be provided in close coordination with county behavioral health plans when the hospitalization or residential treatment occurs due to mental illness or substance use disorder.

- Regular culturally and linguistically appropriate contact with members to ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain in the community placement.

- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual's health outcomes.

- Supporting the members' behavioral health recovery goals with related improvements in physical and oral health and long-term services and supports.

- Connecting families, caretakers, and circles of support to resources regarding the member's conditions to assist them with providing support for the member's health/behavioral health.

- Coordinating and collaborating with various health, behavioral health, developmental disability, and social services providers including sharing data (as appropriate).

- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed

Individuals Transitioning from Incarceration[16]

Target Population:

Individuals transitioning from incarceration, including justice-involved juveniles who have significant complex physical or behavioral health needs requiring immediate transition of services to the community. A Medi-Cal managed care plan may stratify eligibility based on populations that have multiple incarcerations, other institutionalizations and/or high utilization. Individuals must have been released from incarceration with the last 12 months.

In addition, this population includes individuals who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and therefore are at risk for incarceration and who could, through care coordination and service placement, have a treatment plan designed to avoid incarceration through the use of community-based care and services.

Enhanced Care Management Services:

Some individuals transitioning from incarceration have significant health and behavioral health care needs that require ongoing treatment in the community post-release. Individuals often also experience significant social factors that impact their ability to successfully manage their health/behavioral health conditions, such as lack of safe and stable housing and unemployment. Upon transition back to the community, individuals are required to coordinate a significant number of basic life needs and as a result often experience care disruptions, which result in deterioration of their conditions and increased use of emergency departments and inpatient settings. For some individuals, unmet health care needs can increase their likelihood of returning to incarceration; diversion programs are designed to address these needs and avoid incarceration.

For this target population, enhanced care management requires coordination with the state prison system and local corrections departments, including probation, courts and the local county jail system to both to identify/refer members and also to ensure connections to care once individuals are released from incarceration. Upon release, all individuals receiving ongoing behavioral health treatment (including treatment for SUD) should be referred to county behavioral health programs and managed care plans on an as needed basis. Medi-Cal managed care plans and county behavioral health programs should coordinate closely to better serve clients that receive services from both entities. Therefore, the enhanced care management care managers will need to coordinate and

[16] This target population must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

collaborate closely with county behavioral health departments, and potentially also with Medi-Cal managed care plans, for those individuals.

The initial enhanced care management engagement locations will depend on the collaborations that Medi-Cal managed care plans are able to build with local justice partners. At first, enhanced care management staff will begin work with individuals expected to transition from incarceration in the setting where they are incarcerated (or just outside that setting), or in criminogenic treatment programs.[17] Post-transition, enhanced care management care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based engagement such as a member's home or regular provider office, this may also include parole or probation offices if the managed care plan builds partnerships that allow for engagement in those offices.

Enhanced care management can be used to link individuals transitioning from incarceration (or in diversion programs) with a variety of services to meet their complex needs. This includes (but is not limited to):

- Coordination of an initial risk assessment to evaluate medical, psychiatric, substance use and social needs for which the individual requires assistance.
- Direct connections with community providers to ensure continuity of care for their conditions (especially for medications) and to address any health care needs not treated while they were incarcerated. This will also include peer mentorship to help provide positive social support.
- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to prevent reincarceration and ensure progress towards regaining health and function continues.
- Screening and providing referrals for various health, developmental disabilities, mental health, substance use disorder and social service needs.

[17] DHCS is looking to leverage H.R. 6 SUPPORT Act to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release. enhanced care management dollars will not be able to be used to provide services directly to justice involved members prior to release

- Coordinating and collaborating with various health, behavioral health, and social services providers as well as parole/probation including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.
- Helping members set and monitor health goals to maintain or improve their health.
- Providing culturally and linguistically appropriate education to families, caretakers, and circles of support regarding the member's health care needs and available supports.
- Navigating members to other reentry support providers to address unmet needs.
- Facilitating benefits reinstatement.[18]

[18] To complement these efforts, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023 The enhanced care management care manager would also help facilitate accessing other benefits as needed by the member.

Back to Agenda

Back To Item

Back to Item

Enhanced Care Management Implementation Dates by County

Counties with Whole Person Care and/or Health Homes[19] (Begin implementation on 1/1/22)		Counties without Whole Person Care or Health Homes (Begin implementation on 7/1/22*)
Alameda	HHP, WPC	Alpine
Contra Costa	WPC	Amador
Imperial	HHP	Butte
Kern	HHP, WPC	Calaveras
Kings	WPC	Colusa
Los Angeles	HHP, WPC	Del Norte
Marin	WPC	El Dorado
Mendocino	WPC	Fresno
Monterey	WPC	Glenn
Napa	WPC	Humboldt
Orange	HHP, WPC	Inyo
Placer	WPC	Lake
Riverside	HHP, WPC	Lassen
Sacramento	HHP, WPC	Madera
San Bernardino	HHP, WPC	Mariposa
San Diego	HHP, WPC	Merced
San Francisco	HHP, WPC	Modoc
San Joaquin	WPC	Mono
San Mateo	WPC	Nevada
Santa Clara	HHP, WPC	Plumas
Santa Cruz	WPC	San Luis Obispo
Shasta	WPC	Santa Barbara
Sonoma	WPC	Sierra
Tulare	HHP	Siskiyou
Ventura	WPC	Solano
		Stanislaus
		Sutter
		Tehama
		Trinity
		Tuolumne
		Yolo
		Yuba

[19] List is subject to changed based on WPC pilots decisions to continue operating through 2021.

Back to Agenda

Back To Item

Back to Item

Appendix J: In Lieu of Services Options

Following is the proposed menu of in lieu of services that would be covered under the CalAIM initiative. ILOS are optional for both the plan to offer and the beneficiary to accept. Individuals do not have to be enrolled in Enhanced Care Management to be eligible for in lieu of services. ECM target populations/ILOS Service definitions are subject to further refinement by DHCS.

Each set of services is described in detail below:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Housing Transition Navigation Services

Description/Overview

Housing transition services assist beneficiaries with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to members.
7. If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. [20]
8. Assisting with requests for reasonable accommodation, if necessary.
9. Landlord education and engagement
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the client with landlords.

[20] Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

12. Assisting in arranging for and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.[21]
14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
15. Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted ILOS providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

Eligibility (Population Subset)

[21] The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
            b. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months

or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be

terminated within 21 days after the date of application for assistance;
- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

  - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
  - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
  - Have one or more serious chronic conditions;
  - Have a Serious Mental Illness;
  - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
  - Have a Serious Emotional Disturbance (children and adolescents);
  - Are receiving Enhanced Care Management; or
  - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

Back to Agenda

Back To Item Back to Item

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State Plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services are authorized and identified in the managed care plan contracts.

Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan.

Individuals may not be receiving duplicative support from other State, local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies;
- Providers of services for individuals experiencing homelessness;
- Life skills training and education providers;
- County agencies;
- Public hospital systems;
- Mental health or substance use disorder treatment providers, including county behavioral health agencies;
- Social services agencies;

- Affordable housing providers;
- Supportive housing providers; and
- Federally qualified health centers and rural health clinics.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, Medi-Cal managed care plans must credential the providers as required by DHCS.

Clients who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.[22]

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient Hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

[22] One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

Housing Deposits

Description/Overview

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access and utility arrearages.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with

disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            c. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
            d. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions

included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.

Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing and Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

The entity that is coordinating an individual's Housing Transition Navigation Services, or the Medi-Cal managed care plan case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Housing Tenancy and Sustaining Services

Description/Overview

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
2. Education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
8. Assistance with the annual housing recertification process.
9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
11. Health and safety visits, including unit habitability inspections.
12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

Services do not include the provision of room and board or payment of rental costs. Please see housing deposits ILOS.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

- In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
- By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
    - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
        e. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
        f. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or
    - An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
    - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose

composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C.

254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

- (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
  - Have one or more serious chronic conditions;
  - Have a Serious Mental Illness;
  - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
  - Have a Serious Emotional Disturbance (children and adolescents);
  - Are receiving Enhanced Care Management; or
  - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service 2) beneficiaries are not required to use the in lieu of services, and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what

conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- County agencies
- Public hospital systems
- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Supportive housing providers
- Federally qualified health centers and rural health clinics

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established

enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. Medi-Cal managed care plans should coordinate with county homelessness entities to provide these services.

Clients who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Short-term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization housing provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.[23]

This setting provides individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports such as Housing Transition Navigation.[24]

This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Beneficiaries must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.[25]

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals exiting recuperative care.
- Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder

[23] Up to 90 days of recuperative care is available under specified circumstances as a separate in-lieu service.
[24] Housing Transition/Navigation is a separate in-lieu service.
[25] The development of a housing assessment and individualized support plan are covered as a separate in-lieu service under Housing Transition/Navigation Services.

treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            g. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

            h. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as

described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

Back to Agenda

Back To Item Back to Item

        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or
- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant

barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

The service is only available if enrollee is unable to meet such an expense.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities
- Supportive Housing providers
- County agencies
- Public Hospital Systems

- Social service agencies
- Providers of services for individuals experiencing homelessness

Facilities may be unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for short-term post-hospitalization housing. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Recuperative Care (Medical Respite)

Description/Overview

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
2. Coordination of transportation to post-discharge appointments
3. Connection to any other on-going services an individual may require including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing in lieu of services. Whenever possible, other housing in lieu of services should be provided to members onsite in the recuperative care facility. When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health

conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification. [26]

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Recuperative care/medical respite is an allowable in lieu of services service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support

[26] For this population, the service could be coordinated with home modifications (which are covered as a separate in lieu service) and serve as a temporary placement until the individual can safely return home

- County directly operated or contracted recuperative care facilities

Facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plan must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, skilled nursing facility, and emergency department services.

Respite Services

Description/Overview

Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the participant's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

The Home Respite services are provided to the participant in his or her own home or another location being used as the home.

The Facility Respite services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.

Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)
  - Providers contracted by county behavioral health

Other community settings that are not a private residence, such as:

- Adult Family Home/Family Teaching Home
- Certified Family Homes for Children

- Residential Care Facility for the Elderly (RCFE)
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Respite Facility; Residential Facility: Small Family Homes (Children Only)
- Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
- Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
- Respite Facility; Residential Facility: Group Homes (Children Only)
- Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)
- Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and skilled nursing or other institutional care.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a participant's home or an out-of-home, non-facility setting. The programs are designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For individuals experiencing homelessness who are receiving enhanced care management or other in lieu of services, the day habilitation program can provide a physical location for participants to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

Day habilitation program services include, but are not limited to, training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and,
6. Community resource awareness such as police, fire, or local services to support independence in the community.

Programs may include assistance with, but not limited to:

1. Selecting and moving into a home; [27]
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords; [28]
5. Managing personal financial affairs;

[27] Refer to the Housing Transition/Navigation Services In Lieu of Services
[28] Refer to the Housing- Tenancy and Sustaining Services In Lieu of Services

6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;
9. Building and maintaining interpersonal relationships, including a circle of support;
10. Coordination with Medi-Cal managed care plan to link participant to any in lieu of services and/or enhanced care management services for which the client may be eligible;
11. Referral to non-in lieu of services housing resources if participant does not meet Housing Transition/Navigation Services in lieu of services eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if client is not receiving these services through in lieu of services or enhanced care management; and
13. Coordination with Medi-Cal managed care plan to link participant to health care, mental health services, and substance use disorder services based on the individual needs of the participant for participants who are not receiving this linkage through in lieu of services or enhanced care management.

The services provided should utilize best practices for clients who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Licensed Psychologists
- Licensed Certified Social Workers
- Registered Nurses
- Home Health Agencies
- Professional Fiduciary
- Vocational Skills Agencies

Medi-Cal managed care network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and outpatient hospital services, skilled nursing facility, emergency department services.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities

DESCRIPTION/OVERVIEW

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.

The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the participant, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF); includes non-room and board costs (medical, assistance w/ ADLs.). Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board and includes:

1. Assessing the participant's housing needs and presenting options.[29]
2. Assessing the service needs of the participant to determine if the participant needs enhanced onsite services at the RCFE/ARF so the client can be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of participants who need enhanced services to be safely and stably housed in RCFE/ARF settings have in lieu of services and/or enhanced care management services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services.

[29] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.

Eligibility (Population Subset)

A. For Nursing Facility Transition:
   1. Has resided 60+ days in a nursing facility;
   2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
   3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:
   1. Interested in remaining in the community;
   2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
   3. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive NF 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

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals are directly responsible for paying their own living expenses.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Case management agencies

- Home Health agencies
- Medi-Cal managed care plans
- ARF/RCFE Operators

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

The RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the participant's housing needs and presenting options.[30]
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with landlord, if applicable and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.[31]
7. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations. [32]

Eligibility (Population Subset)

[30] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.
[31] Refer to Home Modification In Lieu of Services for additional details.
[32] Refer to Housing Deposits In Lieu of Services for additional details.

1. Currently receiving medically necessary nursing facility LOC services and in lieu of remaining in, the nursing facility setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;
2. Has lived 60+ days in a nursing home;
3. Interested in moving back to the community; and
4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Community Transition Services are payable up to a total lifetime maximum amount of $5,000.00. The only exception to the $5,000.00 total maximum is if the participant is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the participant, and without which the participant would be unable to move to the private residence and would then require continued or re-institutionalization.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- County mental health providers
- 1915c HCBA/ALW providers
- CCT/Money Follows the Person providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Personal Care and Homemaker Services

Description/Overview

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management.

Services provided through the In-Home Support Services (In-Home Supportive Services) program include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments and protective supervision for the mentally impaired.

Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes.

In lieu of services can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
- As authorized during any In-Home Supportive Services waiting period (member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Services application date.
- For members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker in lieu of services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

Eligibility (Population Subset)

- Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- Individuals with functional deficits and no other adequate support system; or

- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker in lieu of services during this reassessment waiting period.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health agencies
- County agencies
- Personal care agencies
- AAA (Area Agency on Aging)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, skilled nursing facility.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist beneficiaries in accessing the home;
- Doorway widening for beneficiaries who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the beneficiary; and
- Installation and testing of a Personal Emergency Response System (PERS) for persons who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the individual. For a home that is not owned by the individual, the individual must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as an in lieu of service, the managed care plan must receive and document an order from the participant's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary.

For environmental accessibility adaptations, the managed care plan must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:

   A. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;

   B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant *and reduces the risk of institutionalization*. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and

   C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.

3. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

4. That a home visit has been conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- EAAs are payable up to a total lifetime maximum of $5,000. The only exceptions to the $5,000 total maximum are if the beneficiary's place of residence changes or if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the beneficiary, or are necessary to enable the beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.
- EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may manage these services directly or may coordinate with a provider to manage the service.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Area Agencies on Aging (AAA)
- Local health departments
- Community-based providers and organizations

All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to nursing facility services, inpatient and outpatient hospital services, emergency department services and emergency transport services.

Meals/Medically Tailored Meals

Description/Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased member satisfaction.

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.
2. Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.
3. Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries and healthy food vouchers.

Eligibility (Population Subset)

1. Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or
3. Individuals with extensive care coordination needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate

and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Up to three medically-tailored meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Meals are not covered to respond solely to food insecurities.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home delivered meal providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services.

Sobering Centers

Description/Overview

Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify clients with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu

of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service is covered for a duration of less than 24 hours.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Sobering Centers, or other appropriate and allowable substance use disorder facilities. Medi-Cal managed care plans should consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.
- These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transportation services.

Asthma Remediation[33]

Description/Overview

Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;
- Other interventions identified to be medically appropriate and cost effective.

The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver.

When authorizing asthma remediation as an in lieu of service, the managed care plan must receive and document:

1. The participant's current licensed health care provider's order specifying the requested remediation(s);
2. Depending on the type of remediation(s) requested, documentation from the provider describing how the remediation(s) meets the medical needs of the participant. A brief written evaluation specific to the participant describing how and why the remediation(s) meets the needs of the individual will still be necessary;
3. That a home visit has been conducted to determine the suitability of any requested remediation(s).

[33] Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided and ILOS should be complementary. See https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf; Appendix B)

Asthma remediation includes providing information to individuals about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.
2. Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.
3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

Eligibility (Population Subset)

Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.
- Asthma remediations must be conducted in accordance with applicable State and local building codes.
- Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
- Asthma remediations are payable up to a total lifetime maximum of $5,000. The only exception to the $5,000 total maximum is if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the beneficiary, or are necessary to enable the

beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.

- Asthma remediation modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

- Before commencement of a physical adaptation to the home or installation of equipment in the home, the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may: manage these services directly; coordinate with an existing Medi-Cal provider to manage the services; and/or contract with a county agency, community-based organization or other organization, as needed. The services should be provided in conjunction with culturally appropriate asthma self-management education.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- American Lung Association
- Allergy and Asthma Network
- National Environmental Education Foundation
- Local health departments
- Community-based providers and organizations

Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

- Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services and emergency department services.

Glossary

Medicaid Section 1115 Demonstration Waivers: Section 1115 wavers permit States to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative is an "experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives of the program." Section 1115 waivers are generally approved for a five-year period.

Section 1915(b) "Freedom of Choice" waivers: States generally use section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many States originally used Section 1115 waiver authority to move enrollees into managed care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) "Home and Community Based Services" waivers: States generally use 1915(c) waivers to develop programs that meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Behavioral Health: Mental health and substance use disorder services.

Behavioral Health Managed Care Plan: The county prepaid inpatient health plan (PIHP) that would provide specialty mental health services and SUD treatment services under a single contract with DHCS, after full implementation of the behavioral health integration proposal.

CalAIM: California Advancing and Innovating Medi-Cal: DHCS' multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Coordinated Care Initiative (CCI): CCI was implemented in 2014 in seven California counties with the goal of coordinating the delivery of medical, behavioral, and long-term services and supports to Medi-Cal beneficiaries also eligible for Medicare ("dual eligibles"). The CCI is composed of Cal MediConnect and Managed Medi-Cal Long-Term

Services and Supports (MLTSS). The Cal MediConnect portion of CCI is currently authorized through December 31, 2022.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure that county inmates/juveniles who are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. The proposed process would require all county jails and juvenile facilities to implement a process for facilitated referral and linkage from county jail release to specialty mental health, Drug Medi-Cal, DMC-ODS and Medi-Cal managed care providers, in cases where the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal beneficiaries in a COHS county receive their care from the COHS health plan.

Cal MediConnect: A program that coordinates medical, behavioral, and long-term services and supports (i.e. both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Dental Transformation Initiative (DTI): The DTI is a component of the Medi-Cal 2020 demonstration that aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Designated Public Hospitals: A California hospital operated by a county, a city and a county, or the University of California.

Designated State Health Programs: Designated State Health Programs (DSHPs) are existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing States that they would phase-out federal funding for DSHPs beginning in 2017, meaning that California's DSHPs will not receive federal funding past December 31, 2020 when the Medi-Cal 2020 demonstration expires.

Drug Medi-Cal: Drug Medi-Cal pays for the SUD treatment services a Medi-Cal beneficiary receives through a Drug Medi-Cal certified program.

Drug Medi-Cal Organized Delivery System (DMC-ODS): DMC-ODS is a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized in during the

2010 Bridge to Reform demonstration and was reauthorized in the current Medi-Cal 2020 demonstration.

Enhanced Care Management: A collaborative and interdisciplinary benefit to provide intensive and comprehensive ('whole-person') care management services to high-need Medi-Cal beneficiaries.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, DMC-ODS, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with managed care plans and corresponding counties who have mutually volunteered to participate.

Global Payment Program (GPP): Established a statewide pool of funding for the remaining uninsured by combining federal disproportional share hospital and uncompensated care funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventive services. GPP is currently set to expire on December 31, 2020 and with approval pending under the Medi-Cal 2020 Demonstration extension to continue for calendar year 2021.

Health Homes Program: Enables participating health plans to provide a range of supports to Med-Cal beneficiaries with complex medical needs and chronic conditions. The HHP includes coordination of the full range of physical health, behavioral health, and community-based long-term services and supports.

Indian Health Care Providers: Means a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization per 42 CFR §438.14(a).

In lieu of services: Services offered by a Medi-Cal health plan that are not included in the State Plan, but are medically appropriate, cost-effective substitutes for State Plan services included within the contract. Applicable in lieu of services must be specifically included in a managed care plan's contract. Services are offered at the plan's option and an enrollee cannot be required to use them.

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution with more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

Long Term Care: Included skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long Term Service and Supports: Services that include medical and non-medical care for people with a chronic illness or disability. Long-term care services are those provided

to an individual who requires a level of care equivalent to that received in a nursing facility. Most long-term care services assist people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long Term Services and Supports (MLTSS) Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medi-Cal 2020: California's current Section 1115 waiver that expires on December 31, 2020. Medi-Cal 2020 authorized the Whole Person Care program, Global Payment Program, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Dental Transformation Initiative, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.

Medi-Cal Managed Care Plan: A health plan that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid beneficiaries through a network of providers at a capitated rate. Managed care plans emphasize primary and preventive care.

Mental Health Managed Care Plan: A health plan that has a contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries. Mental health managed care plans in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Population Health Management Program: A cohesive plan of action for addressing member needs across the continuum of care, based on data-driven risk stratification, predictive analytics, and standardized assessment processes. Each Medi-Cal managed care plan will provide DHCS with a strategy for how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate the social determinants of health and reduce health disparities or inequities.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive program for Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high quality, value-based care. PRIME is the successor program to the first-in-the-nation DSRIP (Delivery System Reform Incentive Payment) program that was authorized in the Bridge to Reform demonstration in 2010. PRIME funding is authorized under the Medi-Cal 2020 demonstration and expired on June 30, 2020.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount of funding tied to quality outcomes. California's Designated Public Hospitals receive incentive payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals started to participate in the QIP once PRIME expired.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, in order to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value based payment structures.

Safety Net Care Pools (SNCPs): Federal Medicaid funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals. California had SNCPs in the Section 1115 demonstrations that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in the Medi-Cal 2020 demonstration.

Serious Mental Illness/Seriously Emotional Disturbance Demonstration Opportunity: A federal opportunity for States to receive federal Medicaid funding for short-term residential treatment services in settings otherwise subject to the institution for mental disease (IMD) exclusion. (See SMD #18-011)

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2020).

Targeted Case Management: Targeted Case Management (TCM) is a Medi-Cal program that provides specialized case management services to certain Medi-Cal eligible individuals to gain access to needed medical, social, educational, and other services. The TCM Program is an optional Medi-Cal Program operated with federal and local funds. Eligible populations include:

- Children under age 21;
- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psycho-social outcomes; and
- Individuals with a communicable disease.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal beneficiaries. The program is authorized under the Medi-Cal 2020 demonstration and expires on December 31, 2020, with approval pending to extend through calendar year 2021.

California Advancing and Innovating Medi-Cal (CalAIM) In Lieu of Services Fact Sheet

Background

The Whole Person Care (WPC) pilots and Health Homes Program (HHP) built a foundation for an integrated approach to coordinating medical care, behavioral health and social services to improve beneficiary health outcomes. Consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need, establishing coverage of a set of In Lieu of Services (ILOS) will make a statewide offering of these critical interventions for Medi-Cal beneficiaries. The Department of Health Care Services (DHCS) is proposing to implement ILOS, which are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay.

According to federal Medicaid program rules, ILOS are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. They are typically delivered by a different provider or in a different setting than traditional State Plan services. An ILOS can only be covered if:

- The state determines that the service is a medically appropriate and cost-effective substitute or setting for the State Plan service;
- The services are optional for the managed care plan to provide;
- The services are optional for beneficiaries and they are not required to use the ILOS; and
- The ILOS are authorized and identified in the state's Medi-Cal managed care plan (MCP) contracts.

MCPs will develop a network of providers that have the expertise and capacity regarding specific types of services.

DHCS is proposing to include the following 14 distinct services as ILOS under Medi-Cal managed care. Each service will have defined eligible populations, code sets, potential providers, restrictions and limitations:

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

In order to be equipped with the required MLTSS and housing infrastructure, the DHCS must use its ability to provide MCPs with financial incentive payments to work with their providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and ILOS services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

To maintain continuity of care, CalOptima is considering offering services currently provided under WPC and HHP during initial implementation. Those four proposed ILOS are Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services and Recuperative Care. Each is explained further below.

Housing Transition/Navigation Services

- Housing Transition/Navigation Services assist beneficiaries with obtaining housing and include:
  - » Conducting a tenant screening and housing assessment that identifies the participant's needs, preferences and barriers related to successful tenancy
  - » Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal
  - » Searching for housing and presenting options
  - » Assisting with:
    - ◦ Securing housing, including the completion of housing applications and securing required documentation
    - ◦ Requests for reasonable accommodation
    - ◦ Arranging for and supporting the move
    - ◦ Benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process.
  - » Identifying and securing available resources to assist with
    - ◦ Subsidizing rent and matching available rental subsidy resources to members
    - ◦ Covering expenses if included in the housing support plan
  - » Landlord education and engagement
  - » Ensuring that the living environment is safe and ready for move-in
  - » Communicating and advocating on behalf of the client with landlords
  - » Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized
  - » Identifying, coordinating, securing or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day
  - » Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility
- The services provided:
  - » Should be based on individualized assessment needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.
  - » Should use best practices for clients who are experiencing homelessness and who have complex health, disability and/or behavioral health conditions
  - » May involve coordination with other entities to ensure the individual has access to supports needed for successful tenancy
  - » Do not include the provision of room and board or payment or rental costs
- For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems (CES), homeless services authorities, public housing authorities, and other operators of local rental subsidies

Eligibility Criteria:[1]

Individuals who:

- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES; or
- Meet the Housing and Urban Development (HUD) definition of homeless; or
- Meet the definition of an individual experiencing chronic homelessness; or
- Meet the HUD definition of at risk of homelessness and meet certain other DHCS criteria.

Restrictions and Limitations:

- Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.
- Members who meet the eligibility requirements should also be assessed for ECM and Housing and Tenancy Supportive Services (if provided in their county)

Back to Agenda

Back To Item

Back to Item

Housing Deposits

- Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as:
  - » Security deposits required to obtain a lease on an apartment or home
  - » Set-up fees/deposits for utilities or service access and utility arrearages
  - » First month coverage of utilities, including but not limited to telephone gas, electricity, heating and water
  - » First month's and last month's rent as required by a landlord for occupancy
  - » Services necessary for the individuals' health and safety, such as pest eradication and one-time cleaning prior to occupancy
  - » Goods, such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home, such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies, etc.
- The services provided should utilize best practices for clients who are experiencing homelessness and have complex health, disability and/or behavioral health conditions, including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing and Trauma Informed Care.

Eligibility Criteria:[1]

Individuals who:

- Received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition Navigation Services; or
- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES; or
- Meet the HUD definition of homeless; or
- Meet the definition of an individual experiencing chronic homelessness; or
- Meet the HUD definition of at risk of homelessness or are determined to be at risk of experiencing homelessness; or
- Meet the State's No Place Like Home definition of "at risk of chronic homelessness"

Restrictions and Limitations:

- Housing Deposits are an allowable ILOS if they are:
  - » Available once in an individual's lifetime
  - » Can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt CalOptima is expected to make a good faith effort to review information available to determine if individual has previously received services
  - » Identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense
  - » Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner

Back to Agenda

Back To Item

Back to Item

Housing Tenancy and Sustaining Services

Housing tenancy and sustaining services are aimed at maintaining safe and stable tenancy for individuals once housing is secured and include:

- Providing early identification and intervention for behaviors that may jeopardize housing
- Providing independent living and life skills, including assistance with and training on budgeting, including financial literacy and connection to community resources; education and training on the role, rights and responsibilities of the tenant and landlord
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy
- Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized
- Health and safety visits, including unit habitability inspections
- Coordinating with the landlord and case management provider to address identified issues that could impact housing stability and the tenant to for modifications to their housing support and crisis plan on a regular basis
- Assistance with:
  - » Resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action
  - » Benefits advocacy, including assistance related to SSI eligibility and the SSI application process.
  - » The annual housing recertification process
  - » Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized

The services provided:

- Should be based on individualized assessment needs and documented in the individualized housing support plan.
- May involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy.
- Do not include the provision of room and board or payment of rental costs.

Eligibility Criteria:[1]

Individuals who:

- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES; or
- Meet the Housing and Urban Development (HUD) definition of homeless; or
- Meet the definition of an individual experiencing chronic homelessness; or
- Meet the HUD definition of at risk of homelessness and meet certain other DHCS criteria.

Restrictions and Limitations:

- Available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed
- Available for a single duration in an individual's lifetime
- Can be approved one additional time with appropriate documentation regarding success on a second attempt
- Services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance
- Although not required, many individuals will have also received Housing Transition/Navigation Services in conjunction with this service

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner
- Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports
- Clients who meet the eligibility requirements for Housing Tenancy and Sustaining Services should also be assessed for ECM and may have received Housing Transition/Navigation services (if provided in the county)

Back to Agenda

Back To Item

Back to Item

Recuperative Care

- Recuperative care, or medical respite care, is short-term residential care for individuals who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment.
- Recuperative care includes but is not limited to the following services:
  - » Limited or short-term assistance with Instrumental Activities of Daily Living and/or Activities of Daily Living
  - » Coordination of transportation to post-discharge appointments
  - » Connection to any other ongoing services an individual may require, including mental health and substance use disorder services
  - » Support in accessing benefits and housing
  - » Gaining stability with case management relationships and programs

Eligibility Criteria:

Individuals who are at risk of hospitalization or are post-hospitalization and live alone with no informal supports or face housing insecurity or have housing that would jeopardize their health and safety without modification

Restrictions and Limitations:

- Necessary to achieve or maintain medical stability and prevent hospital admission or readmission
- Not more than 90 days in continuous duration
- Does not include funding for building modification or building rehabilitation
- Providing other housing ILOS is encouraged in conjunction with recuperative care and on-site in the recuperative care facilities.

Licensing and Allowable Providers:

- Providers must have experience and expertise with providing these unique services. Licensing and allowable providers include but are not limited to:
  - » Interim housing facilities with additional on-site support
  - » Shelter beds with additional on-site support
  - » Converted homes with additional on-site support
  - » County directly operated or contracted recuperative care facilities
- CalOptima must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained.

**Subject to change as per DHCS guidance*

Endnotes

[1] For an exhaustive list of all eligibility requirements, please reference the most current DHCS CalAIM Proposal.

Back to Agenda

Back To Item

Back to Item

CalAIM

California Advancing and Innovating Medi-Cal

June 3, 2021

Rachel Selleck, Executive Director, Public Affairs
Tracy Hitzeman, Executive Director, Clinical Operations

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Back to Agenda
Back To Item
Back to Item

Background

- January 2021: Department of Health Care Services (DHCS) released revised California Advancing and Innovating Medi-Cal (CalAIM) proposal

- Expands Medi-Cal Managed Care Plans' responsibilities

- Addresses longstanding challenges in Medi-Cal
  - High cost of services for a small number with high needs
  - Significant variation and complexity in service delivery

Back to Agenda

Back To Item

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Back to Item

Background (Cont.)

Whole Person Care (WPC) (2016–21)
Lead Entity: County of Orange
Services:
- Housing Navigation and Sustainability (includes housing deposits)
- Recuperative Care

Health Homes Program (HHP) (2020–21)
Lead Entity: CalOptima
Services:
- Comprehensive Care Management*
- Housing Navigation and Sustainability

California Advancing and Innovating Medi-Cal (CalAIM) (2022–27)
Lead Entity: CalOptima
Services:
- Enhanced Care Management**
- Phase 1 In Lieu of Services (ILOS):
  1) Housing Transition Navigation Services
  2) Housing Tenancy and Sustaining Services
  3) Housing Deposits
  4) Recuperative Care

Phase 1 Implementation: January 2022

***Comprehensive Care Management:** Care management addressing primarily clinical needs

****Enhanced Care Management:** Care management addressing both clinical and nonclinical needs

Note: CalOptima is concurrently planning for Phase 2 ILOS.

Back to Agenda
Back To Item
Back to Item

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CalAIM Initiatives

Initiatives	Implementation Date
Enhanced Care Management (ECM) Benefit	January 2022
In Lieu of Services (ILOS)	January 2022
Plan Incentive Payments	January 2022
Shared Risk/Savings (Seniors and Persons With Disabilities/Long-Term Care Blended Rate)	January 2023
Discontinue Cal MediConnect and Require Dual Eligible Special Needs Plans	January 2023
Population Health Management Program	January 2023
Regional Managed Care Capitation Rates	January 2024
National Committee for Quality Assurance (NCQA) Accreditation[1]	January 2026
Full Integration Plans[2]	January 2027

[1] CalOptima is already NCQA accredited and a top-rated plan in California

[2] CalOptima status: BH partially integrated; dental not integrated

Back to Agenda
Back To Item
Back to Item

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Enhanced Care Management (ECM)

- Creates a single, intensive and comprehensive benefit
  - Designed to meet clinical and nonclinical needs of the highest-cost and/or highest-need beneficiaries
- Builds upon existing Health Homes Program (HHP) delivery system infrastructure
- Uses a phased implementation approach based on DHCS-defined Populations of Focus

Back to Agenda

Back To Item

Back to Item

DHCS Preliminary Timeline

Implementation Date	Population of Focus	WPC	HHP
January 1, 2022	Homeless* Adult High Utilizers Adults with Serious Mental Illness/Substance Use Disorder (SMI/SUD)	Yes Yes Yes	Yes Yes Yes
January 1, 2023	Members transitioning from incarceration Members eligible for Long-Term Care (LTC) or at risk of institutionalization Nursing facility residents transitioning to community	No No No	No No No
July 1, 2023	Child/Youth (High Utilizers; Serious Emotional Disturbance (SED)/high psychosis risk; California Children's Services (CCS) or Whole Child Model (WCM); involvement/history of involvement with Child Welfare; and transitioning from incarceration)	No	No

* To avoid disruption in service, children/youth currently served by HHP/WPC will transition into ECM on January 1, 2022, and be reassessed.

Back to Agenda

Back To Item

CalOptima A Public Agency

Back to Item

WPC/HHP Member Transition to CalAIM

- All WPC/HHP enrolled members will automatically be approved for ECM
  - Reassessment required within six months
    - Ensure appropriate level of case management (ECM, Complex Case Management, Basic Case Management) and non-duplication of services
    - Evaluate member's current needs
    - Update member's plan of care

Back to Agenda

Back To Item

CalOptima
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Back to Item

DHCS Population of Focus: Homeless

Person experiencing homelessness*

+

Complex physical/behavioral/developmental health

+

Unable to self-manage health successfully

+

Health outcomes would improve with service coordination

OR

High-cost services would decrease with coordination

* New HUD homelessness definition: Lacks adequate nighttime residence, primary residence is public place not used for habitation, living in a shelter, exiting an institution to homelessness, will lose housing in next 14 days, unaccompanied youth, homeless families with children, victims fleeing domestic violence

Back to Agenda

Back To Item

CalOptima
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Back to Item

DHCS Population of Focus: High Utilizers

Frequent use of Emergency Department* could be avoided with better outpatient care/treatment adherence

OR

Frequent unplanned hospitalizations** could be avoided with better outpatient care/treatment adherence

OR

Frequent Skilled Nursing Facility stays*** could be avoided with better outpatient care/treatment adherence

* 6 or more Emergency Department visits within 12 months
** 2 or more unplanned hospital admissions within 12 months
***2 or more skilled nursing facility stays (does not include custodial care/Long-Term Care)

Back to Agenda

CalOptima A Public Agency

Back To Item

Back to Item

DHCS Population of Focus: SMI/SUD

County Specialty Mental Health/Drug Medi-Cal eligible

+

Complex social factor influencing health

+

At least one of the below

At high risk for institutionalization	Overdose/at risk of overdose
Pregnant or parenting	At risk of suicide
ER visit for SUD/alcohol use	Admission for SUD/alcohol use
Use of crisis services/ER/urgent care/hospital for primary care	

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Back to Agenda
Back To Item
Back to Item

CalOptima ECM-Eligible Populations

Populations of Focus*	Medi-Cal Only	OneCare/Medi-Medi	Total
Homeless	2,863	439	**3,302**
High Utilizer	11,432	605	**12,037**
SMI/SUD	16,819	1,458	**18,277**
Total	**31,114**	**2,502**	**33,616**

*DHCS established criteria, subject to change

Back to Agenda

Back To Item

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Back to Item

CalAIM ECM Outreach Plan

- Designed to meet the unique needs of each Population of Focus
  - Homeless population outreach
    - Personal Care Coordinators offer services at shelters, navigation centers and recuperative care facilities
    - Clinical Field Team/Homeless Response Team are in-person contacts
  - High utilizer outreach
    - During discharge planning
    - At Interdisciplinary Care Team meetings
    - Multimodal approach (telephonic, e-communication, in-person)
  - SMI/SUD outreach
    - At Interdisciplinary Care Team meetings
    - Offer services where members receive care

Back to Agenda

Back To Item

CalOptima
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Back to Item

In Lieu of Services (ILOS)

- Definition of ILOS
  - Flexible wrap-around services
  - Authorized and identified in the state's Medi-Cal Managed Care Plan contracts
  - Optional for both the plan to offer and the beneficiary to accept
  - Provided as a substitute to, or to avoid, other covered services, such as hospital or skilled nursing facility admission, emergency department use or delay in discharge

DHCS ILOS Options

1. Housing Transition Navigation Services	8. Nursing Facility Transition/Diversion to Assisted Living Facilities
2. Housing Deposits	9. Community Transition Services/Nursing Facility Transition to a Home
3. Housing Tenancy and Sustaining Services	10. Personal Care and Homemaker Services
4. Short-Term Post-Hospitalization Housing	11. Environmental Accessibility Adaptations (Home Modifications)
5. Recuperative Care (Medical Respite)	12. Meals/Medically Tailored Meals
6. Respite Services	13. Sobering Centers
7. Day Habilitation Programs	14. Asthma Remediation

Refer to Appendix J: In Lieu of Services Options in the CalAIM proposal for eligibility criteria, allowable providers and restrictions/limitations

Back to Agenda
Back To Item
Back to Item

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CalOptima's Proposed Approach

- Build upon WPC and HHP infrastructure
- ECM/ILOS providers will need to pass readiness assessment

	ECM	ILOS
Contracting	CalOptima to contract with HHP Community-Based Care Management Entities (CB-CMEs)	CalOptima to contract directly with WPC and HHP ILOS providers
Funding	State funded	No initial funding expected from State

Back to Agenda

Back To Item

Back to Item

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CalOptima's Proposed Approach

- Build upon WPC and HHP infrastructure
- ECM/ILOS providers will need to pass readiness assessment

	ECM	ILOS
Contracting	CalOptima to contract with HHP Community-Based Care Management Entities (CB-CMEs)	CalOptima to contract directly with WPC and HHP ILOS providers
Funding	State funded	No initial funding expected from State*

*DHCS anticipates funding through savings due to reduction in utilization of covered State Plan Services

Back to Agenda
Back To Item
Back to Item

CalOptima
A Public Agency

Providers Readiness Assessment

- CalOptima will collaborate with ECM and ILOS providers to ensure readiness on the following, as applicable, but not limited to:
  - WPC and HHP transition plan
  - Model of Care expectations
  - Network adequacy
  - Provider capacity
  - Policies and procedures compliance

Proposed Timeline	
Summer 2021	Request for Proposal and Consultant selection
Fall 2021	Conduct Readiness Assessment

Back to Agenda

Back To Item

Back to Item

CalOptima
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Provider Training

- Provider training will be conducted either via in-person sessions, webinars and/or calls
- Training shall encompass:
  - Program overview
  - Member care plan, care coordination and care transitions expectations
  - Community resources, referral process, as well as operational and condition-specific trainings
  - Special populations
  - Social determinants of health
  - Motivational interviewing, trauma-informed care
  - Health literacy assessment and information sharing

Next Steps

2021–22	Actions
June 2021	Seek CalOptima Board approval for DHCS submission
July 2021	Submit completed Model of Care (MOC) Template Part 1 to DHCS
Late Summer	Obtain DHCS approval of completed MOC Template Part 1
October 2021	Submit completed MOC Template Part 2 (provider capacity and contract templates) deliverable due to DHCS
Fall 2021	Hold stakeholder planning event
Fall 2021	Complete readiness assessments and provider training
December 2021	Sunset WPC and HHP
January 2022	Go-live with ECM and Phase 1 ILOS

Back to Agenda

CalOptima
A Public Agency

Back To Item

Back to Item

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

CONTRACT NO. «Contract Number»
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
«Company Name»
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of the date last signed below, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and «Company Name», a «Buisness Entity», hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide «Description», as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

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

D. CONTRACTOR desires to perform these services for CalOptima; and

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

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto; (ii) CalOptima's Request for Proposal ("RFP"), if applicable, inclusive of any revisions, amendments and addenda thereto; (iii) CONTRACTOR's best and final offer dated [Insert Date of Best and Final Offer], if applicable, and; (iv) CONTRACTOR's proposal dated [Insert Date CONTRACTOR's Response to RFP]. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 21, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. CONTRACTOR shall also perform in accordance with its Proposal dated [Insert RFP Date] , and supplemental

other information submitted to CalOptima on [INSERT Supplemental Information Date], consisting of [Describe Supplemental Information Document].

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

Name	Function/Title
_____	_____
_____	_____
_____	_____

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, 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 is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

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

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

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

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such

alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any and all liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of, or pertaining to, or relating to the negligence, recklessness, or willful misconduct of CONTRACTOR, its employees or agents, or anyone that they control, in CONTRACTOR's performance of services under this Contract, or its failure to comply with any of its obligations contained in this Contract, except such loss or damage that is caused by the sole negligence or willful misconduct of CalOptima. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.3 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.4 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.5 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.6 It is not the intent of the Parties that the provisions of this Section and the Indemnification provision(s) set forth in the Business Associate Protected Health Information Disclosure Agreement executed by the Parties shall be in conflict. In the event of any conflict, the Indemnification provision(s) in the Business Associate Protected Health Information Disclosure Agreement shall be interpreted to relate only to matters within the scope of that Agreement.

4.7 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other

amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

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

harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR, and any person designated by CONTRACTOR to make or participate in making a governmental decision on behalf of CalOptima, is considered a "Consultant" pursuant to CalOptima's Conflict of Interest Code, and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually.

10.5 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.6 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 CONTRACTOR and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, 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. CONTRACTOR and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its Subcontractors' obligation 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.

12.2 CONTRACTOR and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

12.3 CONTRACTOR and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions

herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 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.

12.5 CONTRACTOR and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

12.7 CONTRACTOR and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Prevailing Wage. To the extent required by state law, CONTRACTOR agrees that CONTRACTOR, and any of its subcontractors, shall comply with the requirements under California Labor Code §§ 1720, et seq., and shall pay not less than the prevailing wage rates for services performed in the execution of this Contract as required under California Labor Code § 1774. It is CONTRACTOR's responsibility to

interpret and implement any prevailing wage requirements, and CONTRACTOR agrees to pay any penalty or civil damages resulting from a violation of the prevailing wage laws. In accordance with Labor Code § 1773.2, copies of the prevailing rate of per diem wages are available upon request from CALOPTIMA's Purchasing Department or the website for State of California Prevailing Wage Determinations at www.dir.ca.gov/OPRL/PWD. If applicable, a copy of the prevailing rate of per diem wages must be posted at the job.

14. Surety Bonds. As changes to the contract documents occur by way of approved amendments or change orders, the CONTRACTOR shall ensure that the amounts of the Bond(s) required under this Section are adjusted to reflect 100% of the contract price. This Contract shall not become effective until such bond(s) required under this Section are provided to, and approved by, CalOptima.

14.1 Payment Bond. CONTRACTOR shall, prior to beginning any work pursuant to this Contract, furnish a bond in the amount of one hundred percent (100%) of the Contract Price to guarantee payment of all claims for labor and materials furnished.

14.2 Performance Bond. CONTRACTOR shall, prior to beginning any work pursuant to this Contract, furnish a bond in the amount of one hundred percent (100%) of the Contract Price to guarantee the faithful performance of the work.

15. Labor Code Compliance. To the extent required by state law, the compensation under this Contract includes funds sufficient to allow CONTRACTOR to comply with all applicable local, state, and federal laws or regulations governing the work to be performed under this Contract, including, without limitation, any such laws or regulations requiring CONTRACTOR to pay prevailing wages, and CONTRACTOR will fully comply with all such laws and regulations. By its signature, CONTRACTOR acknowledges that CalOptima has requested CONTRACTOR to provide CalOptima with all accurate and updated information required to comply with the provisions of Labor Code Section 2810(d). CONTRACTOR agrees to provide CalOptima with all such information, including, without limitation, the information to be inserted in Exhibit J to this Contract.

16. Standard of Performance; Warranties.

16.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

16.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

16.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified, and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

16.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

16.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

16.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

17. Compensation.

17.1 Payment.

17.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

17.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

17.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

17.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

17.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise

to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

17.2 Contractor Travel Policy. CONTRACTOR agrees to abide by the terms of the CalOptima Travel Policy, attached hereto as Exhibit C, and incorporated herein by this reference.

17.3 Contractor Travel Policy. CONTRACTOR is not entitled to any reimbursement for travel, meals, accommodations, or other similar expenses under this Contract.

18. Term. This Contract shall commence on the date last signed below, and shall continue in full force and effect through «Current Expiration», ("Initial Term"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to «Extended Term spelled» («Extended Term») additional consecutive one (1) year terms ("Extended Terms"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. As used in this Contract, the word "Term" shall include the Initial Term and any and all Extended Term(s), to the extent CalOptima exercises its option pursuant to this paragraph.

19. Term. This Contract shall commence on the date last signed below, and shall continue in full force and effect through «CurrentExpiration», unless earlier terminated as provided in this Contract.

20. Termination.

20.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

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

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

20.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

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

20.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the

benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

20.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 29, (Confidentiality).

20.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

20.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise), and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

20.5.2 CalOptima may take over the services, and may award another party a contract to complete the services under this Contract.

20.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

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

22. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

23. Confidential Material.

23.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

23.2 For the purposes of this Section 23, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

23.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

23.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

23.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 29, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

24. Record Ownership and Retention.

24.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

24.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

24.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

24.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 23) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

24.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

25. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

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

27. Business Associate Protected Health Information Disclosure Agreement. CONTRACTOR agrees to and shall enter into a Business Associate Protected Health Information Disclosure Agreement with CalOptima, with a Security Requirements Attachment for DHCS Data and Protected Health Information/Personal Information (PHI/PI) if CONTRACTOR will create, receive, maintain, use, or transmit DHCS data or PHI/PHI, which agreement shall be incorporated herein by this reference. CONTRACTOR acknowledges and agrees that CalOptima reserves the right to modify the Business Associate Protected Health Information Disclosure Agreement at any time should such modification be required by applicable law or regulation.

28. Business Associate Protected Health Information Disclosure Agreement. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

29. Confidentiality of Member Information.

29.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

29.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

29.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

29.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

29.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

29.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

29.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

30. Offshore Performance.

30.1 Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by CalOptima.

30.2 CONTRACTOR shall complete, sign, and return Exhibit H, entitled "Attestation Concerning the Use of Offshore Subcontractors," which is attached hereto and incorporated herein by this reference, and shall submit an executed Offshore Subcontractor Attestation no less than annually thereafter.

30.3 CONTRACTOR acknowledges that CalOptima requires CONTRACTOR to obtain approval from it of CONTRACTOR's use of any offshore subcontractor whereby offshore subcontractor will have access to any type of confidential CalOptima Member information, including, but not limited to, protected health information. CONTRACTOR represents and warrants that it has disclosed to CalOptima any and all such offshore subcontractors within Exhibit H and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the effective date of this Contract.

30.4 Any new subcontract with an offshore entity under which the offshore entity will have access to any confidential CalOptima Member or other protected health information must be approved in writing by CalOptima prior to execution of the subcontract. CONTRACTOR is required to submit future Offshore Contractor Attestations to CalOptima's Purchasing Department within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

30.5 Unless specifically stated otherwise in this Contract, the restrictions of this Section do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

30.6 The provisions of this Section apply to work performed by subcontractors at all tiers.

31. Offshore Performance. No restrictions on offshore performance are required under this Contract.

32. FDR Compliance. Upon execution of this Contract, CONTRACTOR agrees to execute and abide by the terms of the "FDR Compliance Attestation," which is attached hereto as Exhibit F and incorporated herein by this reference, and shall submit an executed FDR Compliance Attestation no less than annually thereafter.

33. FDR Compliance. FDR Compliance requirements are not applicable under this Contract.

34. Medicare Advantage Program. CONTRACTOR agrees to abide by the terms of "Addendum 1, Medicare Advantage Program," attached hereto as Exhibit G and incorporated herein by this reference.

35. Medicare Advantage Program. Medicare Advantage Program requirements are not applicable under this Contract.

36. Time is of the Essence. Time is of the essence in performance of this Contract.

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

38. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

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

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

41. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
	CalOptima
	505 City Parkway West
	Orange, CA 92868
Attention:	Attention:

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

43. Unavoidable Delays.

43.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused

CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

43.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

43.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

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

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

46. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

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

48. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

49. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR

discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

50. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

51. Debarment and Suspension Certification.

51.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

51.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

51.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

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

51.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 51.2.2 herein;

51.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

51.2.5 Have not and shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart

9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

51.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

51.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

51.4 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

51.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

52. Lobbying Restrictions and Disclosure Certification.

52.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

52.2 Certification and Disclosure Requirements.

52.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 52.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

52.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") 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 52.3 of this provision if paid for with appropriated funds.

52.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 52.2.2herein. An event that materially affects the accuracy of the information reported includes:

52.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

52.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

52.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

52.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 52.2.1of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

52.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 52.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

52.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions, the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

53. Smoke-Free Workplace Certification.

53.1 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.

53.2 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.

53.3 By signing this Contract, CONTRACTOR 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.

53.4 CONTRACTOR further agrees that it will insert this Certification into all subcontracts under this Contract entered into that provide for children's services as described in the Act.

54. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 et seq.), as amended.

55. Liquidated Damages. If CONTRACTOR fails to complete the work within the timeframe specified in Exhibit A, Scope of Work, or any CalOptima authorized extension thereof, CONTRACTOR shall pay to CalOptima, as fixed, agreed-to liquidated damages, and not as penalty, for each calendar day of delay, the sum of «Liquidated Damages Spelled» Dollars «Liquidated Damages». CONTRACTOR shall not be charged with liquidated damages when the delay is determined to be excusable, in accordance with the "Unavoidable Delays" paragraphs herein, or at the behest of CalOptima.

56. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend,

Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

57. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

58. Third Party Beneficiaries. There are no intended third party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

59. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

60. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

61. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. «Internal Number» on the day and year last shown below.

«Company Name»	CalOptima
By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

If CONTRACTOR is a corporation, two officer signatures
or a Corporation Resolution or Corporate Seal is required

Exhibit A

SCOPE OF WORK

Exhibit B

PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

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

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. «contract Number».]; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed [Insert Maximum Cumulative Payment Amount, Written] Dollars ($[Insert Maximum Cumulative Payment Amount, Number]), including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract.

E. CONTRACTOR's hourly billable rate shall be «Hourly billable spelled» Dollars ($«Hourly Billable») per hour. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

F. CONTRACTOR’s fees for the goods and/or services provided under Exhibit A, Statement of Work, will be billed based upon completion of the milestones as set forth in the schedule(s) in Exhibit B-1, which is attached hereto and incorporated herein by reference. These fees are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

G. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Statement of Work, will be billed on a time and materials basis. Each CONTRACTOR employee will have an associated hourly rate, which CONTRACTOR will extend by the hours of service performed in order to determine the amount of fees to invoice. The CONTRACTOR employees to participate in this Statement of Work, their titles/labor category, and the [hourly/daily] rate associated with this Contract as set forth in Exhibit B-1, which is attached hereto and incorporated herein by reference. These fees and rates are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees and rates to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

H. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Statement of Work, will be billed based upon completion of the milestones as set forth in the schedule(s) in Exhibit B-1, which is attached hereto and incorporated herein by reference. For any additional work beyond that specified in Exhibit A, Scope of Work, that is authorized by CalOptima in a written amendment or change order, CONTRACTOR shall be paid at the hourly billable rate of «Hourly Billable Spelled» Dollars ($«Hourly Rate») per hour. These fees and rates are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees and rates to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

I. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Statement of Work, will be billed at the rates set forth in "Exhibit B-1," attached hereto. These fees are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

J. CONTRACTOR shall also invoice CalOptima on a monthly basis for travel-related expenses. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. Travel related expenses shall not exceed [Insert Negotiated Value Spelled Out] Dollars ($Insert Negotiated Value Number) in the aggregate. CONTRACTOR shall obtain CalOptima's written approval, which shall not be unreasonably withheld or delayed, before incurring any expenses exceeding, in the aggregate, [Insert Negotiated Value Spelled Out] Dollars ($Insert Negotiated Value Number). CalOptima shall not pay CONTRACTOR for time spent traveling.

Exhibit B-1

PAYMENT SCHEDULE

Milestone	Completion Date	Fee
_____	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL		

Name	Title/Labor Category	Rate
_____	_____	_____
_____	_____	_____
_____	_____	_____

Exhibit B-1

Not applicable for this Contract

Exhibit C

CalOptima Travel Policy

Policy #:	GA.5004	
Title:	**Travel Policy**	
Department:	Finance	
Section:	Purchasing	
CEO Approval:		Michael Schrader MS
Effective Date:	8/1/12	Revised: 9/6/12, 3/1/13
Board Approval:	9/6/12	

I. PURPOSE

To establish a process for reasonable and equitable reimbursement of approved travel and other related expenses incurred by CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants while traveling on authorized CalOptima Business.

II. POLICY

A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.

B. CalOptima shall provide an expense reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel expenses and miscellaneous expenses incurred by authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal regulations.

C. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible.

1. Travel Expenses shall include the following items:

   a. Transportation: including commercial carriers, rental vehicles, and mileage for use of personal vehicle;

   b. Lodging;

   c. Meals;

   d. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

   e. Insurance for rental vehicles;

   f. Parking fees and tolls fees (i.e., toll roads and necessary parking);

g. Miscellaneous expenses including:

i. Authorized local and long-distance telephone calls;

ii. Baggage fees;

iii. Internet or Wi-Fi charges;

iv. Facsimiles;

v. Expenses in connection with the preparation of authorized company reports or correspondence;

vi. Taxi or public transit fares, required to conduct business; and

vii. Other unforeseen or unusual expenses that are properly justified and substantiated.

D. Board Member/Standing Committee Member Travel

1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.

a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

i. CalOptima business-related activities;

ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

1. Attendance at any given conference and/or seminar shall be:

   a. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

   b. Approved by Human Resources.

2. Payment of Fees

   a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

   b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

1. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

2. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

   a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

      i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

ii. The authorized Individual elects to pay for the meals of individuals with whom authorized CalOptima Business was conducted; or

iii. Extraordinary circumstances may cause it to be impractical or unfeasible for the authorized Individual to stay within the established meal rates, and the authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

iv. Expense reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her designee.

b. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses, as stipulated in this policy. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member meal reimbursement rate.

3. CalOptima shall reimburse for Business Meals at actual reasonable and necessary expenses for refreshments or meals, excluding alcoholic beverages, provided in conjunction with on-site or off-site meetings (e.g., in-house developed formal training sessions, conferences, seminars, workshops, staff meetings, and board and commission meetings) which extend over normal breaks or meal periods. An Expense Report for Business Meals must include receipt, names of those in attendance, and the business topic.

H. Lodging Expenses

1. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-Local Travel.

2. Adequate lodging expenses will be allowed. Price is an issue in selecting "adequate lodging". Prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged; booking through online travel Websites, as opposed to directly with the lodging facility, might provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

3. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) Website; www.gsa.gov.

4. CalOptima may reimburse additional lodging expenses for Non-Local Travel if:

a. It results in offsetting lower airfare; and

b. The cost of returning to home or office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

5. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

a. It is not practical or feasible for the authorized Individual to return home due to extremely poor weather conditions; or

b. Less than eight (8) hours will elapse from the time business is concluded on one (1) day and the time business is scheduled to reconvene on the following calendar day; or

c. It is not practical or feasible for the authorized Individual to return home due to an extended commute.

6. Once approved, the Individual or his or her designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Purchasing Department.

7. The Individual shall be responsible for necessary cancellation of travel and lodging reservations, in accordance with the respective rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any cancellations.

I. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for Travel Expenses.

2. The Executive Management team shall approve cash advances for anticipated authorized travel.

3. CalOptima may authorize cash advances on a limited basis if the traveling Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized Travel Expenses, as defined in this policy.

4. When authorized, cash advances shall be based on an estimate of reasonable Travel Expenses, including travel, meals, lodging and miscellaneous expenses.

5. Individuals receiving cash advances shall complete an Expense Report within five (5) business days of the Individual's return to home or place of work, whichever occurs first. The Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate any cash amounts due back to CalOptima, in the event the cash advance was greater than actual authorized expenses, or cash amounts due the Individual, in the event actual authorized expenses exceed the amount of the cash advance.

J. Transportation

1. The mode of transportation shall be based on the distance of the final destination from the Individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of transportation.

2. Cost of arrangements for personal travel in conjunction with a business travel itinerary will be at the authorized Individual's expense. The Individual shall document the incremental travel costs assessed to CalOptima, in accordance with this policy.

3. The Individual shall make transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of transportation. A Saturday night stay may be required to obtain the lowest possible rate, and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

   a. Flight arrangements made through CalOptima's travel services provider shall be reviewed by CalOptima's Purchasing Department, and submitted directly to Accounts Payable for payment.

   b. Flight arrangements not made through the CalOptima travel services provider shall be submitted by the Individual on an Expense Report.

   c. Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance by the CEO. An Individual shall pay any increase in transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time, but shall be charged to the appropriate type of leave.

   d. Additional expenses shall not be the responsibility of the Individual if, through no fault or control of the Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time, and shall not be charged to any type of leave.

   e. Whenever available, all Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved.

   f. Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

   g. Any deviation from lowest available rate for commercial carriers shall be at the Individual's expense.

4. The Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carrier rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established carrier rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any such cancellations.

5. Use of Privately-Owned Vehicles

   a. An authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The Individual must be licensed, and shall carry liability insurance as required by the State of California, at the Individual's sole expense.

b. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate. Total mileage reimbursed should consider the Individual's daily commute.

c. CalOptima shall not reimburse costs for fuel, automobile repairs, or other automobile expense items.

d. If more than one authorized Individual is traveling for CalOptima Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

e. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

f. CalOptima shall compensate property damages to an Individual's automobile incurred without fault or cause on the part of the Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the Individual's insurance policy, whichever is the lesser amount, for each accident.

6. Rental Automobiles

a. An Individual may rent automobile when such rental is considered to be more advantageous to CalOptima than other means of transportation.

b. Advance reservations shall be made whenever possible. Reservations for employees, Board and Committee members shall be made in the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

c. The vehicle rental agreement for the authorized Individual shall reference the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

d. Rental automobile approved classes are as follows:

i. Economy Class: An Individual shall select an economy class vehicle whenever four (4) or fewer individuals, including the driver, will be passengers in the rental automobile at any one time.

ii. Mid-size Class: An Individual may select a mid-size class vehicle in the event more than four (4) individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure.

iii. Luxury Class: Under no circumstances shall an Individual select a luxury class vehicle.

7. Other Modes of Transportation

a. Taxi Fares: CalOptima shall reimburse taxi fares when public transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

III. PROCEDURE

A. Travel and Training Authorization Form

1. Shall be accessed and completed on-line by all Individuals or their designee using CalOptima's Intranet system (or similar system in place at the time request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Shall be routed for approval systemically based on the Individual's level, cost center, and whether they are a CalOptima employee according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

3. Shall also be routed systemically to the Human Resources Department in order to track the Individual's training.

4. Shall also be routed systemically to the Finance Department for confirmation that requested expenses are budgeted, and that enough budget remains to cover requested expenses.

5. Requestors shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

6. The Purchasing Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel commitments.

B. Travel and Training Arrangements

1. Authorizations that include event registration fees shall be pre-paid and processed by CalOptima's Purchasing Department, where possible. CalOptima's Purchasing Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Individual for the event.

2. The requestor, or his or her designee, shall make air travel arrangements through CalOptima's travel services provider, where possible. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima's travel services provider are subject to approval by CalOptima's Purchasing Department.

3. All other arrangements shall be made with the Individual's personal credit card, either through CalOptima's travel services provider, another approved method, or directly with the establishment(s), subject to CalOptima's Purchasing Department approval.

C. Expense Reimbursement using Expense Report

1. Individuals or designees shall prepare and submit request claims for reimbursement of Travel Expenses on a CalOptima Expense Report. The report shall be completed by the Individual or designee, including all details, and shall be routed with a copy of the previously-approved Travel and Training Authorization Form for appropriate Expense Report approval signatures, if applicable, as follows:

Individual	**Approver**
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee*
CEO	Board Chairperson or designee*
Board Member/Standing Committee Member	Board Chairperson, CEO or designee*

*Designee authorization is not valid when self approval would result.

2. Receipts

   a. For any expenses in excess of twenty-five dollars ($25.00), the Individual shall include an original credit card receipt, if available, or other computer-generated or hand-written receipt, in the event a credit card receipt is unavailable. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure.

   b. Small receipts, such as credit card, gas and airline receipts, shall be attached to an 8 ½ by 11 inch sheet of paper. Hotel receipts and other larger receipts may be submitted as is.

   c. In the absence of credit card receipts, or other proof of actual expenditure, CalOptima shall reimburse lodging expenses only if marked "paid" by the management of the lodging facility.

   d. In most instances, airfare for CalOptima employees and Board members shall be prepaid by CalOptima. CalOptima contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit passenger receipts for reimbursement consideration.

   e. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima shall not allow the amount.

3. Completed and approved Expense Reports and supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel.

4. No reimbursement shall be made for Expense Reports submitted beyond six (6) months after completion of travel.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

2. Code expenses to appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The Purchasing Department shall:

1. Provide travel reports to the CEO, Executive Management, and Department Directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event, and may be required to distinguish between budgeted and non-budgeted travel.

2. Review details of statements/invoices received from the CalOptima travel services provider for accuracy and reasonableness;

3. Attach appropriate copies of completed Travel and Training Authorization Forms related to travel service provider invoice line items, and submit to Accounts Payable for payment.

4. Review details of statements/invoices received from credit card account used by Purchasing to arrange attendance at conferences, training, and other events, and to make authorized purchases.

5. Attach appropriate copies of completed Travel and Training Authorization Forms related to credit card invoice travel and training line items, and submit to Accounts Payable for payment.

IV. ATTACHMENTS

A. Electronic Travel and Training Authorization Form
B. CalOptima Expense Report
C. Cash Advance Form

V. REFERENCES

A. Internal Revenue Service Publication 463
B. California Government Code Section 53232.2
C. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994

VI. APPROVALS OR BOARD ACTION

9/6/12: CalOptima Regular Board Meeting

VII. REVISION HISTORY

A. 9/6/12: GA.5004: Travel Policy
B. 8/1/12: GA.5004: Travel Policy

VIII. KEYWORDS

Approved Lodging
CalOptima Business
Executive Management

Expense Report
Individual
Local Travel
Lodging
Meals
Miscellaneous Expenses
Non-Local Travel
Non-Reimbursable Expenses
Parking, Fees and Tolls
Registration Fees
Reimbursable Expenses
Transportation
Travel
Travel and Training Authorization Form
Travel Expenses

Exhibit C

Not applicable for this Contract

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

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

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

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

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: _____ Date: _____

Print Name: _____

Title: _____

Exhibit E
Part 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that :

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

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Name of Contractor	Printed Name of Person Signing for Contractor
_____	_____
Contract/Grant Number	Signature of Person Signing for Contractor
_____	_____
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

Exhibit E

Part 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: ☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	2. Status of Federal Action: ☐a. bid/offer/application ☐b. initial award ☐c. post-award	3. Report Type: ☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____
4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*:	
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:	
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____	
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*): (*attach Continuation Sheet(s) SF-LLLA, if necessary*)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):	
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned 12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value_____	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____	
14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: *(Attach Continuation Sheet(s) SF-LLL-A, If necessary)*		
15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No		
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:	
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL	

Exhibit E

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

Exhibit E

Not applicable for this Contract

Exhibit F
FDR Attestation

CalOptima
Better. Together.

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org , or mail: CalOptima, Office of Compliance, Attn: Annie Phillips 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days for (existing FDRs) or sixty (60) calendar days for (new FDRs) of this notice.

Which CalOptima program(s) does this form pertain to? Select all that apply:	☐OneCare Connect ☐OneCare HMO SNP	☐Medi Cal ☐PACE

I hereby attest that [_____ (the "Organization")], and all its downstream entities, if any, that are involved in the provision of health or administrative services for any of the CalOptima programs identified above:

I. **General and HIPAA Compliance and FWA Training.** Provide effective Fraud, Waste and Abuse training, General Compliance training, General HIPAA training to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers, within ninety (90) calendar days of appointment, hire or contracting, as applicable, and at least annually thereafter as a condition of appointment, employment or contracting. The Organization and its downstream entities currently use (Select all that apply):

- ☐ CMS's Fraud, Waste, and Abuse training, General Compliance training, and General HIPAA training module. (The Organization shall maintain records per CMS retention requirement)
- ☐ An internal training program that meets CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements. (The Organization shall maintain records per CMS retention requirement)

Note: If selecting an internal training program that meets CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers: (i) based on their job function within the first ninety (90) days of hire and at least annually thereafter as a condition of appointment, employment or contracting, (ii) when requirements change; (iii) when such persons work in an area previously found to be non- compliant with program requirements or implicated in past misconduct.

III. **Compliance Plan and Code of Conduct Requirements.** Have established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A) which information, and any updates thereto, are distributed to all Organization and downstream entity board members, officers, employees, temporary employees, and volunteers within ninety (90) days of appointment, hire or contracting, as applicable, and at least annually thereafter. Evidence of receipt of such compliance by such persons is obtained and retained by the Organization. (Select which applies to your organization):

- ☐ Organization has adopted, implemented, and distributed CalOptima's Compliance Plan and Code of Conduct
- ☐ Organization has distributed a comparable Compliance Plan and Code of Conduct

Note: If selecting a comparable Compliance Plan and Code of Conduct, please submit a copy of your organization's Compliance Plan and Code of Conduct to CalOptima's Office of Compliance for review, and to ensure they meet CMS's requirements

IV. **Exclusion Monitoring**. Review all Organization and downstream entity board members, officers, potential and actual employees, temporary employees, and volunteers against the (Suspended and Ineligible Provider List) S & I Medi-Cal, (Health and Human Services) HHS, (Office of Inspector General) OIG List of Excluded Individuals & Entities list, (System for Award Management) SAM/(General Services Administration) GSA Debarment list, Centers for Medicare & Medicaid Services (CMS) Preclusion List (as applicable), (here after "Lists") upon appointment, hire or contracting, as applicable, and monthly thereafter. Further, in the event that the Organization or downstream entity becomes aware that any of the foregoing persons or entities are included on these Lists, the Organization will notify CalOptima within five (5) calendar days, the relationship with the listed person/entity will be terminated as it relates to CalOptima, and appropriate corrective action will be taken.

V. **Conflict of Interest**. Screen the Organization and its subcontractors' governing bodies for conflicts of interest as defined in state and federal law and CalOptima policies and procedures upon hire or contracting and annually thereafter.

VI. **Reporting of FWA/Non-Compliance**. Will report suspected fraud, waste, and abuse, as well as all other forms of non- compliance, as it relates to CalOptima, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima policies and procedures are grounds for disciplinary action, up to and including termination of Organization's contractual status.

VIII **Non-Retaliation**. Are aware that persons reporting suspected fraud, waste, and abuse, and other non- compliance are protected from retaliation under the False Claims Act and other applicable laws prohibiting retaliation.

IX. **Records Management**. Retain documented evidence of compliance with the above, including training and exclusion screening (i.e. sign-in sheets, certificates, attestations, OIG and GSA search results, etc.) for at least ten (10) years, and provide such documentation to CalOptima upon request.

The individual signing below is knowledgeable about and authorized to attest to the foregoing matters on behalf of the Organization.

_____	_____
Signature	Date
_____	_____
Name (Print)	Organization
_____	
Email (Print)	

Exhibit F

Not applicable for this Contract

Exhibit G

ADDENDUM 1
MEDICARE ADVANTAGE PROGRAM

The following additional terms and conditions apply to the provision of goods or services to be utilized, directly or indirectly, by or for the Medicare Advantage Program. These terms and conditions are additive to those contained in the main Contract, and apply to the extent applicable to the services provided by CONTRACTOR. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

A. In addition to compliance with the provisions of Section 8 in the Contract, CONTRACTOR expressly warrants that CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

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

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

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

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

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

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

D. For all contracts in the amount of $100,000 or more, in addition to the Equal Opportunity provisions included in the Contract, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 CFR 60-300.5(a) and 41 CFR 60-741.5(a) as follows:

1. **THIS CONTRACTOR AND SUBCONTRACTOR SHALL ABIDE BY THE REQUIREMENTS OF 41 CFR 60-300.5(a). THIS REGULATION PROHIBITS DISCRIMINATION AGAINST QUALIFIED PROTECTED VETERANS, AND REQUIRES AFFIRMATIVE ACTION BY COVERED PRIME CONTRACTORS AND SUBCONTRACTORS TO EMPLOY AND ADVANCE IN EMPLOYMENT QUALIFIED PROTECTED VETERANS. (**41 CFR 60-300.5(d).)

2. **THIS CONTRACTOR AND SUBCONTRACTOR SHALL ABIDE BY THE REQUIREMENTS OF 41 CFR 60-741.5(a). THIS REGULATION PROHIBITS DISCRIMINATION AGAINST QUALIFIED INDIVIDUALS ON THE BASIS OF DISABILITY, AND REQUIRES AFFIRMATIVE ACTION BY COVERED PRIME CONTRACTORS AND SUBCONTRACTORS TO EMPLOY AND ADVANCE IN EMPLOYMENT QUALIFIED INDIVIDUALS WITH DISABILITIES. (**41 CFR 60-741.5(d).)

E. In addition to the termination provisions of Section 20 of this Contract, CONTRACTOR agrees and acknowledges that CalOptima may terminate the Contract if CMS or CalOptima determines that

CONTRACTOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay CONTRACTOR its allowable costs incurred to the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima for matters pertaining to this Contract.

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

G. CalOptima shall review, approve, and audit on an ongoing basis, the credentialing of medical professionals, if any, associated with CONTRACTOR and CONTRACTOR's performance of this Contract.

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

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

Exhibit G

Not applicable for this Contract

CalOptima
Better. Together.

Attestation Concerning the Use of Offshore Subcontractors

Please complete and execute this attestation and return it to CalOptima's Office of Compliance via email Compliance@caloptima.org, or mail: Cal Optima, Office of Compliance, Attn: Annie Phillips 505 City Parkway West, Orange, CA 92868, within thirty (30) calendar days (existing FDRs) or sixty (60) calendar days (new FDRs) of the notice accompanying this form.

Check which CalOptima program(s) this form pertains to:

- ☐ OneCare Connect
- ☐ OneCare HMO SNP
- ☐ Medi-Cal
- ☐ PACE

Are any administrative or other functions conducted on behalf of your Organization by entities located offshore? This shall include employees of your firm, subcontractors and any 3rd party subcontractors. ("X" where appropriate)

No ☐ If NO, please complete Part I:

Yes ☐ If YES, please complete Parts II–VI of this form:

Part I — Our Firm is Not Using Offshore Subcontractors and/or Employees

Offshore subcontractors
☐ Our Organization is not using offshore subcontractors

Offshore employees
☐ Our Organization does not employ workers who are located offshore

Name of organization:	
Name of authorized person:	
Title:	
Signature:	
Date:	

Part II — Offshore Subcontractor Information

Offshore subcontractors
☐ Our Organization is using offshore subcontractors

Offshore employees
☐ Our Organization does employ workers who are located offshore

Subcontractor name:	
Subcontractor country:	
Subcontractor address:	

Describe offshore subcontractor functions:

Proposed or actual effective date for offshore subcontractor: _____

Part III — Precautions for Protected Health Information (PHI)

1. Describe the PHI that will be provided to the offshore subcontractor and/or employee:

2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's/employee's objectives:

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

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

Item	Attestation	Response Yes / No
A.	Offshore subcontractor/employee arrangement has policies and procedures in place to ensure that Medi-Cal and Medicare beneficiary protected health information (PHI) and other personal information remains secure.	
B.	Offshore subcontractor/employee arrangement prohibits subcontractor/employee access to Medi-Cal and Medicare data not associated with CalOptima's contract with the offshore subcontractor/employee.	
C.	Offshore subcontractor/employee arrangement has policies and procedures in place that allow for immediate termination of the subcontractor/employee upon discovery of a significant security breach.	
D.	Offshore subcontractor/employee arrangement includes all required DHCS (Department of Health Care Services) and/or CMS (Centers for Medicare & Medicaid Services) language as stipulated within your contract with CalOptima.	

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

Back to Agenda

Back To Item

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

Part VI — Organization Information

Name of organization:	
Name of authorized person:	
Title:	
Signature:	
Date:	
Email	

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA and CalOptima's code of conduct can be accessed at CalOptima's vendor page: https://www.caloptima.org/en/Vendors.aspx.
Vendors Home -- > FDR Compliance --> Scroll down to Training

»

Back to Agenda

Back To Item

Exhibit H

Not applicable for this Contract

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: _____

Business Entity Type: _____
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: _____

City:_____ State:_____ Zip:_____

Business Phone:_____ Email: :_____

President: _____ Contact Person:_____

Person(s) Signing Contract & Title: :_____

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
_____	_____
_____	_____
_____	_____
_____	_____

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

_____ _____
Authorized Signature Date

_____
Name and Title

Exhibit J

ADDITIONAL INFORMATION TO BE PROVIDED BY CONTRACTOR PURSUANT TO CALIFORNIA LABOR CODE SECTION 2810

Workers compensation insurance policy number: _____
Name of insurance carrier: _____
Address of insurance carrier: _____

Telephone number of insurance carrier: _____

List of vehicles owned, by vehicle identification number: _____

Vehicle liability insurance policy number: _____
Name of insurance carrier: _____
Address of insurance carrier: _____
_____

Telephone number of insurance carrier: _____

Provide address of any real property in which you intend to house any of your workers in connection with the project (or write "None" if no property will be used to house workers): _____

Total number of workers to be employed: *_____

Total amount of all wages to be paid: *_____

Date(s) when wages will be paid: *_____

Total number of independent contractors/subcontractors: *_____

List by name each independent contractor/subcontractor and provide the contractor's license number for each: *_____
_____
_____
_____
_____
_____
_____

*May be estimated if unknown at the time this Contract is signed. CONTRACTOR must provide CalOptima with actual figures when known.

Exhibit J

Not applicable for this Contract

Exhibit K

FAITHFUL PERFORMANCE BOND

Bond No. _____
Premium _____

KNOW ALL PERSONS BY THE PRESENTS: That we,
_____,
as Principal, and _____, as Surety, are held and firmly bound unto the Orange County Health Authority, dba CalOptima, a California Public Agency, ("CalOptima") in the sum of One Hundred Percent (100%) of the Contract Price pursuant to the agreement between Principal and CalOptima made and entered into on **[DATE]** for **[INSERT CONTRACT DESCRIPTION HERE]**, for the payment of which we hereby bind ourselves, our successor, heirs, executors and administrators, jointly and severally, firmly by these presents.

That the Surety's office is located at _____, telephone number _____, and the Surety is licensed to do business in the State of California, and that the California Insurance Agent's License Number, address and telephone number are as follows:

License Number: _____

Address: _____

_____

Telephone Number: _____

That the following clause may be completed if in fact a non-resident agent for the Surety is a party to the transaction:

Name of non-resident agent: _____

Non-Resident agent's office address: _____

_____

Non-resident agent's telephone number: _____

THE CONDITION OF THE FOREGOING OBLIGATION IS SUCH THAT:

1. The principal has entered into a contract, attached hereto, dated the _____ day of _____, 20__, with CalOptima for **[INSERT CONTRACT DESCRIPTION HERE]**.

2. If the Principal shall well and truly perform, or cause to be performed, each and all of the requirements and obligations of the contract to be performed by the Principal, as set forth in the contract, then this bond shall be null and void; otherwise, it shall remain in full force and effect. In the event that suit is instituted to recover on this bond, the Surety will pay reasonable attorney's fees.

3. As a condition precedent to the satisfactory completion of the contract, the above obligation in the said amount shall remain in effect for a period of one (1) year after the completion and acceptance by CalOptima of the work undertaken pursuant to the contract during which time if the Principal, his or its heirs, executors, administrators, successors, or assigns shall fail to make full, complete, and satisfactory repair and replacements or totally protect CalOptima from loss due to damage made evident during said period of one year from the date of acceptance of the work, and resulting from or caused by defective materials, equipment and/or faulty workmanship in the prosecution of the work done, the above obligation in the said amount shall remain in full force and effect. However, notwithstanding anything in this paragraph to the contrary, the obligation of the Surety hereunder shall continue in effect so long as any obligation of the Principal

remains.

4. Further, the Surety, for value received, hereby stipulates and agrees that no change, extension of time, alteration or modification of the contract documents or of work performed shall in any way affect its obligation on this bond, and it does hereby waive notice of any change, extension of time, alteration or modification of the Contract Documents or the work to be performed. The Surety hereby waives the provisions of Sections 2819 and 2845 of the Civil Code of the State of California.

WITNESS OUR HANDS AND SEALS THIS _____ day of _____, 20___.

_____
Principal
BY: _____

_____
Surety
BY: _____
Attorney-in-Fact

_____
California Resident Agent

By: _____
Non-Resident Agent/Attorney-in-Fact

STATE OF CALIFORNIA) ss
COUNTY OF _____)

On _____, 20___ before me, _____, Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY of PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

Acknowledgment by Surety, as a Non-Resident Agent, as Attorney-in-Fact MUST be attached hereto)

STATE OF CALIFORNIA) ss
COUNTY OF _____)

On _____, 20___ before me, _____, Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY of PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

Exhibit K

Not applicable for this Contract

Exhibit L

LABOR AND MATERIAL PAYMENT BOND

Bond No. _____
Premium _____

KNOW ALL PERSONS BY THE PRESENTS:
That we, _____,
as Principal, and _____, as Surety, are held and firmly bound unto the Orange County Health Authority, dba CalOptima, a California Public Agency, ("CalOptima") in the sum of One Hundred Percent (100%) of the Contract Price pursuant to the agreement between Principal and CalOptima made and entered into on «Effective_Date» for «Project_Description» for the payment of which we hereby bind ourselves, our successor, heirs, executors and administrators, jointly and severally, firmly by these presents.

That the Surety's office is located at _____, telephone number _____, and the Surety is licensed to do business in the State of California, and that the California Insurance Agent's License Number, address and telephone number are as follows:

License Number: _____

Address: _____

_____

Telephone Number: _____

That the following clause may be completed if in fact a non-resident agent for the Surety is a party to the transaction:

Name of non-resident agent: _____

Non-Resident agent's office address: _____

_____

Non-resident agent's telephone number: _____

THE CONDITION OF THE FOREGOING OBLIGATION IS SUCH THAT:

1. The principal has entered into a contract, attached hereto, dated the _____ day of _____, 20__, with CalOptima for «Project_Description».

2. If the Principal, its heirs, executors, administrators, successors or assigns, or subcontractors, shall fail to pay (1) any of the persons named in Section 9100 of the California Civil Code, (2) amounts due under the Unemployment Insurance Code with respect to work or labor performed under the contract, or (3) for amounts required to be deducted, withheld, and paid over to the Employment Development Department from the wages of employees of the contractor or subcontractors pursuant to Section 13020 of the Unemployment Insurance Code with respect to the work and labor, the Surety or Sureties will pay for same in the amount not exceeding the sum specified in this bond. In the event that suit is instituted to recover on this bond, the Surety will pay reasonable attorney's fees and costs of CalOptima as shall be fixed by the court.

3. Further, the Surety, for value received, hereby stipulates and agrees that no change, extension of time, alteration or modification of the Contract Documents or of work performed shall in any way affect its obligation on this bond, and it does hereby waive notice of any change, extension of time, alteration or modification of the Contract Documents or the

work to be performed. The Surety hereby waives the provisions of Sections 2819 and 2845 of the Civil Code of the State of California.

4. This bond shall inure to the benefit of any and all persons, companies, and corporations entitled to claims under California Civil Code Section 9100, so as to give a right of action to them or their assignees in any suit brought upon this bond.

WITNESS OUR HANDS AND SEALS THIS _____ day of _____, 20___.

_____
Principal
BY: _____

_____
Surety
BY: _____
Attorney-in-Fact

_____
California Resident Agent

BY: _____
Non-Resident Agent/Attorney-in-Fact

Exhibit L

Not applicable for this Contract

Member Advisory Committee Update
Board of Directors Meeting
August 5, 2021

On June 10, 2021, the Member Advisory Committee (MAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology.

MAC members approved the committee's FY 2020-21 Accomplishments. MAC members contributed at least 364 hours of service to CalOptima during FY 2020-21, including regular and special MAC meetings, compliance courses, ad hoc meetings, and Board meetings which is equivalent to approximately 45 days. These hours do not include the innumerable number of hours that MAC members dedicate to members on a day-to-day basis.

Ladan Khamseh, Chief Operating Officer, provided an updated on the COVID -19 vaccination events that have taken place at CalOptima in partnership with Orange County Health Care Agency and noted that over 800 individuals received vaccines at the most recent event. Ms. Khamseh also informed the committee that CalOptima had received notice that Centers for Medicare & Medicaid Services (CMS) would be auditing the OneCare and OneCare Connect programs. The audit is anticipated to begin in July and conclude in August and will be conducted virtually. Ms. Khamseh asked Michelle Laughlin, Executive Director, Network Operations to provide an update on the CalOptima COVID-19 Provider Toolkit.

Emily Fonda, M.D., Chief Medical Officer, provided a comprehensive COVID-19 update and updated the MAC on the current vaccine status in Orange County and the gift card distribution for CalOptima members who received a vaccine.

Pshyra Jones, Director, Population Health Management (PHM), provided the MAC with an update on the Department of Health Care Services - Population Needs Assessment Program Annual Update. Ms. Jones reviewed CalOptima's Population Needs Assessment (PNA), which summarizes the results of an annual assessment based on a variety of data, including health and wellness, chronic conditions, specialty programs and quality initiatives. Ms. Jones also updated the MAC on 2021 Member Health Rewards.

MAC members also received a Behavioral Health Update from Edwin Poon, Ph.D., Director, Behavioral Health Services, and a Federal and State Legislative update from Jackie Mark, Sr. Policy Advisor, Government Affairs.

Once again, the MAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the MAC's activities.

Back to Agenda

Provider Advisory Committee Update
Board of Directors Meeting
August 5, 2021

On June 10, 2021, the Provider Advisory Committee (PAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology.

During the June meeting, PAC members approved their FY 2020-2021 Accomplishments. In addition to their 10 annual meetings, PAC members have participated in at least five ad hoc subcommittees and dedicated approximately 465 hours or the equivalent of 47 business days to PAC endeavors.

Ladan Khamseh, Chief Operating Officer, updated the PAC on the vaccination events that were taking place in CalOptima's parking lot. She thanked the Orange County Health Care Agency for its partnership in this endeavor and noted that over 800 individuals had received vaccines at the most recent event. Ms. Khamseh also informed the committee that CalOptima had received notice that Centers for Medicare & Medicaid Services (CMS) would be auditing the OneCare and OneCare Connect programs. The audit is anticipated to begin July 19, 2021 and conclude on August 6, 2021. As part of her update, Ms. Khamseh asked Michelle Laughlin, Executive Director, Network Operations, to review the CalOptima COVID-19 Provider Toolkit that was included as part of the PAC materials.

Emily Fonda, M.D., Chief Medical Officer, provided a comprehensive COVID-19 update, including information on the vaccine status in Orange County and the distribution of the vaccine gift cards for CalOptima members.

Alexander Rossel, Chief Executive Officer of Families Together of Orange County, provided a video and a verbal update of how Families Together has been able to assist CalOptima members during the COVID-19 pandemic.

PAC also received a Federal and State Legislative update from Jackie Mark, Sr. Policy Advisor, Government Affairs.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the PAC's activities.

Back to Agenda

Board of Directors Meeting
August 5, 2021

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

On June 24, 2021, the OneCare Connect Member Advisory Committee (OCC MAC) held its bi-monthly meeting via teleconference using GoTo Meeting Webinar technology.

The OCC MAC members reviewed and approved the committee's FY 2020-2021 Accomplishments. OCC MAC members contributed approximately 234 hours to CalOptima during the 2020-21fiscal year, which included OCC MAC meetings, compliance courses, ad hoc meetings, and Board meetings. These hours equate to approximately 29 days of service to CalOptima members.

Ladan Khamseh, Chief Operating Officer, provided an updated on the COVID-19 vaccination events that have taking place at CalOptima in partnership with Orange County Health Care Agency and noted that over 800 individuals have received vaccines at the most recent event. Ms. Khamseh also informed the committee that CalOptima had received notice that Centers for Medicare & Medicaid Services (CMS) would be auditing the OneCare and OneCare Connect programs. The audit is scheduled to begin in July and conclude in August. She noted that the audit would be conducted virtually. Ms. Khamseh also noted that the CalOptima COVID-19 Provider Toolkit information had been included as part of the OCC MAC meeting materials.

Emily Fonda, M.D., Chief Medical Officer, provided a comprehensive COVID-19 update that included the vaccine status in Orange County for CalOptima members.

Sara Lee, Supervising Attorney Health Consumer Action Center of Community Legal Aid SoCal, provided the Ombudsman Update.

The committee also received an update on CalOptima's plans to transition the OneCare Connect program to the OneCare program on December 31, 2022. The committee also received a Behavioral Health Update from Edwin Poon, Ph.D., Director, Behavioral Health Services, and a Federal and State Legislative update from Jackie Mark, Sr. Policy Advisor, Government Affairs.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

Back to Agenda